



In-Home Therapy Practice Guidelines

CBHI In-Home Therapy Practice Guidelines

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Purpose of the In-Home Therapy Practice Guidelines

These Practice Guidelines detail the components of the In-Home Therapy service and best practice approaches in furtherance of the Children’s Behavioral Health Initiative. The guide is intended to support alignment of In-Home Therapy practice with the values that are important to families, support positive outcomes, and reflect the best intentions and expectations of the Children’s Behavioral Health Initiative (CBHI). The Guidelines reference professional standards, recommended practices, required service components, and quality measures consistent with Wraparound principles. This document is **not** intended to restate what is described in other governing CBHI documents. Also, the Practice Guidelines are **not** intended to substitute for the training, knowledge, and experience of clinical practitioners or to instruct in basic skills of assessment, diagnosis, treatment planning, and practice that are taught in graduate programs and reinforced through in-service training, innovation, and continuing education. The Practice Guidelines address the integration of In-Home Therapy practice in the MassHealth behavioral health system, including best practices for collaboration with other home-based service providers and expectations for assisting families in determining and securing the most appropriate level of care coordination. In-Home Therapy should be delivered with the highest order of family-driven care consistent with the *Wraparound* principles manifested in the Children’s Behavioral Health Initiative.¹ For more information on High-Fidelity Wraparound, see the National Wraparound Initiative website at www.nwi.pdx.edu.

The primary audience for this document is providers of In-Home Therapy (IHT). All IHT providers and their staff should read, reflect upon, and use these guidelines on a regular basis. In addition, the Guidelines may be useful to youth and families in understanding, choosing and evaluating services, and to other stakeholders, including providers of other behavioral-health services and child-service state agencies. We strongly recommend that stakeholders also consult Practice Guidelines for other MassHealth behavioral health services—not just to understand those services, but also because insights from other services may illuminate In-Home Therapy practice.

Many documents, including Performance Specifications and Medical Necessity Criteria referenced throughout the Guidelines, are found in the Appendices section. Many are also available as a resource to providers in the Children’s Behavioral Health Initiative section of the Massachusetts Behavioral Health Partnership website at www.masspartnership.com and on the Commonwealth’s website at www.mass.gov/masshealth/cbhi. Additional CBHI resources described in the Appendices may help IHT providers to better understand IHT services in the context of the Children’s Behavioral Health Initiative,

¹ While Intensive Care Coordination fully implements high-fidelity *Wraparound*, IHT operates in ways that are *consistent with* *Wraparound* principles. ICC offers a process intervention, providing capacity for family and collateral engagement through monthly face-to-face team meetings, frequent and formal communications, a set of required documents, and a clearly structured team process. ICC provides coordination in the most complex situations. By contrast, IHT provides a treatment intervention, addressing the behavioral health needs of the referred child in the context of his/her family, with coordination as a component of the treatment. IHT staff should understand *Wraparound* principles and assess how much formal *Wraparound* process they need to implement, as well as when a family might be better served through ICC.

and the range of other services available to youth and their families. Each provider² agency is responsible for ensuring that all staff working in IHT understand and comply with Managed-Care Entity Documentation Standards, CBHI Performance Specifications, and Medical Necessity Criteria. In all cases, the Standards, Specifications, and Criteria referenced in the Appendices contain the mandated administrative requirements.

We welcome feedback on all the Practice Guidelines to inform future revisions. Please address questions and comments to cbhi@state.ma.us, or call the Assistant Director, Children's Behavioral Health Interagency Initiatives, at 617-573-1791.

The Children's Behavioral Health Initiative

Vision

Massachusetts places the family and child at the center of our state's service delivery system and has a coordinated system of behavioral-health services that meets the individual needs of the child and family. Policies, financing, management, and delivery of publicly funded behavioral-health services are integrated so that families can find and use appropriate services. The system is intended to ensure that all families feel welcomed and respected, and they receive services that meet their needs, as defined by the family.

Mission

The Children's Behavioral Health Initiative is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services, whose mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care to ensure that families and their children with significant behavioral, emotional, and mental health needs obtain services to support success in home, school, and community.

CBHI Values³

- **Child-Centered and Family-Driven**

Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.

- **Strengths-Based**

Services are built on the strengths of the family and their community.

² The term "provider" is used to refer to an agency, program, or general group of clinicians. When referring to a single clinician, the term "clinician" or "practitioner" is used.

³ CBHI values are aligned with System of Care principles, Wraparound principles, and the principles of Youth Development. For Wraparound principles, see <http://nwi.pdx.edu>; for System of Care principles, see http://gucchdtacenter.georgetown.edu/SOC_Framework.html.

- **Culturally Responsive**
Services are responsive to the family's values, beliefs, and norms, and to the socioeconomic and cultural context.
- **Collaborative and Integrated**
Services are integrated across child-serving agencies and programs.
- **Continuously Improving**
Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence, and best practice.

Strategic Priorities

1. Increase timely access to appropriate services
2. Expand array of community-based services
3. Reduce health disparities
4. Promote clinical best practice and innovation
5. Support positive outcomes for children and families
6. Establish an integrated behavioral health system across state agencies
7. Strengthen, expand, and diversify workforce
8. Mutual accountability, transparency, and continuous quality improvement

In-Home Therapy Program Description

In-Home Therapy (IHT) is a structured, strength-based, collaborative, therapeutic relationship between a clinical team and a youth and his/her family for the purpose of treating the youth's behavioral health needs, in a manner consistent with Wraparound principles. IHT works to enhance the family's present capacity to understand the youth's needs and to support changes that promote healthy functioning where the youth lives, learns, works and plays. Interventions draw on youth and family strengths, astute clinical judgment, evidence-based practices, and creative change agents to assist a family in moving toward their preferred vision for their child. Interventions are a collaborative effort to set objectives that build incrementally one upon another to effect change. Successful interventions help children attain developmental, behavioral, relational, and emotional competencies that are the basis for a youth to succeed in family, school, and community life. They build the family's capacity to prevent or reduce the disruptions caused by the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment setting outside the youth's home community. High quality IHT services show youth and families that their experience matters and that the impact of IHT can be a future that is more hopeful than the present.

How the IHT and Therapeutic Training & Support (TT&S) deliver services with families is at least as important as **what** the team does. The “**how**” means that IHT must be delivered in ways that are child-centered and family-driven, strengths-based, culturally responsive, collaborative, integrated, and continuously improving.

- The IHT and TT&S must encourage the youth and his/her parent/caregiver to participate in all meetings regarding the care and treatment of the youth.
- Moreover, the IHT and TT&S must make room, both in family meetings and in larger groups of stakeholders, for careful listening to the family and genuine respect for their experience.
- IHT treatment planning should always show evidence that the family has shaped the plan.
- Strengths as well as needs must be clearly incorporated into assessment and treatment planning as a basis for building positive change.
- During implementation of the plan, the team needs to use specific strengths of both youth and family in real and tangible ways.
- The IHT and TT&S must actively work to understand the overall cultural norms for the family's identified culture, the conditions of their local community, and the specific beliefs and traditions of the individual family.
- IHT must consistently collaborate with other natural supports and service providers who are working with the family to ensure common understanding, draw upon a variety of perspectives, and result in cohesive efforts to achieve outcomes.
- The IHT provider agency must continuously improve the quality and responsiveness of services through high quality supervision, training, outcome data collection, and feedback from children and families.

What the IHT clinician and TT&S staff do is arrive at a clear picture of the referred child's strengths and needs and collaborate with the family to formulate their shared understanding into a thoughtful, proactive action plan that is likely to sustain positive change in the child and family. IHT collaborates with family, other providers, and natural supports to carry out the resulting plan. They join with the family to supplement existing strengths that support the family in finding a path forward through current challenges. Finally, they assist the family in transitioning out of IHT services as changes become self-sustaining. The following example illustrates the course of high quality IHT.

An Example: The Jackson Family

Eight-year-old Jonny, his mother Diane, and stepfather Jim Jackson are struggling with wild, violent tantrums which Jonny throws almost daily and which threaten to injure family members, including toddler Teresa. The parents' stated goal is to stop Jonny's tantrums. The IHT clinician's challenge is to gather enough information from family discussions, observation, past and current treatment, and conversations with collateral helpers to accurately assess the nature (frequency, intensity, duration, and triggering events) of the tantrums, as well as the broader relational context in which they occur and to elicit moments when Jonny and/or his parents have responded somewhat differently in these situations in order to build on those moments and help them develop more proactive coping strategies.

With respect to the former, Jonny can't say why he tantrums, but he "hates" when his stepfather yells at him. Diane and Jim both dote on their daughter Teresa, and when they are "partying," they expect Jonny to mind his sister. Jim says that Diane is too lenient with Jonny, especially when Jonny lets the toddler "get into things." Diane, on the other hand, tries to protect Jonny from Jim's volatile temper. She believes that Jim favors their daughter over Jonny (her son from a previous

relationship). Diane describes Jonny's birth father as "useless." She denies any substance abuse, stating that she and Jim "party" occasionally to "get out of the daily grind."

With respect to the latter, Diane reports that at times when Jonny starts to lose it and she doesn't immediately react, he yells some but then is able to calm himself. She relates that Jonny and Teresa play cooperatively together when Jim or Diane is around and more in charge. When Jim takes Jonny aside and talks with him about why it is important to watch Teresa, Jonny responds well. The IHT clinician notices that when Jim is showing Jonny how to do things, he can be very patient and caring with his stepson, and Jonny listens and takes an interest in what Jim has to say. The clinician also learns that Jim and Diane have been thinking about rejoining a coed bowling league (at a bowling alley where there is no alcohol) that in the past helped them to "get out of the daily grind."

The IHT clinician puts together the information about what has been problematic as well as what has worked or could work well and begins to develop a proactive version of the parents' goal of "stopping Jonny's tantrums." Together, the clinician and family arrive at an overall goal of helping Jonny to master his outbursts by helping Jonny to use words to express distress and helping his parents respond differently to him in the process. They break down this goal into specific, measurable objectives and begin to make a plan to achieve it, depending on both IHT and TT&S to support the family in carrying out the plan.

A place to start is planning to assure everyone's safety at the Jackson home, in particular to protect Teresa from Jonny's violence and to protect Jonny from Jim's "discipline" in response to the tantrums. The safety plan builds on what has already contributed to existing safety and examines what more could be done to strengthen safety for everyone. In this context, the clinician and family focus on helping Jonny to use words for his pain and rage. The plan includes removing Teresa from the room when Jonny seems on the verge of aggression and encouraging both parents to give Jonny a bit of space to calm down, as he has in the past, before they react. Jim is supported in having a conversation with Jonny about his valued role as "big brother" to Teresa. Jim and Diane agree that Diane will be the "first responder" to Jonny if things start to escalate. With this safety plan in place, the IHT and TT&S team moves into ongoing work with the family.

The IHT clinician models with Jim and Diane how to "take five" in response to Jonny's anger, while the TT&S worker practices with Jonny how to use words to express feelings. Meanwhile, the TT&S worker helps to find healthy outlets in the community to enhance Jonny's peer friendships, build on his interest in science, and give him places to go for safety and a sense of self-efficacy. The IHT clinician seeks out psychiatric consultation to evaluate whether medication is indicated for an underlying mental health condition if Jonny's emotional disregulation does not respond to environmental changes.

The IHT and TT&S team also addresses the broader relational context in which Jonny's tantrums occur. Drawing on the shared goals of helping Jonny to express himself differently and helping his parents to respond to him differently, they begin to negotiate the sensitive territory of parental capacity to support Jonny's healthy development. This takes time. The IHT and TT&S prepare together for conversations with the parents that will build on the parents' observations about times

when things have gone better, while they gently but persistently probe issues of leaving Jonny responsible for his sister, favoring Teresa over Jonny, the boy's separation from his biological father, harsh discipline by Jim, and parental drug use as a possible trigger for Jonny's tantrums. The team practices to make sure they are using consistent language to honor the parents' strengths while making room for changes in their parenting.

They prepare together for family meetings with the purpose of building on Diane's desire to see Jonny thrive and to promote harmony in their family and on Jim's pride as a "good husband" to Diane and his ability to be patient and caring with Jonny. They build on the parental reports about times when they have responded to Jonny in a more constructive fashion. They model alternative ways of giving consequences for tantrums. They explore with Jim and Diane the idea of reconnecting to the bowling league as a way of reducing the stress of the "daily grind" without drug use.

The team finds and engages natural supports. Jonny's second-grade science teacher is an important resource, as a man who encourages children's fascination with science and is fond of Jonny. Contacting Jonny's father to assess potential for his role in Jonny's life is essential. Reaching out to these natural supports may be undertaken by the IHT clinician, while the TT&S staff discovers through interactions with Jonny that his grandmother in another state can be a calming influence in phone calls and possible source of respite (Jonny wants to visit for a week or two in the summer). The team helps to find qualified child care to allow the parents to attend AA/NA meetings.

The IHT and TT&S team weathers the ups and downs of progress, adjusting actions to match the weeks when Jonny's tantrums are fewer as well as the times when the situation seems intransigent. They keep in touch with the assembled group of service providers, state agency representatives, and natural supports to monitor progress and relapses. When Jim "spanks" Jonny for a tantrum, they quickly mobilize to adjust the safety planning and leverage the Department of Children and Families concerns into getting Jim to consider substance abuse treatment. When both parents relapse after a few months of being clean and sober, the team shores up the child care resources to make sure that both children are safely cared for and Jonny isn't left "in charge" of Teresa. They revisit the safety plan with Diane and Jim from the point of view of protecting both children from Jim's temper flares when using substances.

Months later, when the family, the IHT and TT&S, and external supports agree that Jonny's tantrums are consistently fewer and less intense, and that Diane and Jim, with support, are able to provide a satisfactory environment for Jonny, they begin the process of gradually tapering off their intervention. Together they test whether the family and natural supports can continue with greater autonomy to help Jonny manage his distress, as the distress itself becomes less acute. They expect setbacks and help Diane and Jim to recoup without losing hope. IHT steps out when the family has shown that they can continue to support Jonny's improved behavior and emotional state, relying on themselves, their natural supports, and lower intensity services.

The detailed example above describes one situation in which a strengths-based, child-centered and family-driven approach to IHT incorporates the principles of *Wraparound*. Clinical expertise, as demonstrated in this example, is rooted in the ability to build relationships with the family members by maintaining a nuanced, appreciative, and thoughtful stance in relation to their individual situation. This collaborative, respectful approach (the “how”) brings to life the structured process of assessment, diagnosis, treatment planning, and ongoing intervention/therapy (the “what”).

Core Elements of IHT: In-Home Therapy may be delivered by a clinician working alone or with the team approach that includes Therapeutic Training & Support (TT&S). A typical core IHT⁴ team includes a primary, licensed clinician and qualified, professional support staff, unless the family requests a solo clinician, or there are compelling reasons, approved by the family, to deviate from the team approach. *When a single clinician provides the IHT services, all functions of coordination, skill-building, gathering of resources, and other supports must still be done; the clinician becomes responsible for all components of the service.* Together, the primary clinician and support staff offer a flexible combination of medically necessary Family Therapy and Therapeutic Training & Support. The clinical focus of the therapy is to ameliorate the youth’s mental health issues in the context of family, while Therapeutic Training & Support assists the family to strengthen structures and supports for the youth. These two parallel functions of clinical and support work comprise the In-Home Therapy service.

In-Home Therapy is distinguished from traditional therapy in several ways.

- The full IHT team always includes family members as well as the IHT clinician.
- IHT services are delivered primarily in the home and community, rather than in an office.
- The IHT service uses a team approach, unless the family prefers a single clinician.
- Services include 24/7 urgent response capability by the provider.
- The frequency and duration of a given session matches the needs of the youth and family rather than a prescribed length of time or number of sessions.
- Scheduling of appointments is flexible and responsive to family considerations, such as school and family work hours. Evening and weekend hours must be arranged when traditional business hours are a barrier to family access.
- IHT providers are required to identify natural supports that can help to carry out the intervention and maintain improved functioning after the IHT service ends.
- IHT must coordinate care among the service providers, community resources, and natural supports (as appropriate) that are engaged with the family.

If a family declines ICC, or ICC is not Medically Necessary, and IHT has been selected to serve as the hub provider, the IHT team or clinician must assume the following care coordination responsibilities.

- Developing a comprehensive, integrated treatment plan which supports and guides the work of hubdependent providers;

⁴ Hereafter, the term “core IHT team” used here refers to the IHT clinician and TT&S staff working together; family members who comprise the full team are noted as “family.” When other formal providers, natural supports, or system representatives are collaborating with the core IHT team, this will be noted as a “full team” or other references to additions to the core team.

- Contacting hub-dependent providers on a regular and frequent basis to solicit updates and monitor progress towards the goals of the treatment plan (Note: in times of crisis or increased acuity for the youth, or when multiple hub-dependent services are involved, weekly or more frequent contact with hub-dependent services may be necessary to ensure effective care coordination.);
- Completing required service authorizations for hub-dependent providers;
- Maintaining regular contact with other behavioral and physical health providers (with consent of the family) and coordinating their participation in the treatment planning process;
- Including state agencies in the development and ongoing monitoring of treatment and safety plans, with consent and when involved with the youth and family;
- Providing support and assistance in working with special education providers and integrating the delivery of school and home-based services with appropriate consent;
- Convening regular team meetings when necessary to promote effective coordination of services, clarify provider roles, assess the effectiveness of interventions and modify service and planning goals as needed; and
- Leading the coordination of transition plans for youth who experience short term crisis events or out-of-home-placements.⁵

If at any time IHT providers are unable to perform these functions, or to ensure the intensity of care coordination required by a youth and family's situation, a referral should be made to ICC.

In-Home Therapy will look different for each family, as the service is customized for the specific strengths and needs presented by each child and family. The IHT clinician, in collaboration with the youth and family, assesses needs and strengths, develops an understanding of the family's culture, works with the youth and family to select treatment goals and objectives, and helps the family carry out actions that have been collaboratively identified to reach their goals. The team may work with or without additional CBHI services. IHT may focus on enhanced problem solving, limit setting, risk management/ safety planning, communication, building skills to strengthen the family, and/or identifying and connecting to community resources. It always includes coordination with other providers and fostering natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains.

Therapeutic Training & Support (TT&S) staff support implementation of the In-Home Therapy treatment plan, as the youth and family move toward their preferred ways of being. TT&S is not available as a stand-alone service. No single formula divides the responsibilities between TT&S and the IHT clinician. Interactions with family members will vary depending on personalities, skills, and knowledge of the two staff and their affinity with the family member needs. In general, the clinician will lead in areas that depend on clinical training, while TT&S plays a supporting role. The constant in all cases is effective teamwork, beginning with a thorough understanding of and appreciation for Wraparound principles, and carried out through: timely communication of important new information,

⁵ These and other IHT responsibilities are described further in [Appendix G: Working with Hubs and Other Services](#).

regular sharing of observations, collaborative planning, focus on measuring progress in cogent, meaningful ways, and equitable division of tasks of the work.

Guided by the IHT treatment plan, the TT&S worker may teach the youth to understand, direct, interpret, manage, and control feelings and emotional responses to situations. For example, in Jonny's case, the TT&S could practice language with Jonny and help the parents keep count of successful handling of Jonny's outbursts. In another instance, a TT&S staff might work with a young adult to build skills of self-care and independent living (taking medication on time, planning for a work schedule, using meditation instead of illegal drugs). A TT&S worker might help parents/caregivers to practice and generalize the concrete actions, including communication skills, that they can take to respond safely and effectively to critical behavioral or emotional situations. The TT&S staff also help the family to seek out and use community resources and to build networks of support.

IHT services may be provided in any setting where the youth is naturally located, including, but not limited to, the youth's home (including foster homes and therapeutic foster homes), schools, child care centers, respite settings, and other community settings. By participating in the youth's environment, the core IHT team can more fully understand the context around the resources and challenges at work in a youth's life. In-Home Therapy services may take place in the provider's office or another determined location, convenient to the youth and family, only by family request or when there are immediate, specific concerns about safety at the home.

Finally, IHT providers participate in the service area's System of Care Committee (SOC), which works at a system level to promote collaborative problem-solving around barriers to services, scarce resources, enhanced coordination among school systems, state agencies, and providers, and other regional concerns. The System of Care Committee is hosted by the local Community Service Agency and invites participation across the system, including representatives of state agencies, school districts, Courts and Probation, all CBHI service providers, hospitals and other 24-hour levels of care, medical practices, Managed-Care Entities, family members and young adults, and the wide array of community resources.

An especially important function of the SOC is to promote relationships among different resources in order to benefit children and their families. For example, a core IHT team can build a cordial relationship with the representative from the community hospital that serves children in psychiatric crisis, clinicians from the Mobile Crisis Team, school adjustment counselors in area schools, and several of the juvenile probation officers. These connections made at the SOC remind everyone of the shared mission and facilitate communication when a youth requires quick response and shared responsibility between IHT and one of these collateral organizations.

Culturally Relevant Practice

The Children's Behavioral Health Initiative requires that all services are provided with the greatest possible cultural relevance to the children and families in need. Cultural relevance is best manifested in truly multicultural agencies that welcome diversity at all levels from the first phone call to the last document at discharge. Cultural relevance means respectful consideration of differing cultural values

and life experiences of the youth, family, school, and other providers. This includes, but is not limited to, recognition of economic status, gender, sexual orientation, ethnicity, race, language, and the unique values and goals of each youth and family. Culturally relevant services draw upon the strengths of these values and experiences in developing a comprehensive plan of care. At minimum, in developing culturally relevant practice, providers must make every effort to recruit staff that represent the diversity of the youth and families served, and to deliver services in the primary language of the youth and families, including sign languages.

Culturally relevant practice is an ongoing learning process which respects the dynamics arising from cultural and linguistic differences in planning and delivering services to diverse populations. Culturally relevant practice is committed to the following:

- Importance of cultural awareness
- Sensitivity to cultural diversity brought by a variety of factors including ethnicity, language, lifestyle, age, sexual orientation, and society status
- Bridging linguistic differences in appropriate ways
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Adaptation of services to meet the specific cultural needs of the consumers
- Access to non-traditional services
- Using established protocols to pass on referrals to colleague providers with American Sign Language (ASL) and other language capacity, as needed

In-Home Therapy providers will utilize the strengths of all in order to provide effective services, and providers will seek consultation and additional services when necessary to overcome barriers to the delivery of care.

The following describes provider responsibilities regarding cultural responsiveness.

1. The program provides services that accommodate the youth, consider the youth's family and community contexts, and build on cultural strengths to meet the youth's behavioral health, social, and physical needs.
2. Program staff have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. Program staff have the ability to translate their awareness into actions that fit their proposed interventions to the family culture. Program staff, supervisors, and administrators seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care.
3. The provider ensures access to qualified staff to be able to meet the cultural and linguistic needs of all families served in their local community.
 - a. Providers ask the family's language of choice.
 - b. Because staff with linguistic capacity is **by far** preferable to interpreters, providers offer the youth a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so.
 - c. The provider has access to qualified interpreters and interpreting services that are experienced in behavioral health care and appropriate to the needs of the local

- population served. In case the program must seek interpreter services outside of the agency, it must maintain a list of qualified interpreters to provide this service or utilize interpreter referral agencies that identify and refer interpreters qualified to interpret in the needed languages.⁶ Interpreter services are provided at a level which enables a youth to participate fully in the provider's program.
4. To support and maintain the integrity of the therapeutic relationship, when interpreting services are needed to provide access to services, providers will make every effort to use the same interpreter for all service encounters with the family. Documentation must be made available in the family's primary language when requested, including discharge documents. For languages that do not have a written form, such as ASL, the provider must ensure that the family understands written information when it is provided. This may mean working with a qualified interpreter to interpret the written information for the family.
 5. Programs must provide ongoing, in-service training that includes cultural competency issues pertaining directly to the client population served.
 6. Programs include cultural accountability in their ongoing quality assessment and improvement activities. Providers strive to become truly multi-cultural organizations with diversity at all levels of the organization, policies which promote inclusion of the spectrum of differences (including race, ethnicity, religion, sexual orientation, disability communities, and others), and ongoing efforts to build cultural relevance through training, reflection, team-building, and shared celebrations.

In-Home Therapy Operations

This section describes the stages of typical, high-quality In-Home Therapy, with particular attention to the nature of interactions between the IHT provider and family in each phase.

A. Referral

Referral Sources: A referral for In-Home Therapy may come from any one of a variety of sources. Families are welcome to request services themselves. School personnel, state agency workers, Court personnel, hospital discharge staff, physicians, day care providers, residential programs, outpatient clinicians, and other community resources all may recommend IHT services to families and/or make a referral for a family. Frequently, referrals will come from the Intensive Care Coordinator or Family Partner of a CSA already working with the family or from the Mobile Crisis Intervention clinicians in the area in response to a psychiatric emergency.

Response: Decisions that support engagement start with the referral process. When a family member calls (say, Mrs. Sanchez), a live person answering the call is more responsive than a machine. Offering

⁶ To locate a qualified ASL interpreter, providers can contact the Massachusetts Commission for the Deaf and Hard of Hearing www.mass.gov/eohhs/gov/departments/mcdhh/request-an-interpreter.html, or 617-740-1600 VOICE and 617-740-1700 TTY) and Partners Interpreting (www.partnersinterpreting.com/ 508-699-1477 VOICE and 508-809-4894 VP).

the Sanchez family a face-to-face appointment to initiate services within 24 hours, guided by the Sanchez family preference for time and place, sets the space for engagement. When a referral comes from a non-family source, the IHT provider must contact the family within 24 hours of the date of referral. Quick response demonstrates to the family that the IHT provider is ready to hear their concerns and treat them with appropriate urgency.

Immediate response is especially important when a youth has just entered, or is about to leave, 24-hour level of care, such as a Community Based Acute Treatment program or psychiatric hospital. The stays tend to be very short, the child and family very distressed, and the turnaround time very tight for meeting with hospital staff. Responding with urgency to these situations allows the family to see the gravity with which their situation is understood, and it gives the core IHT team and family a chance to start the work of safe reunification as early as possible in the hospitalization. The core team must do everything in their power to initiate and/or attend a discharge meeting from the acute treatment setting. (An established, ongoing relationship with the acute care setting facilitates this process.)

Availability: Provider agencies must be available to accept referrals 24 hours a day, seven days a week. While provider agencies have different ways of managing referrals, a good practice is to have one point of access —a coordinating clinician or Coordinator—who manages the referral process with the authority to assign new referrals to staff, based on the presenting clinical needs, cultural factors, and family preference. Back-up clinicians are available to cover the 24-hour response requirement as well as vacation, holidays, and other times.

The Coordinator (as determined by each provider) is responsible for ensuring that a youth meets the Medical Necessity Criteria for In-Home Therapy (see [Appendix D](#)), is age 20 or younger, and has the correct, current MassHealth insurance product to cover the service. The Coordinator should have a clearly defined rationale for how the IHT service will help resolve current needs. The first and most important criterion for IHT is that the parent/caregiver (for children aged 17 and younger) and youth—or youth alone, if between age 18 and 21—agree to participate in the voluntary service. In general, as in the case of Mrs. Sanchez and her son Luis, these eligibility determinations are made in the first phone contact with the family.

Also in the initial contact with the Mrs. Sanchez, the Coordinator gathers basic information and provides Mrs. Sanchez with clarity about next steps. In best cases, the Coordinator will consult with the Sanchez family about preferences for the clinical team. For example, Mrs. Sanchez may request an expert in substance abuse for Luis, or an individual with whom the family worked in the past, or a Spanish-speaking team, and the Coordinator will be able to give name and contact information for the preferred clinician right away. When this is not possible, the Coordinator lets Mrs. Sanchez know that an assigned clinician with the family preferences will be calling by the end of the day to offer the Sanchez family an initial appointment.

In assigning an IHT clinician to work with a family, the provider agency must make every effort to match **both** the clinical expertise that best serves the youth **and** the linguistic and cultural preferences of the family, as far as known at the time of referral. This requires respectful consultation with families to override possible assumptions about what might be best and a candid assessment of the provider's

scope of specialty knowledge. Is there a substance abuse expert on staff to work with Luis Sanchez? Or, in other situations, a clinician trained to work with trauma survivors, autism spectrum disorders, and so on?

Wait Lists: If the provider agency (Agency X) is unable to offer quality services within the established time frame, the Coordinator is responsible for assisting the family in finding another provider with immediate capacity, or, if the family chooses, placing them on the Agency X wait list. The Coordinator must make clear to the family that they have a choice of other providers who have openings. If the system has no immediate capacity, the family decides whether to wait for an opening with Agency X or to wait for the first available IHT provider. In either case, the Coordinator must make clear what assistance he/she can give, who will make the follow-up calls, and how the family will be kept informed of their waiting status. The IHT provider is expected to check in weekly with the family to see if the family is still waiting or has started services with another provider.

In the interest of high-quality care, the IHT Performance Specifications (see [Appendix C](#)) mandate that all referrals to IHT – whether immediately served or waiting for services – are recorded and tracked on an IHT Referral Log/Waitlist spreadsheet (see [Appendix L](#)). IHT providers may use the sample Referral Log/Waitlist provided by the Managed-Care Entities, or a similar mechanism of their own design for tracking this information. (For further information on Waitlists, see [Appendices J](#) and [K](#).) The waitlist requirements allow the Managed-Care Entity to note where practice expectations are being met and where changes are needed to match demand for services.

The Children’s Behavioral Health Initiative Clinical Pathways grid (see [Appendix F](#)) was developed to assist providers and referral sources, in collaboration with families, in choosing the most appropriate Hub service based on the individual strengths and needs of a youth and his/her family. As noted within the grid, the responsibility for care coordination lies with the most intensive Hub service that the youth is receiving: Intensive Care Coordination, followed by In-Home Therapy and Outpatient Therapy. At the time of referral, the IHT Coordinator and/or clinician must make the care coordination options known to the family and support an informed decision about the appropriate level of service with the understanding that level of service may change as the services proceed. The IHT Coordinator also must make clear that IHT can begin as an interim service while the referral to ICC and its treatment planning process is underway.

B. Intake

Administrative Process: The administrative process, which is commonly known as “intake,” occurs at the start of services and consists of giving a family (say, Jessie Smith and her family) sufficient information for them to understand the scope of IHT services and obtaining from the Smiths their consent to proceed with treatment. There are forms to be read and signed, client rights to be reviewed, confidentiality and its exceptions to be explained, and permissions granted. This process can be overwhelming for a family in crisis. It may take one or more initial meetings with the Smiths to complete the intake. A talented core IHT team will use these “dry” administrative tasks to begin a positive engagement with the family. The conversations set the tone for how the core IHT team will listen to the Smiths and whether the Smiths will feel that their concerns matter.

Engagement: The core IHT team will listen with patience and sensitivity as Mr. and Mrs. Smith describe their stressors, perhaps in hectic language that reflects the chaos that they are experiencing, at times interrupting the flow of required paperwork. A parent at “the end of her nerves” over a child’s struggles is not likely to relay or take in information in an organized manner. Or, Mrs. Smith may be a parent who “looks good” with the IHT clinician; however, as one parent put it, “just because a family looks good doesn’t mean they aren’t desperate.” A youth in a fragile emotional state will have a hard time sitting through a long meeting. The core IHT team should be prepared to manage the intake in stages that match the Smiths’ state. It may take more than one meeting to complete the intake business. The team approach allows separate conversations between the child and the parents, when indicated by the child’s presentation or family preference, with the two IHT staff effectively holding parallel meetings.

As part of intake, the IHT staff review information about IHT services, even if the Smiths were given information at the time of referral, to clarify any remaining questions. The intake blends with the start of the Comprehensive Assessment process as the core IHT team gathers required consents, addresses Jessie’s immediate safety concerns, and begins to understand the strengths and needs of Jessie and her family. Standard best practice is to discuss school behavior and achievement and obtain consent for contact with Jessie’s school personnel as promptly in the intake process as possible.

There is no requirement related to the use of standardized intake forms. However, IHT intake must document behavioral and other health care information that may impact overall treatment planning. Documentation of relevant medical information (*i.e.*, pre-existing medical conditions, food allergies, asthma, prescribed medications, preferred medical providers, most recent physical) is guided by the documentation requirements in [Appendix E](#). Additionally, In-Home Therapy providers must document that the family (or legal guardian), or the young adult (or emancipated youth), has consented to IHT. While written assent⁷ by a youth age 17 or younger is not legally required, it is strongly preferred as a means of building engagement with the youth.

C. Assessment

Basic Requirements: The In-Home Therapy team completes an initial clinical Assessment within 24 hours. There is no specific requirement regarding the format of this initial document. Its purpose is to set the IHT work in motion with clarity about the family’s goal for the future, what helps, what gets in the way, and what to do next. One recommended method for completing an effective, initial assessment is to use the “Collaborative Helping Map” outlined here and more fully discussed in [Appendix P](#).⁸ The initial assessment is simple and concise and sketches a map of the work to be done.

⁷ “Consent” refers to the legal requirement that providers obtain written authorization to proceed with treatment; “assent” is not required but indicates a youth’s willingness to participate and is best practice in engagement.

⁸ The volume *Collaborative Helping: A Strengths Framework for Home-Based Services* by William C. Madsen and Kevin Gillespie (Wiley, 2014) offers possibilities for a family-centered framework for helping that applies equally to support staff and clinicians. Chapter 3 provides additional detail on “Mapping.” The chapter is summarized in [Appendix P](#).

It is based on conversations with the family in the first few days of contact. The key questions to answer in the initial assessment are

- Where would you like to be headed in your life? (Vision statement)
- What gets in the way? (Needs, challenges, obstacles)
- What helps you get there? (Strengths, supports)
- What needs to happen next? (Prioritized needs, plan)

The initial assessment is followed by a complete Comprehensive Assessment due in 14 days. Through structured, attentive conversations with family members, the IHT clinician develops a well-rounded understanding of the youth at the center of the In-Home Therapy service. This includes his/her relevant history, health, life experiences, impact of past trauma, successes and challenges, interactions with family and peers, the needs that have brought the youth and family to IHT, and the vision that they have for a preferred future.

A completed Comprehensive Assessment includes, but is not limited to, presenting concerns; medical history; psychiatric history; substance use history; developmental history; allergies/adverse reactions; medications; risk assessment; mental status exam; child and family strengths; clinical formulation; and DSM V diagnosis. The full Assessment must include available, relevant assessments and evaluations from prior/current providers (with written consent from the family), as well as clinical observations gleaned from talking with family members, meeting in the family home, and interacting with the youth. To the extent these assessments are unavailable or outdated, the IHT will assist the family in identifying areas where additional or specialized consultation is needed, making arrangements for those evaluations to occur, and incorporating relevant clinical recommendations into the treatment planning process.

A typical assessment is heavily weighted towards the problems that demonstrate medical necessity for treatment. A brilliant assessment balances attention to the presenting problems with evidence of times when the youth/family has managed the problems effectively and a statement of the future that the family prefers over the current situation.

In addition to this strengths and needs discovery, a central purpose of the initial clinical Assessment is to determine the youth's need for other CBHI services, the involvement of any State Agencies, the need for integration of behavioral health and special education supports, and the extent to which the youth needs or receives services from multiple providers. This information will assist the IHT in determining, at the earliest possible stage, whether the youth and family is presenting with a need for both IHT and a more intensive, team-based wraparound service.

Family-centered purpose: While the program-centered purpose of these early conversations is to gather information for the required initial Assessment, the family-centered purpose is to build a therapeutic relationship that establishes provider credibility and mutual accountability. The family learns that the clinician can listen to their strengths and needs in a nonjudgmental way and that the core IHT team can work collaboratively with the family to blend existing strengths with helpful interventions. The family conversations that inform the Comprehensive Assessment occur in the youth's home or other location where the youth and family are comfortable, interactions are likely to

be natural, and the conditions of the family's environment are evident. The quality of the therapeutic relationship established in these conversations may be the most significant factor in the subsequent family engagement and treatment of the child's behavioral health challenges.

Rewrites: Because the Assessment is a living document, a comprehensive, home-based, behavioral health Assessment will change over time and must be reviewed at minimum every 90 days. Disclosure of new information – as trust builds between the family and the core team, or changes occur in a child's circumstances or behavior – requires revision of the initial Assessment. The clinician may decide to add information, such as a genogram, to clarify the Assessment. Consultations with a child psychiatrist, consulting psychologist, and/or clinical supervisor are valuable perspectives in building a full Assessment. IHT is likely to receive clinical documents from former providers or new information from collateral sources (such as schools or pediatricians) outside the 14-day initial window for assessment. These need careful consideration to determine their current relevance and accuracy and should not simply be added to the Assessment at face value. Important changes in the understanding of a child and her family that may result in a change in diagnosis or treatment planning warrant revisions to the Assessment as soon as the changes come to light. These should not wait for a 90-day review.

A quality Comprehensive Assessment clearly documents enough information so that a person who is not familiar with the situation could form an accurate picture of the child and family's current strengths and needs, the behavioral health conditions that require treatment, and the family circumstances that are affecting those behavioral health concerns. Regular, clear communication between a two-person IHT team ensures that information presented to either individual appears in the Assessment updates.

Strengths: The Assessment must include evidence of child and family strengths. A sophisticated Assessment will do more than list a child's interests in the "strengths box." While "Joe plays basketball" or "Jenny likes arts and crafts" are a sketch of strengths, a best-quality Assessment will expand on the ways characteristics that show resiliency and potential capacity are embedded in these interests. For example, "Joe plays basketball" suggests that Joe is able to interact productively with peers, function as part of a team, and take direction from a coach. These are valuable strengths across many life domains. A simple response, such as signing Joe up for a community basketball program, may miss crucial opportunities to help Joe recognize, practice, and transfer the underlying capacities to, say, taking direction from his math teacher, or cooperating as a team player at home. Similarly, Jenny's interest in arts and crafts may indicate powers of self-expression and an ability to channel emotions into creativity, which can serve her well in other aspects of life.

Culture: Excellent Assessments also address family culture, including racial, linguistic, and ethnic background as well as specific family culture and beliefs. Since family cultures are nuanced and unique within larger categories, it is insufficient to describe a family's culture as "Hispanic" or "Chinese"—or even as "Puerto Rican" or "Taiwanese." In addition to establishing racial, ethnic, and linguistic identity, clinicians need to ask gently about beliefs, traditions, and language. Religious beliefs also play an important role in some families and may influence treatment choices. Especially important are questions to help guide treatment options by inquiring about the following.

- Definitions of family (Whom do you consider to be family, immediate family, extended family?)
- Family dynamics (When does your family get together? What does your family typically do together? Who is the primary decision maker, caregiver, bread winner? Which family members seem to get along best, have most difficulty?)
- Beliefs about health and sickness (How do you know when your child is healthy? When your child is sick, what has worked to help her recover? How would you know if someone in your family had a mental illness?)
- Spiritual considerations (What spiritual practices affect your family's choices?)
- Concerns about privacy (With whom do you share personal information about your child or family?)

The CANS contains six questions probing “Cultural Considerations.” These questions were developed by a panel of clinicians, including those with recognized expertise on the role and impact of culture in behavioral health assessment and treatment.⁹ The Cultural Consideration questions explore such issues as the strength of a child’s cultural identify, the child or family’s experience of discrimination, and whether or not there are cultural differences within a family.

The core IHT team members need to examine their own cultural identities in relation to the youth and family. For example,

- What privileged status might I hold in relation to this family because of my race or ethnicity?
- Can I accept and support family roles that are much more, or much less, traditional than my own?
- How do my beliefs about mental health align or conflict with those of this family?

IHT staff need to be especially open to realizing that the white, Eurocentric, professional mental health culture tends to categorize, diagnose, medicate, and treat behavioral health “disorders” in ways that are profoundly different not only from many non-Western cultures but even from large segments of the American population with white, European backgrounds. Acknowledgement of one’s own biases is at least one half of cultural responsiveness and accountability.

CANS: As part of the Comprehensive Assessment, the IHT clinician must complete the Massachusetts CANS, including both rating and narrative detail, to cover the spectrum of domains in a youth’s life over the past 30 days. The CANS provides guiding questions to incorporate into the assessment of a child and family’s current situation. The CANS establishes consistent, standard, statewide criteria for recording client data to simplify communication among treatment providers (at a practice level) and allow for meaningful aggregate data (at a system level). The CANS is not intended as a “check off” list but rather as a way to identify and prioritize needs while recognizing strengths. This process creates a

⁹ CBHI Cultural Considerations Work Group: Roxana Llerena-Quinn, Ph.D, Co-Chair; Sara Trillo Adams LMHC, Co-Chair; Silvana Castenada, MSW; Jesse Tauriac, Ph.D.; Victor Griffiths, LMFT; Hannah Karpman, MSW, Ph.D.

common language for both families and providers to communicate during the Comprehensive Assessment and over the course of care.

Administration of the CANS should prompt IHT providers to assess the youth and family's need for other CBHI services, including Intensive Care Coordination (ICC). For many youth and families IHT clinical interventions are required in addition to the intensive wraparound, team-based planning process provided by ICC. The CANS requires IHT providers to evaluate the youth's need for ICC and other home-based services and to make referrals with consent. The CANS also supports communication with other service providers who may become involved at the youth and family's request.

The CANS alone does not constitute a Comprehensive Assessment. However, all of the information required for the CANS is embedded in the conversations that lead to the Comprehensive Assessment. Regardless of other amendments which may occur after the initial Assessment, the IHT clinician must update the CANS at a minimum of every 90 days from the last changed CANS.

The provider must document completion of the CANS in the Virtual Gateway. If the parent/caregiver consents, an IHT staff enters the full CANS into the Virtual Gateway. If the parent/caregiver does not consent to have the full CANS entered on the Virtual Gateway, then the In-Home Therapy clinician completes the CANS on paper and documents this in the Virtual Gateway along with demographic data and SED status. Gathering standardized data in a systematic way helps the Children's Behavioral Health Initiative to monitor the state of children's behavioral health in Massachusetts, learn from successes, and look for possibilities for improvement.

D. Risk and Safety Planning (Safety Plan)

Basic Requirements: Risk and safety planning begins in the first meeting with the child and family. The IHT clinician who is conducting the intake exercises judgment over when the Safety Plan documents must be completed and/or revised, based on direct questions, observations, other existing plans, and family preference. For example, if the IHT service was initiated by the Mobile Crisis Intervention (MCI) team after a psychiatric emergency, MCI should have provided the initial Safety Plan that was drafted during the crisis response. The core IHT team will address safety with the family, using the existing plan while monitoring for changes that may require adjustment over time. For youth involved with Intensive Care Coordination, there is likely an ongoing Safety Plan that can be reviewed with the family to guide risk prevention and safety responses.

If IHT begins with no previous plan, the IHT clinician will collaborate with the family to create a Safety Plan no later than 48 hours after the start of services. Regardless of who created the plan, if a family calls their core IHT team, IHT is responsible for assisting in a safety crisis and helping the family to access the MCI service, if needed.

The core IHT team plans for safety in partnership with the youth and family. Together, they assess the signs of safety in the family, the likelihood of their child experiencing a psychiatric crisis, the capacities of family members to avert or take action in a crisis, and the risks of a crisis escalating beyond their

control. A Safety Plan is not a list of services. It is a proactive plan for actions that a parent/caregiver, youth and other natural supports can take to prevent crisis, to reduce the severity of a crisis, and to respond effectively in the event of a full-blown crisis.

Family Strengths: A Safety Plan must incorporate individual and family strengths that can be brought to bear in an escalating encounter. The plan specifies factors that may trigger a crisis and prompts for early intervention. For example, heated arguments with his single-parent father tend to trigger Josh's angry and sometimes aggressive outbursts. Josh likes listening to music. When Josh and his father succumb to a yelling match, a diversionary action that Josh can take is to withdraw to the sanctuary of his room and listen to music. His father can take actions that support Josh's relaxing with music, such as leaving Josh alone until he is calm (even if he slams a door or the music is too loud), or stepping outside for air. In another situation, a favorite aunt or babysitter might be "on call" to talk on the phone with young Clara when she needs soothing to prevent becoming disconsolate. The action for the caregiver is to call the designated adult and hand the phone to Clara. The best work of IHT includes practicing the interventions, modeling the "stepping away" from an argument with Josh, rehearsing what to say to the aunt when Clara needs soothing, and helping parents to feel confident to intervene early.

Emergency Response: The IHT clinician's contact information and the provider agency's 24-hour emergency service number must be part of the Safety Plan, as is the contact information for ICC when Intensive Care Coordination is involved. The area's MCI emergency number and the local police number (911) are always included in the event that a crisis is not averted by the family's earlier stages of intervention (including calling on IHT or ICC resources), or in cases where an emergency occurs without preamble and one or more individuals are at imminent risk of harm. The IHT clinician and family should discuss the situations in which Mobile Crisis is the best first option and those serious, high-risk incidents when seconds count that require a police response. A thoughtful, well-developed Safety Plan **never** suggests calling the police or the MCI team, or going to a hospital emergency room, **as the only step**.

Best Practices: An IHT response to a crisis typically happens when the family is trying the early stages of crisis prevention that are suggested in the Safety Plan. In one situation, a parent (say, Mary Connelly) has lost confidence in the approaches that have worked in the past. She is afraid that her teenage daughter's emotions are escalating beyond Mary's present capacity. Mary calls the emergency number for the IHT clinician. The clinician listens calmly and coaches Mary through trying the steps of the planned response, helping her to stay focused. At another time, if safety permits, the trusted clinician is available to go to the family's house and coach Mary in person, as she practices helping her daughter master her provocative behavior. This on-the-spot coaching may be the most important intervention that an IHT clinician can do, as the IHT clinician sees in person the challenges that Mary is facing, adjusts the response to account for unexpected details, and helps to build Mary's confidence in her ability to avert a crisis. Mary and the IHT clinician can see together if the situation is spiraling out of control, when the risk calls for higher-level intervention, how quickly help arrives, and how the subsequent crisis team response affects Mary, her daughter, and any other family members.

Safety planning can be a sophisticated, therapeutic intervention in itself. In one situation, an 18-year-old Manuel and his mother were dealing with two parallel risks of crisis: a psychiatric emergency brought on by Manuel's depression (clinical crisis), and the risk of arrest if Manuel was seen associating with a certain criminally involved group of peers (legal crisis). The IHT clinician and family created two Safety Plans, one for each type of emergency with different actions for each. Both plans, in Spanish and English versions, were organized into packets (for example, phone contacts for the probation officer and immigration papers in the legal crisis file, and the number for a Spanish-speaking, on-call clinician and prescription information in the clinical file) and hung on the refrigerator door. They served as a daily reminder to Manuel's mother that she – even with limited English and undocumented status – could be an important help to her adult son in each emergency, and Manuel had visual evidence every day of his mother's and team's commitment to his safety across domains.

Other Tools: The In-Home Therapy team uses the Safety Plan and/or other Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families in [Appendix H](#)) to document both the precipitants to risk and the range of safety measures. If a Safety Plan has been created by the core IHT team, they must give a copy of the Safety Plan to those providers, with appropriate family consent, that are supporting the youth and family. The IHT provider must work with the youth and family and others to update the safety plan as needed—*i.e.*, upon Mobile Crisis Intervention, discharge from 24-hour levels of care and at the time of transition from IHT or other services, and disseminated accordingly to all those involved.

The Safety Plan is required for use by IHT, ICC, and MCI providers, unless the family declines and this is documented clearly. The other tools (listed above and in [Appendix H](#)) are optional, but utilization of these tools promotes consistency across levels of care, particularly in those instances where a youth is involved with both IHT and ICC.

E. Care Coordination

Considering Levels of Care Coordination: As part of the Assessment and treatment planning process, IHT practitioners make informed judgment in partnership with the family about whether a higher level of intensive care coordination (ICC) is indicated, both at the start of services and when the family situation changes. ICC should be considered when

- one or more state agency is working with the family;
- new state agency involvement begins;
- two or more treatment providers are involved;
- Special Education services need to be integrated into the treatment plan;
- treatment of complex physical health issues need to be integrated into the treatment plan;
- two or more plans of care are duplicative or conflicting; or
- the family is confused by multiple treatment or “service” plans.

If, after consultation with the family (say, Tim Clark and his parents), the IHT clinician makes a referral to the area CSA for ICC, IHT is responsible for facilitating access to CSA services (ICC and Family Support & Training (FS&T) aka Family Partner). The Clarks may be reluctant to engage with the CSA for fear that they will need to “start all over” with a new team. The core IHT team should offer reassurance that this is not the case, and that IHT will manage the care coordination transition in a seamless manner, with minimum “re-telling” of the Clarks’ story, and only the necessary adjustments to team composition, all without missing a beat in treatment.

If the Clarks make an informed decision to decline ICC services and IHT is chosen as the hub provider, the IHT clinician starts the care coordination by identifying other current treatment providers, relevant prior providers, and other systems (for example, school or state agency) that impact the child and family. With caregiver consent, the IHT clinician gathers available clinical documents and/or speaks with prior or current stakeholders to pull together different perspectives. Talking with a school adjustment counselor yields some insight into Tim’s functioning at high school, the record from a prior individual therapist gives a glimpse into the effect of past trauma on Tim’s current behavior, and the Department of Children and Families (DCF) social worker can detail the state’s protective concerns about conditions in the Clark home. From this initial contact, the IHT team continues to coordinate services throughout the IHT intervention.

Especially for families such as the Clarks, with multiple providers and state agency involvement, IHT must regularly reevaluate the need for more intensive care coordination and engage the youth and family around the potential benefits of this more robust, team-based treatment planning approach.

Coordinating a Team: IHT is responsible for primary coordination of care whenever IHT is the Hub service of highest intensity. This coordination occurs in the context of a single, comprehensive treatment plan, which includes both IAP goals for IHT, and goals and objectives to be carried out by other providers and hub-dependent services. IHT is expected to ensure there is a smooth and seamless process for linking the child and family with additional services, if needed.

Some aspects of the coordination can be effectively accomplished by regular telephone and HIPAA-compliant electronic communications (email, texting). However, there is no effective substitute for face-to-face team meetings in which all the significant, concerned individuals take part. In collaboration with the family, IHT must use best judgment in how frequently meetings occur. At minimum, best practice indicates a full, in-person meeting early in treatment to ensure that everyone understands the purpose of treatment, the family’s goals, the planned intervention, and the roles of each service or support. Regularly planned meetings during the course of intervention are highly recommended as the most robust coordination tool to ensure proactive, valuable responses to changing circumstances. Meetings may include both formal providers and informal supporters and should be held in locations that facilitate participation by all team members. As a youth and family’s needs and goals change over time, it is critical that the IHT clinician maintain regular contact with other team members to ensure that interventions are effective, objectives are modified or updated as needed, and that there is a timely, coordinated response to any unexpected crisis situation.

The core IHT team leads the coordination among service providers, natural supports, schools, state agencies, 24-hour levels of care, the court and probation system, medical providers (including psychiatry), outpatient counseling, and community resources for recreation, support, and social activities. (See Other Operational Considerations and [Appendix G.](#))

Participating in ICC: When the higher level Intensive Care Coordination service is involved, ICC holds primary responsibility for coordination care among the diverse participants. In this case, IHT participates in—but does not generally initiate—Care Plan team meetings and team communications. IHT works with the family on specific treatment goals, as agreed by the Care Plan Team. IHT initiates meetings only when an emergent issue requires more communication than the regular, planned coordination approaches of the Intensive Care Coordinator. *However, when a family declines the use of ICC (regardless of the IHT recommendation), the core IHT team is responsible for ensuring delivery of the level of coordination that the family situation requires.*

One Family/ One Plan: IHT coordination that results in one comprehensive treatment plan, based on the family's vision, gives enough detail so that the youth and his caregivers know

- What is expected of them during IHT involvement;
- What they can expect of each different provider or service;
- How the different pieces of work fit together;
- What capacities need to be developed in order to achieve the family goal/vision;
- What family strengths will IHT draw on to support change;
- Who will help build on these strengths and in what ways;
- How new skills and capacities can become generalized to a variety of situations; and
- How the family and their helpers will know when the family is ready to carry on without IHT.

It is essential to make sure that psychopharmacology (if used) is included in the treatment planning and coordination. Because the majority of children who use IHT services, like Tim Clark, are also on one or more psychiatric medications, proper treatment planning and implementation requires direct, regular communication between the prescribing clinician and the IHT clinician. Responses to medication (both positive and negative), questions about changes in dosage or type, compliance with medication regime, and related topics must be addressed by the core team. For children who are not using medication, discussion between the IHT clinician and a consulting psychiatrist is best practice when ruling out medication.

Coordinating with a Family Partner: The Family Partner, employed by a CSA to provide Family Support & Training, may be a direct supplement to IHT. One Family Partner describes her role as “instilling hope,” which is a key part of carrying out change. Family Partners have their own lived experience of caring for a child with serious emotional/ behavioral disturbance. They have weathered crises, navigated service systems, found useful resources, and gained both empathy and perspective in the process. Family Partners can be a source of much-needed support to struggling parents, but their role is much more skill-based than simply offering compassion. Family Partners are especially important in modeling specific skills with parents, such as

- organizing information about their child that they will need for future school or clinical services;

- understanding their Special Education rights and responsibilities;
- applying for and maintaining MassHealth insurance;
- communicating effectively and confidently in school and other team meetings;
- advocating for the services, special expertise, and accommodations that will support their child's success in school, home and community;
- finding community supports and education about children's mental health;
- knowing when and how to ask for help for themselves; and
- joining with other parents in voicing their experience of strengths and barriers in the mental health system.

The core IHT team, with family consent, can request a Family Partner as a Hub-dependent service. However, the family and team can only benefit from Family Partner involvement when the IHT clinician explains the FP role to the professionals and other supports who are working with the family. The Clarks, for example, will gain little if the Family Partner role is limited to driving Mrs. Clark to meetings at DCF, or if school personnel think of her as an Education Advocate in an adversarial role.

Coordinating with MCI: For best care coordination, the IHT clinician must communicate effectively with the MCI team in the area. Communication is required both to and from IHT whenever a child experiences a crisis that results in an emergency MCI contact. In general, the MCI team will initiate contact with the IHT program, but it is equally the responsibility of the IHT clinician to follow up.

The IHT clinician must discuss with both family and the MCI provider the nature and outcome of the contact. The IHT team needs to know – both from the family and from MCI – the precipitants to the MCI contact, the youth and caregivers' responses to MCI, the MCI assessment of current and future safety for the Clarks, and recommendations for changes to the existing Safety Plan. By understanding the episode from both MCI and family perspective, the IHT clinician and family can make practical changes to the Safety Plan and better understand what will prevent an emergency in the future. Best practice indicates that the core IHT team should also act proactively to alert the local MCI provider to situations in which a child/ family may be at imminent risk of a crisis and to provide a copy of the Safety Plan ahead of time.

Ongoing Coordination: Ongoing care coordination by the IHT provider addresses shared learning among family helpers. The primary function is to ensure that treatment and support services are clear, necessary, and working toward common goals without duplicating effort or blurring roles. For example, when IHT began with Tanisha and her family, a school adjustment counselor was meeting weekly with Tanisha, she had an outpatient therapy session every two weeks, and the IHT clinician began to make home visits twice each week. The IHT convened a meeting within the first month of working with Tanisha to clearly differentiate roles of each. The family and participating helpers agreed that the school counselor would focus on peer social skills with Tanisha, while the outpatient therapist addressed healing from past physical abuse, and the IHT clinician worked with the family to improve communication patterns between Tanisha and her siblings at home. By facilitating consistent, timely communication (as allowed by family consent) among all three counselors, the IHT clinician guided a quality treatment process that started to feel valuable to Tanisha and her parents rather than overburdened and confusing.

F. Treatment Plan/Individual/Action Plan

Developing the Plan: The IHT clinician and family, working together, develop a youth and family centered treatment plan, also known as an Individual Action Plan (IAP) and based on the Comprehensive Assessment, including the CANS. The best practice in developing a treatment plan is to start with the youth and family's vision for themselves as both a healthy family and as capable individuals. When the initial assessment is based on a Collaborative Helping Map, "mapping" the family's vision, obstacles, supports, and plan, this document forms the framework for treatment planning even as the Comprehensive Assessment takes shape.

Questions that elicit useful responses in both assessment and treatment planning focus on possibilities. Asking the family to describe what they look like when they are their best selves promotes hope. For example:

- Picture a dinner time when your family is well. Who is talking? What are the others at the table doing? How are family members feeling about each other?
- When your son is not stricken by depression, what are three things he is able to do?
- Ten years from now, when they are adults, what will you want your teenagers to remember and tell others about you as a parent?

Answers to questions like these can guide the whole team in setting goals with full and compassionate regard for the truth of their experience.

In all cases, the treatment plan must provide a prescription for resolving the combination of prioritized needs that the family and clinical team have identified in the Assessment. The IHT clinician formulates the prescription in terms of specific goals, objectives, and actions (or treatments) and the existing strengths that they will draw on.

- How will the IHT intervention help the family move toward their vision?
- What goals will respond to what activities (treatment)?
- What does the family already do that works well?
- How much (what dosage) of each treatment will combine with existing strengths to produce the best results?
- In what order will goals and objectives be addressed?
- What specific indicators—for example, 50% increase in dinner times when the family can eat together with no angry outbursts and everyone smiling at least once, or 90% attendance at school for the month, or feeling hopeful more often than not for three days in a row—will the team use to measure efficacy of treatment and progress toward goals?

For example, in the Jackson family scenario (above, pages 6-8), the treatment plan matches interventions to the specific behavioral goal (replacing Jonny's tantrums with preferred communication) and safety issue (protecting family members from harm) that are most important to the Jackson family. The IHT clinician and TT&S worker along with the family choose several strategies

to start their work. They develop a Safety Plan that puts Diane in charge as “first responder” to Jonny, removes Teresa from immediate harm, and allows Jonny some space to gather himself.

They agree next to focus on helping Jonny to use words for his distress, and the TT&S worker is charged with practicing emotion words with Jonny. The IHT clinician role-plays with Jim and Diane how to give Jonny some space, coaches Jim in talking with Jonny in a strengths-based way about Jonny’s role as big brother to Teresa, and observes Jonny’s progress in verbalizing his feelings. Their high quality IAP details how often each activity will take place and who is responsible for each. They include initial measures of progress that will let everyone know when an objective has been met: Jonny will use words instead of tantrums at least 50% of the time; Jonny’s tantrums will reduce from daily to no more than three per week.

As initial objectives begin to show signs of success, the IHT and family move to address the next priority needs. The TT&S worker finds outlets in the community for Jonny and helps to arrange mentoring time with the science teacher. The clinician begins, in the context of the family’s desire to live in harmony, to explore sensitive issues of the birth father’s role, preferential treatment of Teresa, substance use, and physical discipline in the home. IHT works at the family’s pace to introduce interventions that can build on Jim’s enjoyment of teaching Jonny, Diane’s protective stance toward her children, the parent’s mutual regard, and Jonny’s range of interests to expand on progress that is already evident.

Treatment planning is a nuanced developmental process that responds to each situation as it unfolds in a unique mix of family strengths and needs. Planning occurs in collaboration with the family (and child whenever possible), relies on excellent coordination among professional helpers, seeks out and builds natural supports in the family’s local environment, works in concert with family culture, establishes and monitors measurable outcomes, and continuously reassesses the efficacy of treatment in the light of new information.

Basic Requirements: The initial IAP is completed by the qualified In-Home Therapy clinician in collaboration with the youth, parent/guardian/caregiver(s), and in consultation with other current providers (with proper consent). It identifies goals for the youth and family that are focused, structural, strategic, or behavioral, and which enhance problem solving, limit-setting, risk management/safety planning, communication, and skill-building to strengthen the family or improve ineffective patterns of interaction and that meet medical necessity criteria. The parent/caregiver and youth (age 13 and older) sign the IAP as do the IHT clinician, TT&S support worker, and any others with responsibilities in the plan.

The initial IAP/ treatment plan must be completed within 14 calendar days of first contact. The signed IAP is copied to the family and, with required family consent, to other providers engaged with the family as a basis for coordination of care. The short time frame for completing the IAP is intended to ensure that families are considered as profoundly important when they reach out for help and that their situation is treated as urgent by those who have been entrusted to help.

Revisions: The IHT clinician reviews and modifies the IAP as needed. Like the initial Assessment, the IAP will need to change when new information comes to light. Every core IHT team should be checking in regularly with the youth, caregivers, and collaterals to understand whether the child is making progress toward prioritized goals. While the treatment plan need not change in response to all changes, it also should not remain “stuck” when an intervention is not helping to meet objectives. This is the territory of clinical judgment in combination with family experience—knowing when to revise and when to hold steady.

Best practice suggests that whenever the Assessment changes, the IHT clinician and family review the IAP to see whether changes are needed or at minimum once every 90 days. In this way, the system manifests its commitment to ensuring that behavioral health treatment changes in nuanced ways that reflect the growth and change in a youth and family.

G. Evidence-Based Practices

Evidence-Based Practices (EBPs) encompass crucial and valuable approaches to working with families in a variety of prevention and treatment models, including In-Home Therapy. Models of intervention that have been shown through rigorous testing to produce positive outcomes are given status as “evidence-based practice” and listed in the National Registry of Evidence-based Programs and Practices on the Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services) website, among other places. The Managed-Care Entities and others involved with continuously improving the quality of CBHI services suggest using evidence-based models that match the main need/focal problem to guide treatment planning and interventions.

When evidence shows that a particular line of questioning or set of activities results in positive changes, such as symptom reduction, increased self-efficacy, improvements in social skills, recovery from past harm, or other gains, it makes sense to replicate the practices. In the context of CBHI services, several important concepts need to be applied to the use of evidence-based practices.

First, consistency with Wraparound principles require that therapeutic work with families be individualized. This means that providers who are adopting EBPs must ensure that training in these practices does not become formulaic. Training and supervision must be sufficiently sophisticated to support practitioners in choosing EBPs and applying proven models to the specific conditions of the families that they work with according to their best clinical judgment. IHT clinicians need to keep in mind that therapy is fundamentally a collaborative process, with client factors and clinician factors each exerting vectors of force on the therapeutic interaction. By definition, no two interventions can be the same when different clinicians and clients are engaging in them.

Secondly, the CBHI and Wraparound premium on family driven practice suggests that the evidence from families – that is, what families say about their experience of care, what has helped, what has left them feeling hopeful – is itself evidence. In a family driven system, family evidence is as valuable as the empirically based evidence aggregated through outcome studies. This is especially true as research into the common factors that predict successful therapeutic outcomes has shown that client perception of positive relationships are a better predictor of positive outcomes in mental health

treatment than clinician perceptions. That is, **how we are** with people counts for at least as much as **what we do** with people. Best quality in **both** is essential to successful intervention.

Finally, best practice consistent with Wraparound principles emphasizes the importance of envisioning, working toward, and monitoring progress to positive outcomes. Whether using EBPs with demonstrated positive outcomes in the past or testing a new or different intervention, IHT practitioners must rely on what the data is telling them about the youth and family's progress toward goals. Whether the youth's behavioral health conditions are improving is the clearest determinant of any intervention's quality.

H. Implementation of the Individual Action Plan/Treatment Plan

Implementation Practices: IHT consists of a sequence of purposeful meetings (typically, at least weekly, but adjusted to more or less for each family situation) with the IHT clinician and TT&S staff to best address the prioritized needs of the family, as described in the IAP. In the following scenario with Rachel, a young girl with a mild autism diagnosis along with conduct disorder, and her family, the shared goals may include improving communication among family members in the home, helping Rachel to learn appropriate social behaviors so that she can have friends, and helping the parents understand the mental health conditions affecting Rachel.

The IHT clinician suggests that the family consider using the expertise of an In-Home Behavioral Services (IHBS) therapist and behavior monitor to guide the behavior changes that the family wants to see in Rachel. IHT also proposes that the TT&S worker find informational websites about Rachel's mental health conditions and local parent support groups to help the parents rebuild their capacity to parent Rachel. However, the family is opposed to having too many new faces at once for Rachel and too many appointments for their schedule. In the end, the core IHT team and the family agree that IHT can request consultation about Rachel's behavior from an IHBS specialist, but they will "wait and see" whether IHBS will be engaged and will use the TT&S worker as a behavior support in the meantime.

Rachel's parents highly value the shared experience of other parents, so IHT makes a referral to the local CSA and serves as the hub for the Family Partner (FS&T service). The Family Partner joins the full team to help with finding internet resources and to guide the family to a choice of support groups.

Each team member focuses on a clear function. At one weekly family meeting, the IHT clinician talks with Rachel, her parents, and her older sister to discover times when they have experienced more concordant and forthright ways of communicating with one another. Building on moments of prosocial interactions, the therapist then helps Rachel to identify qualities of her most likable self, such as patience (with her pet cat) and determination. They practice behaviors that manifest these qualities, such as waiting for a turn, and trying again after a mistake. One week, the Family Partner accompanies Rachel's mother to a support group to try it out; another time, the Family Partner discusses diagnosis information with Rachel's father whose cultural beliefs frame mental health conditions differently from the prevailing ideas of treatment.

The TT&S worker concentrates on meeting with Rachel and her sister to document both their difficult and their loving interactions. The TT&S worker helps Rachel to practice using “cues” for the behavior objectives that have been established in the family meetings. Together, they explore Rachel’s interests (including baton twirling, video games, and playing with her cat) to find outlets in the community that can foster healthy interests and improve social connectedness. When Rachel’s mother mentions the lady down the street who has cats, they take steps to meet the neighbor and her cats. The TT&S worker finds an organization that will help pay for a baton twirling class for Rachel.

The IHT clinician, TT&S support staff, and the Family Partner talk together regularly to make sure that they are communicating consistently (no mixed messages) with family members, share observations of measurable progress, and are up-to-date on perspectives of all family, professional, and natural supports that are contributing on Rachel’s behalf.

Purposeful Meetings: Best practice requires that meetings with the family are much more than “check-ins” to see how the family is doing. High-quality meetings always include purposeful discussions and actions that will further progress toward a goal. If parents report that Rachel is “doing fine” in interactions with her family, a purposeful discussion explores what “doing fine” actually means with questions that elicit evidence.

- Can the parents give examples of times that they have been able to rely on Rachel’s strengths and their own to achieve better outcomes?
- Have they used suggested strategies for communication, and have the results been any different from past communications?
- Has the family found other tactics that are more effective, and in what ways?
- Do Rachel and her sister agree with their parents’ impressions?
- Do observations by the TT&S staff, Family Partner, and IHT clinician support the family’s description?

The Collaborative Helping Map that can form a simple initial assessment can also structure the subsequent meetings with families. Structure is especially crucial when families are balancing many priorities and/or when a family’s culture has tended toward reacting to big and small crises with less emphasis on proactive steps. Holding to a simple structure can help both the IHT team and the family members to stay focused on the overarching goal (the family’s vision for a better future), examples of actions they have taken that support the goal, examples of things that have gotten in the way, and deliberation about what to do next to overcome the obstacles and build on the strengths.

When evidence shows progress, the team can keep practicing to make sure the gains “take hold” or move on to the next objective, or a combination of the two. If the family is reluctant to use the communication patterns or behavior cues that they planned, then the team can help to model the techniques, as many times as necessary until Rachel’s parents feel confident. The team will periodically revisit the idea of IHBS as a specific expertise that can be very effective with children who have autism spectrum disorders. When Rachel’s family is proceeding according to plan, meetings may be predictable. However, family meetings are never rigidly structured, and IHT should expect that their time with a family will ebb and flow.

Working through Crisis: An especially sensitive event for IHT services is any emergency stay in a psychiatric hospital or other short-term acute care program during the course of an IHT intervention. An emergency stay is by definition unplanned and unsettling, but it is not the end of the IHT service or “proof” that IHT “doesn’t work.” The crisis can be a defining event for the family and IHT. The core IHT team can help to contain the stress that Rachel and her parents are experiencing. Rachel’s shaken family will need information about what happens in a hospital, reassurance about what repercussions to expect during and after the acute episode, and (possibly) concrete assistance in getting to the acute care site, sorting out health insurance issues, or communicating with the array of providers. The parents may prefer to talk to their Family Partner with experience of her own child’s hospitalization, while the core team communicates with the hospital clinicians and other team members.

Rachel’s parents will need to take Rachel home, probably in less than a week. This is an opportune time to reconsider the treatment plan and array of providers. In light of Rachel’s crisis, would the family now consider In-Home Behavioral Services? The IHT clinician reaffirms the IHBS expertise in modifying behaviors that are hard to influence, again reviewing the pros and cons of this commitment and helping the family to overcome obstacles (for example, reduce TT&S to offset the increase in IHBS meetings). The IHT clinician floats the idea of Intensive Care Coordination, as it now appears that the intensity of services may increase and school services may need adjustment.

The core IHT team works with the family and the full team of supports throughout the hospital stay—for example, talking with the Mobile Crisis Intervention team that responded to Rachel’s crisis, revising the Safety Plan to reflect newly emerging concerns, rehearsing positive responses to Rachel’s symptoms, practicing family communication again in light of the crisis, coaching the sister on when to give Rachel some space, upping the Family Partner role, and so on—to shore up parental capacity.

Supervision and Consultation: Throughout the course of work with a family (and especially in a crisis situation), the IHT clinician and TT&S worker must use the expertise available to them to check their own assumptions and biases and to consider other treatment options. Prime among the resources is individual supervision with an independently licensed clinician who can bring to bear clinical judgment and supervisory skills that have been honed over years of experience.

At minimum, an IHT clinician will have an opportunity to review every family during weekly supervision meetings, with an on-call supervisor available at all times for consultation on emergent issues. A consulting psychiatrist or clinical specialist offers an important medical perspective, and (with Rachel’s family) a specially trained In-Home Behavioral Therapist is a valued resource. Psychological or neuropsychological assessment may yield new insights. Other situations might call for consultation with experts in occupational therapy, substance abuse treatment, or trauma recovery. Ongoing training for IHT personnel is also essential in widening the expertise required for effective work with children and families.

Monitoring Progress: In-Home Therapy providers must regularly monitor progress toward the youth’s goals with the full team. When each objective in the IAP is measurable, qualitative (self-report or impressions of an observer, for example) and/or quantitative data (such as number of days attending school, count of hours without tantrums) provide clear evidence of progress. Another method of

monitoring progress is a simple survey for youth at regular intervals – say, every three months – to allow youth to report experience of their own progress in a structured way. Providers can use the CANS as often as 30 day intervals as a sensitive barometer of changes in behavior and emotional states. Promising practices have included offering families and youth age 13 and older the option of filling out their own scores on the CANS, thereby giving first voice to those closest to the experience. The clinician completing a CANS update can learn where they agree or diverge from the family's sense of current status and can adjust accordingly.

When effective interventions led to improvement in areas initially prioritized for intervention (*i.e.*, safety; reduction of aggression), but the child still meets Medical Necessity Criteria for IHT, providers should explore potential replacement goals with the youth and family, building on their progress and creating space to tackle other challenges, such as effective communication, enforcing household/community expectations, and enhancing problem-solving skills.

When the full IHT team—that is, the IHT clinician, TT&S staff, youth and family, any other providers who are involved, school personnel, DCF or other state agency representative, and natural supports—have concerns that progress is stalled, best practice requires that the IHT staff pull together one or more team meetings to compare perspectives on the youth's progress, address barriers to success, and alter the “prescription” of the IAP to take into account changes in type or dosage of treatment. This may include

- bringing in additional services, such as a Hub-dependent CBHI service or Intensive Care Coordination;
- increasing existing service frequency;
- making a more concerted effort to elicit and use emerging strengths;
- shifting from a “service” orientation to more robust use of mainstream community resources; and
- improvement in the quality and/or supervision of services that are already in place.

No IHT team should assume that simply adding more services is the appropriate response to every barrier.

Natural Supports: Every IHT service episode needs to find the right mix of supports to make and maintain reasonable progress, and the “right” combination almost always includes an array of natural supports. The role of natural supports cannot be overstated. They are resources in carrying out interventions during an episode of treatment; they are indispensable in helping families to maintain positive outcomes after professional services end. The core IHT team should actively use natural supports as a part of every ongoing intervention.

Networks of natural supports do not come easily or ready-made.

- Natural supports need to be discovered in some cases. Many families with children with mental health conditions are disconnected from their communities.
- Natural supports sometimes need to be nurtured back to a supporting role. Many families have “burned out” the friends and relatives that they have relied on in the past.

- Natural supports may need to be invented. Many children don't fit neatly into established activities and need some creative adaptations to make use of the resources.
- Family cultures differ on how much or how little they want to share about their stressors and with whom they want to share.

Both the IHT clinician and the TT&S worker can play important roles in addressing these situations. To discover natural supports, a creative TT&S worker might ask: If your daughter were graduating from high school, who would you invite to celebrate with her? If you were baptizing your son, who would you want to have as godparents? This will elicit a different list from questions about who can "help" your daughter or son, and in this way can start to build a wider network with a hope-affirming basis. These affirmative questions allow families to see that they can engage a network of supports without disclosing all the private struggles that they are experiencing. The TT&S worker can also research community resources, such as activities that mesh with a child's strengths, support groups for parents, or places for family outings that offer new social circles.

An important role of IHT is to help families recover from burn-out, not just of the parents but also of the extended family and friends who have had negative experiences with a child (say, Suzy) at holiday gatherings or have witnessed Suzy in an episode of extreme behavior and feel wary of caring for her. Helping Suzy's single mother to approach potential helpers with judicious requests for small bits of help (an hour of respite rather than a whole day, for example) can keep Suzy's list of supports intact.

The small bits add up to a whole intervention. IHT and family can together craft a plan in which, say, one neighbor walks Suzy to the school bus on Monday mornings when Suzy is usually refreshed and sociable. The crossing guard agrees to greet Suzy with a smile every morning and give her a sticker on days when she smiles back. Her third-grade teacher arranges a school volunteer to come in and read to Suzy on Tuesday mornings, when Suzy needs a "time out" that doesn't mark her as "a behavior problem." Suzy's mother attends a parent support group every other Wednesday evening, and two aunts can alternate child care on those days, with a consistent plan to help Suzy master bedtime routines, and so on.

The core IHT team can also help Suzy's mother shift the balance from always being the receiver of help to sometimes being the helper. Suzy's mother may strengthen her own sense of capacity by occasionally exchanging a play date or carpool rides with another parent, making a few free hours to help at her church, or providing comfort to another parent with a child with unique needs.

When a parent can't make use of community resources because the typical routine doesn't accommodate atypical participants, TT&S staff can draw on their own resourceful natures to find the flexibility in a program or activity. They might suggest that Suzy, who has a hard time joining a peer group, be given extra time to adjust at the start of an activity, or a "buddy" to play with during the transition. They can help staff at the Boys and Girls Club to decide on a time-out space where Suzy can be safe and visually supervised if she begins to lose control. The TT&S can "virtually" introduce the club staff to the area MCI team, so the Boys and Girls Club staff know where to call in an emergency that they can't handle.

I. The Role of Supervision

In-Home Therapy is complex, sophisticated, many-faceted work. This service is the premier treatment option offered to children and families who are facing acute mental health challenges, often exacerbated by family and environmental stressors such as poverty, isolation, substance abuse, physical disabilities, and violence—in other words, some of the most highly charged situations that present themselves for treatment anywhere in the mental health system.

High quality, clinically astute, values-driven supervision is critical to quality in IHT. Supervision requires both appropriate licensure/ credentialing as indicators of clinical expertise and a robust understanding of the strengths and needs of youth and families in a wide variety of situations. Foundational principles of quality supervision are continuous development of cultural and linguistic competence, full consistency with *Wraparound* principles as second nature to all services, sensitivity to the importance of how practitioners interact with families, and knowledge of the evidence based practices that might apply to their work. Supervisors must have developed their own areas of clinical expertise and know when to use the expertise of others to untangle knotty clinical presentations.

A supervisor must be able to hold in his or her head a map of the topography of each child and family. He or she must be able see the “landscape” of the work with its prospects and deserts and to balance the wide view against the particular daily challenges—the bumps in the road, the flowers in the desert—the that the clinical team encounters. This map, drawn from accumulated years of learning, helps each supervisee to locate the most promising path for moving forward with the family. Supervision is a place to “road test” possibilities. Note that the “Collaborative Helping Map” referred to in previous sections provides an excellent guide to discussions in supervision, as each family map sketches the four most important components of the work—the family vision, the prioritized needs which obstruct the vision, the supports/strengths that uphold the vision, and the plan for addressing both needs and strengths.

Ideally, supervisors of IHT staff have their own direct service experience with in-home, family-based work. Clinical practitioners who have functioned solely (or primarily) in an office-based, individual treatment mode may have challenges adapting their training and experience to a less structured, more fluid environment. Ideas of boundaries, for example, may be tested. In a traditional office setting, a supervisor may be justifiably opposed to touching a “client” or sharing food; in a home environment, instinctively rejecting a small child’s spontaneous hug or a parent’s offer of a cup of tea could be insulting to a family. Therapists trained to work in controlled environments may be unaccustomed to handling real-time conflicts among a family group, or adjusting the duration and frequency of meetings, or getting conversations back on track after the doorbell rings, or the dog barks, or the baby starts crying. Supervisors who have practiced individual treatment with youth may find family-driven voice in treatment priorities a new and gratifying (or unsettling) experience.

IHT supervisors must guide their supervisees to make sure that basic premises of IHT do not get lost in the rush of the work. One very important piece of supervision is to help clinicians and program management to adjust the number of families assigned to each clinician to allow sufficient time for the extremely fast-paced and crucial engagement, assessment, and planning phases at the start of

services. IHT clinicians also need sufficient flexibility to respond to “bumps” in service intensity during implementation and transition phases in order to ensure that interventions do not fall into a formula (such as two visits per week, one hour per visit).

Other important responsibilities of supervisors include

- reviewing Assessments for completeness, such as identified strengths, sensible clinical formulation, and needs that are the basis of intervention;
- reviewing treatment plans to cross check that the planned intervention matches the full extent of the prioritized needs;
- monitoring the delivery of care coordination services and assessing the need for referral to ICC;
- ensuring that there is ongoing communication with prescribing physicians about medication and consultation as needed with a child psychiatrist;
- identifying needs for specialized therapeutic skills;
- considering the addition and/or subtraction of other CBHI services;
- guiding the use of the CANS and other data in continuous assessment;
- helping clinicians to balance their clinical judgment with the stated priorities of families;
- ensuring that every family meeting has a purpose, rationale, and plan to move forward;
- assisting in identifying indicators pointing to transition readiness, relapse, and completion;
- engaging therapists in continuously learning from their experiences with families and applying their experiential knowledge to new situations; and
- assisting IHT staff in negotiating relationships with other organizations (such as state agencies and schools) and escalating the problem-solving process when needed.

J. Documentation

In-Home Therapy providers must adhere to the Managed-Care Entities Children’s Behavioral Health Initiative Health Record Documentation Standards, which outline the documents that are required to be contained in the youth’s health record (see [Appendix E](#)). All documents in the record must be translated into the youth and family’s preferred language, whether oral or written, if they do not have sufficient understanding of the English version.

Documents that must be in the record include

- A. the original comprehensive behavioral health Assessment, including the Massachusetts CANS and signed by the IHT clinician and TT&S staff, and preferably by the parent/caregiver and youth;
- B. signed consents for each individual and organization that IHT expects to contact for information and coordination;
- C. forms which detail client rights, explanation of the program’s expectations and requirements, and a signed (by the youth and family) agreement to participate in the service;
- D. documentation of all contact regarding assessment, treatment planning, and coordination of services that the In-Home Therapy team has with the youth and family and all other relevant involved parties, including other Hub providers and any other providers who are also involved with the family;

- E. the original youth- and family-centered Individual Action Plan/treatment plan, signed by the parent/caregiver, youth age 19 and older, and preferably youth age 13 and older, and the IHT practitioners;
- F. documentation of each update of the IHT's treatment plan/Individual Action Plan;
- G. copy of the youth's Safety Plan and/or other Crisis Planning Tools;
- H. copies of the Individualized Care Plan for those youth receiving Intensive Care Coordination, treatment plan for youth receiving Outpatient service, Individualized Action Plan for youth receiving Therapeutic Mentoring, treatment plan/ Individual Action Plan for youth receiving In-Home Behavioral, and/or documentation relevant to other services provided to the youth and family, as consented to by the family; and
- I. progress notes that document all contact with youth and family for treatment purposes and clearly demonstrate medical necessity and how the contact supports the treatment planning goals.

The In-Home Therapy clinician and Therapeutic Training & Support staff must document contact (face to face, telephonic, and electronic) with a youth and family. Providers must ensure that IHT staff adequately document medical necessity and must provide ample support for non-clinical staff to document their activity with the family with clear adherence to the goals in the treatment plan. Optimally, facilities have a Multi-Disciplinary Team that can be convened as needed for risk management or clinical consultation, including consultation with a child psychiatrist regarding nuances of diagnosis, psychopharmacology, medication management and other clinically appropriate issues.

Providers may develop their own clinical forms or use optional forms available at www.masspartnership.com/provider/index.aspx?lnkID=TMTraining.ascx and at www.abhmass.org/msdp.html. One advantage of using the Massachusetts Standardized Documentation forms is that they are in general use by many providers, including those using an Electronic Health Record. Consistency across providers may ease a family's experience in reading pertinent clinical documents. Standardization also supports quality care by simplifying providers' ability to share records between agencies or programs, in-house record reviews, and external audits.

It is the responsibility of the each provider agency that offers In-Home Therapy to determine its own policies and procedures regarding overall documentation expectations that are not outlined within these Guidelines. *Reminder: Each provider agency is responsible for ensuring that all staff working in IHT understand CBHI Health Record Documentation Standards, Performance Specifications, and Medical Necessity Criteria. This set of Guidelines gives an overview of documentation standards but does not replace the standards referenced in [Appendix D](#).*

K. Transition Planning and Readiness

Planning for Transition: Planning with a family for the day when their youth is thriving is a powerful statement of hope for the future and respect for the family's resiliency. Discussions in the early IHT meetings about the family vision (what the family looks like when they are doing well) is the start of transition (also known as "discharge") planning. On the other hand, suggesting to the family that they have only a set number of months or "authorized" hours in which to accomplish the progress that they

need has a countering effect of discouragement and worry. There is no set limit on the time that a youth and family can use In-Home Therapy. The service is intended to support a youth's health for as long as the youth meets the Medical Necessity criteria, is age 20 or younger, has MassHealth insurance, and consents to participate in service. An arbitrary time limit must never be the actual or stated reason for terminating IHT services.

The core IHT team engages the family and other team members in conversations early in the treatment process about what it will take to reach the goals, how to adjust to setbacks, what lifelong supports the family may have, and how to sustain healthy functioning over time. Recommended strategies include

- establishing a vision with the child and family for healthy functioning at the start of service to guide and inform progress along the way;
- discussing at the beginning of the service what the family would like to have accomplished in order to be ready for transition;
- continually talking with the youth about his/her achievements;
- providing opportunities for child/parent to experience mastery and confidence in using new skills;
- framing transition in a positive way—recognizing it as a “graduation” and a celebration of their ability to handle life stressors;
- identifying what naturally occurring activities or less intensive services will sustain the youth after transition from IHT;
- using IHT to assist in the transition to the replacement activities;
- planning a transition time frame that allows for setbacks and relapses as the family functions with increasing independence;
- using youth and family feedback on their own progress; and
- reminding families that if new goals are identified, they can use IHT again in the future.

Planning for Setbacks: As the youth (say, Aldous Monelle) is better able to manage his symptoms and family's capacity builds, the full IHT team engages in more focused, robust conversations about the transition from IHT services, setting a carefully discussed time frame for Aldous' anticipated transition from services. The conversations include perspectives of all key stakeholders, including natural and professional supports, preferably in a team meeting format where differing perspectives can be aired. While transition generally means a gradual stepping down in intensity and frequency of IHT contact, the planning needs to take account of the probability that setbacks will occur. Aldous may have a spike in symptom manifestation. Mr. and Mrs. Monelle may suddenly have a jolt of self-doubt. A valued natural support may be lost, if Mrs. Monelle's sister moves away, or Aldous' favorite teacher goes on maternity leave. The team needs to be prepared to respond with a period of renewed vigor, if needed. During the transition, the core IHT team will encourage the family to move toward IHT termination for family-centered reasons because the family has used the service well and the intervention has had the intended positive impact. Program-centered reasons, such as a wait list or an impending staff vacancy, are **not** reasons to terminate services.

In some cases, despite the best efforts of all, the IHT intervention may not be able to prevent more implacable emotional or behavioral crises and the future may hold periods of more intensive services, such as episodes of acute treatment (hospital, CBAT, ICBAT¹⁰) and/or recommendations for residential treatment. In best practice, the core IHT team will have seen concerns in time to pull together a more comprehensive team meeting than typically forms with IHT. IHT may already have engaged DMH or DCF and begun conversations with the assigned case manager or social worker. The best practice is to engage Aldous' school prior to a crisis; but if that did not occur, the school will need to be part of planning for more intensive services.

If Aldous' situation grows more acute, the IHT clinician will seek supervisory support to increase community services to prevent out-of-home care and also to consider how best to prepare for a possible episode of out-of-home treatment. The larger IHT team will need to communicate more urgently and reach out to any state agency social work or case management staff who need to be involved. The state agency staff or IHT may need to initiate communication with the DCF and/or DMH representatives who oversee Caring Together.¹¹ The out-of-district coordinator for the school system, and any other school personnel who know Aldous, need to be invited to the team and kept in communication loop. If a crisis has resulted in a short-term, emergency placement, the MCI team (if used) and clinicians from the hospital or other 24-hour level of care will be part of the team discussion. *In cases where a youth must enter a brief, 24-hour level of care, such as Community-Based Acute Treatment, the IHT service continues to work with the family to support their capacity to manage future symptoms.*

By this point, the core IHT team may have engaged ICC services, if the family agreed, in which case coordination of next steps will shift to the ICC, and the team that IHT has gathered will evolve into the Care Plan Team. In any case, the full IHT team needs to acknowledge the level of risk and discuss both higher levels of community based care and options for referring to a state agency for out of home placement. This is a robust discussion, which takes place over time prior to the transition, both in response to crisis situations and during times when the family can calmly consider alternatives. The youth and family perspective is critically important in this decision and should guide the providers in doing everything possible to support a family's determination to remain together.

The IHT clinician must make it clear to the team that IHT cannot promise residential treatment or "throw in the towel" on community-based services. The final decision to use state agency or school system resources is the prerogative of managers from those systems.¹² Should a state agency make a

¹⁰ CBAT (Community Based Acute Treatment) and ICBAT (Intensive Community Based Acute Treatment) provide 24-hour levels of care for youth who do not meet admission criteria for hospital care but who need short-term, out-of-home treatment for an acute behavioral health crisis.

¹¹ Caring Together refers to a range of residential treatment services available to children in the Commonwealth through a DMH/DCF collaboration in procurement and management of resources.

¹² Residential resources of DCF and DMH are managed through the Caring Together system, accessed through local field offices of DCF or DMH. School Districts' residential school resources are accessed through each School Districts Special Education Program.

decision for residential treatment, with agreement from the family and full IHT team, it is helpful for the IHT clinician to talk with the youth and family about residential treatment being a place to practice for community life and to prepare for readmission to their preferred environment. IHT will end after the youth transitions to residential placement. Of course, re-enrollment in IHT may be appropriate when the youth eventually prepares to step down from the out-of-home placement.

Transition: Toward the end of a transition period for a youth in the community, the best practice is for the IHT clinician to initiate a graduation meeting to acknowledge that Aldous has met his goals and no longer needs (or meets the clinical criteria for) In-Home Therapy services. The core IHT team invites the natural and professional supports for whom the family provides informed consent: the youth, parents/ caregivers, extended family members who have helped, perhaps a school counselor or favorite teacher, and current providers. When Intensive Care Coordination is working with the youth and family, a Care Planning Team meeting may function as the graduation meeting for IHT, with agreement from the ICC team.

The graduation meeting includes a review of the plan to move on in stable, healthy ways with the most appropriate supports that will help sustain the gains. An important part of the meeting is to celebrate success, preferably with qualitative and quantitative data that demonstrates progress. For example, the youth has worked for four months at a part-time job without any incidents of aggression, or a high school student was suspended for only three days for the past semester (compared to 18 days in the prior semester). Another child went from feeling that she had no friends at the start of IHT to having three friends that she spends time with out of school; she also participates in a community dance class with 12 peers. Data comes directly from the treatment plan and progress notes that have guided IHT.

The transition/graduation meeting confirms that everyone agrees on the plan that has been developed over the prior weeks. Usually, this will be a lower level or fewer formal services (for example, outpatient treatment, ongoing Therapeutic Mentoring) supplemented by a strong combination of informal supports (afterschool activities, parent support group, visits to kin). For all families, regardless of subsequent services, it is important that coordination continues as seamlessly as possible. Ideally, future supports are engaged prior to the transition meeting and are invited to participate. Whether in person or in written plans, ongoing supports need to know what specific resources are in place, which (if any) still need engagement, how the youth and family will depend on each support, and which accommodations are required to make best use of future help.

Basic Requirements: The In-Home Therapy transition (“discharge”) plan must identify all of the parties that participated in the plan’s development. The IHT clinician updates the treatment plan when the youth finishes IHT services reflecting that the youth has met his/her goals and no longer needs or meets the criteria for In-Home Therapy services. There is no prescribed length of stay for In-Home Therapy services. Services continue as long as the youth meets the Medical Necessity Criteria for the service (see [Appendix E](#)) and the eligible youth/family wants the service.

If the youth and/or parent/caregiver terminate the IHT service without notice, IHT must make every effort to contact the parent/caregiver or adult/emancipated child to re-engage them in services and to provide assistance for appropriate follow-up plans (*i.e.*, schedule another appointment, facilitate an

appropriate service termination, or provide appropriate referrals). The IHT clinician is responsible for contacting the other providers to inform them of the termination. The IHT clinician also must document this activity in the youth's medical record.

As noted within the Performance Specifications, the IHT clinician, in cooperation with the treatment team, writes a transition plan that includes documentation of ongoing strategies, supports, and resources to assist the youth and family in maintaining gains, as well as the reason(s) for transition and all aftercare plans. The IHT clinician gives the written transition plan to the youth and/or parent/caregiver, and with appropriate consent, to relevant behavioral-health provider(s) within five business days after the last date of IHT service. This mandatory time frame ensures that the youth and family's experience of the transition from IHT is as seamless as possible, guided by a prompt and caring transition plan.

In keeping with the MassHealth goal of ensuring that services meet the needs of youth and families in the most productive ways possible, **any one** of the following criteria will result in MassHealth's withdrawal of authorization for In-Home Therapy Services.

1. The youth no longer meets admission criteria for this level of care, or meets criteria for a less or more intensive level of care.
2. The treatment plan goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. The youth and parent/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
4. Required consent for treatment is withdrawn.
5. The youth is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.
6. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.

Other Operational Considerations

A. Youth Engaged in Intensive Care Coordination

For youth engaged in Intensive Care Coordination, the In-Home Therapy clinician/team becomes a member of the Care Planning Team and attends all Team meetings that occur during the course of In-Home Therapy services with the youth. As Care Planning unfolds, the Care Plan Team, led by the youth and his/her family, chooses the priority needs that IHT will address and helps to determine medical necessity. Along with the youth, parent/caregiver, and other CPT members, the IHT clinician proposes the appropriate number of hours per week/month for IHT services based on the needs identified in the

youth's Individual Care Plan. This includes sharing an anticipated schedule for meeting with the youth and an estimated timeline for treatment completion.

The IHT treatment plan follows from those identified needs, sets goals in the IAP that are in keeping with the Care Plan Team decisions, and shares the IAP (with family consent) with the Intensive Care Coordinator. At the Care Planning meetings, the IHT staff articulate – or support the youth and family in articulating – for the other team members the youth and family's work related to the identified goals of the treatment plan. To synchronize with the Care Plan Team, the IHT and TT&S staff provide regular, ongoing reporting on the work and progress toward goals at the Care Plan Team, in other team communication between CPT meetings, and whenever a change with significant impact on the child's well-being occurs. The IHT clinician is responsible for communicating in advance to other Care Planning Team members when the youth is nearing completion of their work on the treatment goals and no longer needs the In-Home Therapy service. With full Care Plan Team agreement, the IHT clinician coordinates a transition meeting with the Care Planning Team.

When the youth and family are receiving IHT services along with Intensive Care Coordination, ICC provides the primary care coordination function while In-Home Therapy focuses more intensity on the clinical function of the service. IHT coordinates care in step with the youth and family-led Care Planning Team, which makes final decisions about roles and responsibilities for each member of the Care Planning Team, including the In-Home Therapy team. The Team respects the family as the driver of treatment and makes treatment decisions that value family culture, vision, experience, and goals and that accord with performance specifications. While ICC provides therapeutic interventions to support the family in coordinating across providers and systems, ICC does not provide direct clinical treatment as In-Home Therapy does.

B. Therapeutic Training & Support vs. Therapeutic Mentoring

Role differences exist between the individual delivering Therapeutic Training & Support as part of the In-Home Therapy team and a Therapeutic Mentor. Both TT&S and Therapeutic Mentoring may be involved with the youth and his/her family at the same time, if that youth meets the Medical Necessity Criteria for both services. The services themselves are distinct in a number of ways. IHT provides intensive family therapy and, as such, works with the entire family or a subset of the family. In this context, the TT&S staff may do one or more of the following to support the implementation of the treatment goals and therapeutic objectives.

- TT&S staff may coach, teach or otherwise support the youth in developing skills to understand and manage emotional responses to family situations.
- They may assist the family in understanding the youth's emotional and mental health needs.
- TT&S staff may engage in skill building activity to strengthen the youth's functioning in the family.

This differs from skill building provided in the context of Therapeutic Mentoring, which focuses on broader social and communication needs, and is accomplished by engaging the youth in activities in the community in order to support sustaining the youth's optimal functioning in peer settings.

While a provider organization may have staff cross-trained to perform both TT&S and Therapeutic Mentoring functions, care must be exercised in keeping their roles distinct when both services are involved. The same staff member should not provide both services to a family, to avoid confusion with both family and professional collaterals. When there is no Therapeutic Mentor involved (the youth does not meet Medical Necessity Criteria for the service, or the family declines it), the two service functions may overlap, as long as the purpose is clear and the focus remains on supporting the family therapy.

C. Youth Involved with Governmental Entities other than the Office of Medicaid

When other state agencies are involved with the youth, with appropriate consent, the In-Home Therapy team, as applicable, supports the youth and family in achieving the goals with these agencies related to service/care planning, coordination, and planning for transition to adulthood. IHT promotes the interagency collaboration that best serves families, reduces duplication, and offers the best chances of positive impact. Governmental entities may include

- Department of Mental Health
- Department of Children and Families
- Department of Youth Services
- Department of Public Health
- Department of Elementary and Secondary Education/Local Education Authority
- Department of Developmental Services
- Massachusetts Rehabilitation Commission
- Office for Refugees and Immigrants
- Probation office and the Courts

IHT providers may at times receive referrals for youth in residential/group care. The residential/group facility is responsible for meeting the therapeutic needs of the youth. For youth in residential/group care who meet all other Medical Necessity Criteria for IHT and who have a concrete and imminent plan for return to the family home environment, the IHT provider can accept the referral and begin In-Home Therapy services in enough time to attend and participate in the discharge planning meeting from the residential/group care facility, with the family's consent. If no concrete and imminent plan for the youth's return to the family home environment exists, or if the youth is not ready for discharge from the residential/group care facility, the Medical Necessity Criteria for In-Home Therapy are not met (see [Appendix D](#) under "Exclusionary Criteria"). The timeframe in which the youth may return to a home setting should be considered before referring for In-Home Therapy (see [Appendix E](#)). If an IHT provider receives a referral for a youth without an imminent discharge date, the IHT provider should contact the referring residential/group facility and explain the need for such a date.

Supervision Requirements and Staffing

A. Supervision Requirements

The provider agency ensures that staff supervision is commensurate with licensure level and consistent with credentialing criteria. Only appropriately credentialed professionals with specialized training in family, adolescent, and child treatment are permitted to provide supervision. The clinical supervisor must be independently licensed (the highest possible license applicable to discipline, e.g., LICSW or LMHC). The required weekly individual supervision by an independently licensed clinician must ensure that all In-Home Therapy staff receive the necessary support, guidance, and clinical oversight around the planning and treatment of the youth and families that they serve.

In addition, as noted within the In-Home Therapy Performance Specifications (see [Appendix D](#)), the IHT provider must provide

- ✓ A senior-level clinician licensed at the independent level and trained in working with youth and families who is available to consult with the In-Home Therapy staff, 24 hours a day, seven days a week; and
- ✓ A board-certified or board-eligible child psychiatrist or a child-trained mental health psychiatric nurse clinical specialist, who is available within an hour of being contacted, during normal business hours for consultation related to treatment planning, medication concerns, and crisis intervention, as needed.

B. Credentialing Requirements

As outlined in the In-Home Therapy Performance Specifications (see [Appendix D](#)), the IHT services are delivered by a team with both professional clinical and professional support staff. The In-Home Therapy clinician is a Master's-level clinician trained in working with youth and their families, including training in family therapy. The Therapeutic Training & Support worker is capable of providing family members with therapeutic support for behavioral health needs and has a bachelor's degree in a human service field from an accredited university and one-year experience working with children/adolescents/transition-aged youth. In lieu of a bachelor's degree, a TT&S worker may have an associate's degree in a human services field from an accredited school and one year of experience working with a specific population likely to need TT&S services; or, a high school diploma or GED and a minimum of two years of experience working with children/adolescents/transition-aged youth.

C. Use of Interns

Social work or other mental health profession interns may provide IHT services in compliance with the Managed-Care Entities' approved use of interns for In-Home Therapy services. See [Appendix D](#) for Program Specifications.

D. Requests for Waivers of Credentials

Waivers are considered by the Managed-Care Entities to ensure member access, meet member linguistic/cultural need, or meet a member's need for specialized care.

To ensure access to services for a diverse population of MassHealth members or for a specific child and family, In-Home Therapy providers may wish to consider candidates for the In-Home Therapy clinician or Therapeutic Training & Support worker position who do not meet all the credentialing requirements. For example, a master's degree or a bachelor's degree in a non-human services field such as criminal justice or forensic psychology does not meet the Managed-Care Entities' credentialing criteria; however, there may be an exception based on the candidate's work experience and the needs of member population. A provider may submit a waiver request to the Managed-Care Entity with whom the provider-candidate intends to do business.

To be considered by the Managed-Care Entities, waiver requests must be in writing and include the materials itemized in [Appendix J](#). Waivers for the required credentials to provide In-Home Therapy services must be sent to the MBHPCBHI@valueoptions.com mailbox for consideration. Following an initial review of the waiver request by the Managed-Care Entity collectively, each managed-care individual credentialing committees then review the request. Each Managed-Care Entity is responsible for notifying the IHT provider in writing of its individual, final decisions regarding the waiver request. No candidate for a waiver may provide the service without formal and final notice of approval of the waiver application from the Managed-Care Entity with whom the provider intends to do business.

E. Staff Transitions

Because staff changes alter the relationships between the IHT staff and the youth and family, In-Home Therapy providers must have a protocol in place for managing both planned and unplanned staff changes in ways that respect family preference and guarantee access to ongoing services as needed. Suggestions for managing staff transitions include

- Direct contact whenever possible between the staff who is leaving and the child and family to introduce the topic of staff change;
- Reassurance from the staff to the youth and family that it is changes in staff circumstances and NOT rejection of the youth that prompts the change;
- Exploration of youth and family preferences in reassigning a clinician or support staff; for example, some families may prefer to end services rather than start over with a new clinician, while others may be satisfied with a change;
- Reliance on other members of the full IHT team or Hub-dependent service to assist with continuity; for example, a Family Partner (Hub-dependent) with a strong connection with the family may help to ease transition to a new clinician, or a clinician's positive relationship with a youth may carry over to a new TT&S worker;
- The supervisor joining with the treatment team and/or the youth and family to clarify next steps;

- Whenever possible, a joint meeting of the departing staff and newly assigned staff with the youth and family;
- Timely response to all youth/family questions and concerns;
- Uninterrupted schedule of team meetings and other planned activities; and
- Seamless transfer of documentation to the new team member to spare the family from having to reiterate their needs, goals, progress, or stage of planning.

Staff Training

It is the responsibility of the In-Home Therapy provider to ensure that all staff, upon employment and at least annually thereafter, complete a training course that minimally includes the variety of topics listed in the In-Home Therapy Performance Specifications (see [Appendix D](#)). The training course must be provided by the In-Home Therapy provider, or its appropriate, appointed designee(s). Two or more provider agencies may join to share training responsibilities for staff from each organization, or some training topics may be delivered in on-line courses approved by the provider. The intent of the Performance Specifications is to ensure that staff are trained and refreshed yearly on the components that support the top quality In-Home Therapy which youth and families deserve. Training requirements also help to build a culture in the IHT program of accumulated wisdom through experience. When supervisory staff lead training and insert their own examples of work, they reinforce the values that are important to their program. This is especially crucial in building the reservoirs of sophistication in staff new-to-the-field as they learn to develop strong therapeutic relationships; hold a stance of appreciative inquiry; subtly distinguish cultural differences; carry family-centered values through system-centered challenges; and blend evidence-based science with relationship art.

The In-Home Therapy provider must document compliance with the Performance Specifications training requirements for every staff within their organization; this documentation must include details of how such training requirements have been satisfied. The Managed-Care Entities encourage IHT providers to incorporate into their overall organization's orientation curriculum relevant components of *Wraparound* that pertain to the CBHI Performance Specifications' training requirements.

All training topics must demonstrate understanding of the cultural context in which services are being delivered. The In-Home Therapy provider is committed to providing culturally informed services and aims to improve the access and quality of care received by all families. The provider trains staff to provide services with sensitivity, understanding, and respect for diverse cultures. The provider also hires staff who are knowledgeable in the primary languages and cultural backgrounds represented by the families in their service area, and develops programs that respect and reflect community values and policies that are informed by these values.

APPENDICES

Appendix A: Description of Other CBHI Services

Intensive Care Coordination (ICC) is delivered by a Community Service Agency (CSA) and provides care coordination through the *Wraparound* care planning process for youth age 20 and younger who have been diagnosed with a serious emotional disturbance (SED). A Care Coordinator works with the youth, family/caregiver(s), supports, providers, schools, state agencies, and others who play a key role in the youth's life. The Care Coordinator works with those identified to facilitate the development of a Care Planning Team (CPT) for the youth, and together this team comes up with an Individual Care Plan (ICP) to address the youth's needs and support the goals identified by the youth and family/caregiver.

Family Support and Training (FS&T) provides a structured, one-to-one, strengths-based relationship between a Family Partner and a parent/caregiver of a youth age 20 and younger. The purpose of this service is to resolve or ameliorate the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth. FS&T aims to improve the youth's functioning in the community or support the youth's return to the community via work with the caregiver. Services may include education; assistance in navigating the child-serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal/community resources (e.g., after-school programs, food assistance, summer camps, etc.); and support, coaching, and training for the parent/caregiver.

Mobile Crisis Intervention (MCI) is the youth-serving (age 20 and younger) component of an emergency services program (ESP) provider. MCI provides a short-term service that is a mobile, onsite, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if one exists. This service is provided 24 hours a day, seven days a week, and includes a crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to seven days of crisis intervention and stabilization services including onsite, face-to-face, therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral-health services and supports, including access to services along the behavioral health continuum of care. For youth who are receiving Intensive Care Coordination (ICC), MCI staff will coordinate with the youth's ICC Care Coordinator throughout the delivery of the service. MCI also will coordinate with the youth's primary care Clinician, any other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

In-Home Behavioral Services (IHBS) addresses a youth's (age 20 and younger) behaviors that interfere with successful functioning in the community. Services are delivered by one or more members of a

team consisting of professional and paraprofessional staff via a combination of Behavior Management Therapy and Behavior Management Monitoring.

Behavior Management Therapy includes a behavioral assessment (observing the youth's behavior, antecedents of behaviors, and identification of motivators) and the development of a highly specific behavior plan with interventions that are designed to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s). Supervision and coordination of interventions and training other interveners to address specific behavioral objectives or performance goals are provided.

Behavior Management Monitoring includes implementation of the behavior plan developed by the Behavior Management Therapist, as well as monitoring of the youth's behavior and reinforcing implementation of the behavior plan by the caregiver(s). Also included is progress reporting to the Behavior Management Therapist on implementation of the behavior plan, as well as progress toward behavioral objectives or performance goals so that the behavior plan may be modified as needed.

In-Home Therapy Services (IHT) is a structured, consistent, strength-based therapeutic relationship between a licensed¹³ clinician and the youth (age 20 and younger) and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. Interventions are designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment setting. The IHT team develops a treatment plan and uses established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused interventions and behavioral techniques to enhance problem solving, limit setting, risk management/safety planning, communication, building skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; and/or develop and maintain natural supports for the youth and parent/guardian/caregiver in order to promote sustainability of treatment gains.

Therapeutic Mentoring (TM) is provided to youth (age 20 and younger) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and in other community settings such as school, childcare centers, or respite settings. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. Therapeutic Mentoring services include supporting, coaching, and training the youth in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution, and relating appropriately to other children and

¹³ This language is taken from the IHT Performance Specifications dated June 25, 2009; however, additional clarification regarding the requirements of providers who provide both components of IHT services was communicated in a Provider Alert disseminated in early November of 2009. Please refer to each MCE's website for that specific Provider Alert for additional information.

adolescents, as well as adults, in recreational and social activities. TM promotes a youth's success in navigating various social contexts, learning new skills, and making functional progress in the community. Referrals are made solely through one of the Clinical Hub Services of Intensive Care Coordination, In-Home Therapy, or Outpatient Therapy.

Appendix B: In-Home Therapy Service Definitions

www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx

Appendix C: In-Home Therapy Performance Specifications

www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx

Appendix D: In-Home Therapy Medical Necessity Criteria

www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx

Summary of Medical Necessity Criteria for Admission

All the following criteria are necessary for participation in In-Home Therapy.

1. A Comprehensive Behavioral Health Assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) indicates that the youth's clinical condition warrants this service in order to enhance problem solving, limit setting, and risk management/safety planning, communication; to advance therapeutic goals or improve ineffective patterns of interaction; and to build skills to strengthen the parent/caregiver's ability to sustain the youth in their home setting or to prevent the need for more intensive levels of service, such as inpatient hospitalization or other out-of-home, behavioral health treatment services.
2. The youth resides in a family home environment (e.g., foster, adoptive, birth, kinship) and has a parent/guardian/caregiver who voluntarily agrees to participate in In-Home Therapy services.
3. Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education.
4. Required consent is obtained.

A youth who meets any one of the following criteria is not eligible to receive In-Home Therapy.

1. Required consent is not obtained.
2. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting at the time of the referral and is not ready for discharge to a family home environment or community-based setting with community-based supports.

3. The needs identified in the treatment plan that would be addressed by the In-Home Therapy services are being fully met by other services.
4. The environment in which the service takes place presents a serious safety risk to the In-Home Therapy service provider, alternative community settings are unlikely to ameliorate the risk, and no other safe venue is available or appropriate for this service.
5. The youth is in an independent living situation and is not in the family's home or returning to a family setting.
6. The youth has medical conditions or impairments that would prevent beneficial utilization of services.

Throughout the course of services and during treatment plan updates, the In-Home Therapy provider is responsible for ensuring that the youth is reassessed for medical necessity.

All the following criteria are required for continued participation in In-Home Therapy service.

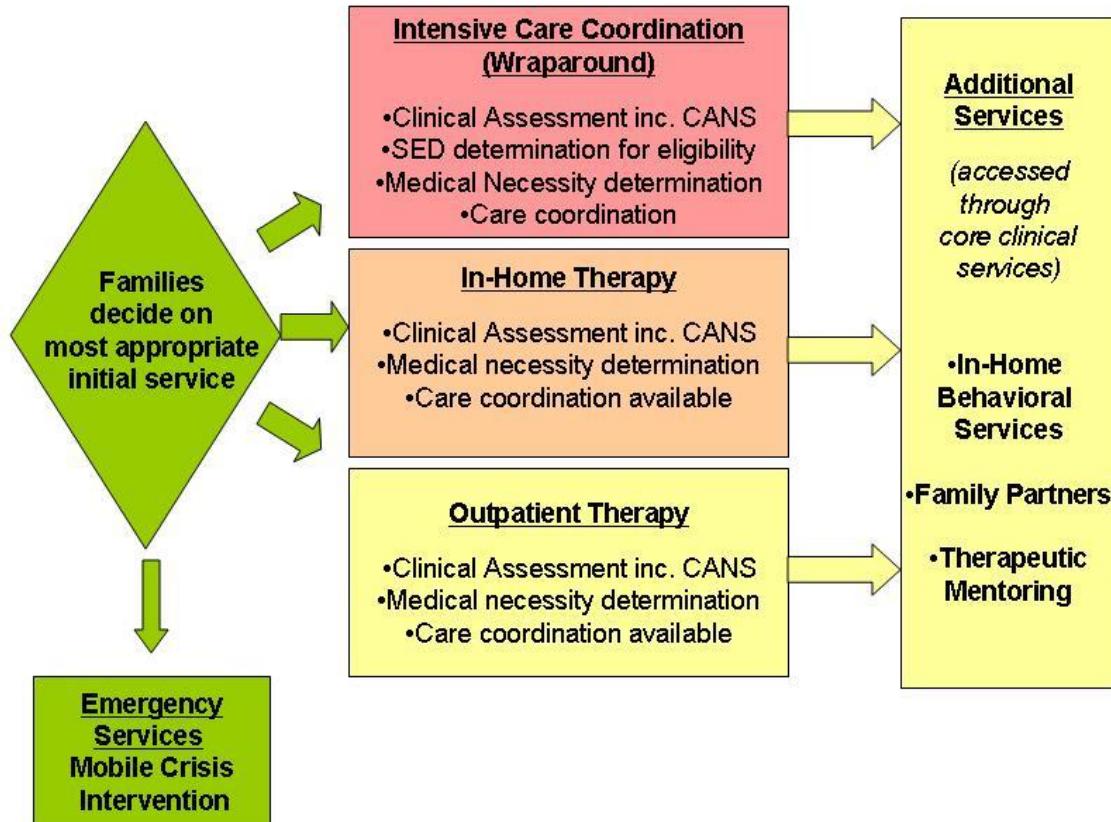
1. The youth's clinical condition continues to warrant In-Home Therapy Services and the youth is continuing to progress toward identified, documented treatment plan goal(s).
2. Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but the goal(s) has not been substantially achieved, or
3. Progress has not been made and the In-Home Therapy team has identified and implemented changes and revisions to the treatment plan to support the goals.
4. The youth is actively participating in the treatment as required by the treatment plan/ICP to the extent possible consistent with his/her condition.
5. The parent/guardian/caregiver is actively participating in the treatment as required by the treatment plan/ICP.

Appendix E: Managed-Care Entity CBHI Health Record Documentation Standards

www.masspartnership.com/pdf/MCE%20CBHI%20Health%20Record%20Doc%20Standards%20March%202013.pdf

These resources may also be found at www.masspartnership.com/provider/CBHIProviderResources.aspx.

Appendix F: Children's Behavioral Health Initiative Clinical Pathways Grid



Appendix G: Working with Hubs and Other Services

All Children's Behavioral Health Initiative providers are responsible for coordinating, collaborating and integrating care and service delivery to meet the youth's needs as well as assisting the youth and parent/caregiver to make informed decisions regarding care and service delivery.

The In-Home Therapy service is responsible for the following.

- Maintaining a linkage and working relationship with the local ESP/Mobile Crisis Intervention (MCI) team in their area in order to provide youth and families with prompt and seamless access to In-Home Therapy Services upon referral;
- Sharing Crisis Plans with ESP/MCI when appropriate and with consent from the family;
- Assesses the safety needs of the youth and family and within 48 hours of the first face-to-face with the youth and family, drafts a safety plan;
- Completes an initial Assessment within 24 hours of the first face-to-face with the youth and family;
- Completes a clinical Assessment inclusive of the Massachusetts CANS within seven days of the initial face-to face meeting with the youth and family, and then provides a copy to the family;
- Providing a focused treatment plan to help guide and expedite treatment by the provider of a higher level of care (*e.g.*, Inpatient, CBAT, Crisis Stabilization), and upon a youth's discharge, requests a copy of the facility's updated CANS;
- Coordinating and integrating care of other providers supporting the youth and family when clinically warranted and agreed upon by the family;
- Contacting the Hub-dependent service(s) (Therapeutic Mentoring, In-Home Behavioral, and/or Family Support and Training) provider at least one time per week to provide updates on progress toward the goals on the treatment plan;
- Coordinating and maintaining contact with other providers of behavioral health and physical health services of the youth family, with consent from the family, as needed to support the treatment goals of the youth and family;
- Including State Agencies, when involved with a youth and family, in the development of any treatment and safety planning with the youth and family;
- Promotes linkages with outpatient treaters by assisting the youth and family in attending outpatient appointments, including medication monitoring and psychiatric services;
- When a youth is receiving In-Home Therapy and has been admitted to Inpatient, CBAT, Therapeutic Care Unit (TCU), the provider engages immediately with the facility to facilitate seamless transition home;
- Ensuring the other providers (*e.g.*, Outpatient, Therapeutic Mentoring, In-Home Behavioral, Family Support and Training, schools) supporting the youth and family are aware of youth's safety plan, as needed and with appropriate consent; and
- Assisting the youth and family with accessing emergent medical care for youth as needed.

Appendix H: Crisis Planning Tools

www.masspartnership.com/provider/index.aspx?lnkId=CrisisPlanningTool.ascx

Appendix I: Managed-Care Entity Children's Behavioral Health Initiative Waiver Request Form

www.masspartnership.com/provider/CBHIProviderResources.aspx

Appendix J: Guidelines for Ensuring Timely Access to Children's Behavioral Health Initiative Services

www.masspartnership.com/provider/CBHIProviderResources.aspx

Access to Care

Guidelines for access to care and for contacting families can be found in the “Guidelines for Ensuring Timely Access to CBHI Services” and “Access to Care Protocol” (see [Appendix K](#) and [Appendix L: Children’s Behavioral Health Initiative Referral Log Waitlist](#), respectively). These protocols are designed to ensure a consistent process for all In-Home Therapy providers. The In-Home Therapy provider is expected to ensure that all relevant staff are trained on all aspects of this protocol, including expectations and guidelines regarding access to care definitions, response time to referrals, and waitlist follow-up expectations.

A. Waitlist Activities

In the event the In-Home Therapy provider is unable to offer a face-to-face appointment and initiate services within 24 hours of contact with the family, the provider must assist the family to obtain services as soon as possible. The In-Home Therapy provider must assist the family in connecting to another agency by checking availability on the MABHAccess website, calling other agencies to confirm availability and communicating the minimum necessary information, as allowable under the Treatment, Payment, Operations exception to the HIPAA regulation, to another agency to enable the family to receive services as soon as possible.¹⁴ If the family requests to wait for an available In-Home Therapy provider at a particular agency, the provider must document the family's preference on the Referral Log/Waitlist. In-Home Therapy providers must contact all waiting families on a weekly basis. If a family requests that the In-Home Therapy provider not call weekly, the In-Home Therapy provider

¹⁴ For more information, see U.S. Department of Health & Human Services website at www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html.

may call at the requested frequency. However, these providers are required to contact families weekly and therefore should not suggest to a family or otherwise offer to call less than weekly. Families should be asked to contact and inform the In-Home Therapy provider when they have been offered an appointment with another provider. Contacting families on the referral log is billable once the referred youth has been assigned to In-Home Therapy and s/he has initiated calls to the family to schedule the initial appointment. Weekly phone calls to waiting youth about their waitlist status are considered administrative and therefore are not a separately billable service (see [Appendix N](#)).

As noted within the Medical Necessity Criteria for Admission section above, it is the responsibility of the In-Home Therapy provider to ensure that referred youth meet the In-Home Therapy Medical Necessity Criteria if they are to provide In-Home Therapy services. The In-Home Therapy provider is expected to have an intake process that triages incoming referrals and links youth and families to more appropriate services as clinically indicated. If an IHT provider does not have the capacity to serve a youth referred for IHT services within the timeframe outlined in the Access to Care Protocol, the IHT provider must refer that youth to an IHT provider who can, unless the family specifically requests to wait for a certain individual or provider agency. It is unacceptable to offer an initial face-to-face appointment if the IHT provider is unable to initiate services and hold ongoing appointments with the youth immediately following the initial appointment. Should the In-Home Therapy provider exhaust the list of local IHT providers and there is no possibility within a reasonable distance from the youth and family, the IHT provider should contact the youth's Managed-Care Entity and provide a comprehensive list of all IHT providers with whom s/he attempted to link the youth.

B. Reporting and Monitoring Access

The Massachusetts Behavioral Health Access website ("MABHAccess") captures In-Home Therapy data weekly and monthly to monitor the access standards as outlined in the Access to Care Protocol and in the performance specifications. As stated above, IHT providers must record and track all referrals on an internal agency Referral Log/Waitlist. This information is used to complete provider reporting requirements on MABHAccess. For definitions of the referral/wait statuses, as well as a guide for entering the data into MABHAccess, see the dropdown menus on the second spreadsheet in the Referral Log/Waitlist ([Appendix L](#)). Should a Therapeutic Mentoring provider be unable to initiate services within 24 hours of contact with the family, and the family is not receiving IHT services from another provider, the In-Home Therapy provider tracks the family as 'waiting' on the Referral Log/Waitlist.

At least once a week, the In-Home Therapy provider enters updated information into MABHAccess regarding the program's available capacity or number of new referrals he/she can accept. At the end of each month, the provider also enters on MABHAccess information on his/her program's enrollment, referrals, and any youth waiting. This monthly data collection set includes

1. The number of youth waiting for the first available agency and the dates of initial phone contact with these families
2. The number of youth choosing to wait for your agency/staff and the dates of initial phone contact with these families
3. Referral information consisting of

- a. referral date
- b. date of initial contact with the family
- c. date of the first available appointment offered to the family

In the event a youth is waiting to be assigned to a new In-Home Therapy team, the In-Home Therapy provider must report the youth in both the waitlist section and the referral section of the MABHAccess data entry form. For "date of contact" and "date of referral" enter the last day that the vacating staff person worked on the case.

Following submission of this information on MABHAccess, the Managed-Care Entities monitor the status of each youth and family who are waiting for services, as well as the overall program capacity across the state.

C. Access for Non-English-Speaking Youth

The IHT provider should ensure access to care for all youth and families seeking In-Home Therapy services. All IHT providers are expected to maintain a list of qualified interpreters, including for the Deaf and Hard of Hearing, to provide services in the event the In-Home Therapy provider needs language capacity not available within their own organization. Because staff with linguistic capacity is preferable to using interpreters, providers are expected to offer the family/youth a staff person who speaks their language of choice whenever possible, or refer him/her to a provider who can do so. If there are no providers with staff who speak the family/youth language of choice within a reasonable distance from the family's residence, then the family's preferred provider is expected to use qualified interpreters and interpreter services, experienced in behavioral healthcare, appropriate to the needs of the local population. Interpreter services are intended to be used in a manner that enables the youth/family to participate fully in the In-Home Therapy service.¹⁵

Appendix K: Access to Care Protocol

www.masspartnership.com/provider/CBHIPrviderResources.aspx

Appendix L: Children's Behavioral Health Initiative Referral Log Waitlist

www.masspartnership.com/provider/CBHIPrviderResources.aspx

¹⁵ The Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.*, (ADA) and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 prohibits discrimination against individuals with disabilities, including depriving them of the full and equal enjoyment of the goods, services, facilities, or accommodations of any place of public accommodation, including hospitals and other health care providers. To ensure an equal opportunity to use their services, hospitals and other health care facilities must provide "effective communication" to individuals who are Deaf or hard of hearing other sign language by providing appropriate "auxiliary aids and services," including the provision of qualified American Sign Language (ASL) or interpreter services and assistive listening devices.

Appendix M: Managed-Care Entities In-Home Therapy Initial and Subsequent Authorization Processes

www.masspartnership.com/provider/CBHIProviderResources.aspx

The In-Home Therapy Service Definitions in [Appendix B](#) outline and describe the various components of the service for which In-Home Therapy providers may bill and be paid. For example, as specified within the Service Definitions, as well as the In-Home Therapy Performance Specifications (see [Appendix C](#)), collateral contacts (phone and face-to-face) is a function and responsibility of the In-Home Therapy provider, and, as such, is billable. Member transportation provided by staff is billable; however, staff travel time is built into the current rate structure, and is not billable as separate units. As noted within the Service Definitions, telephone support for the youth is billable. Care coordination is a function and responsibility of the In-Home Therapy provider (for youth not in Intensive Care Coordination) and the In-Home Therapy provider must collaborate with the members of the youth and family's treatment team or Care Planning Team regarding care-planning activities.

There is no limit on billing for activities related to service components, although all services provided by the In-Home Therapy clinician and/or Therapeutic Training & Support worker must be documented to meet the Medical Necessity Criteria for the service (see [Appendix D](#)). The In-Home Therapy provider is responsible for performing these activities as described within the In-Home Therapy Service Definitions and fulfilling the roles as described within the In-Home Therapy Performance Specifications. As such, the In-Home Therapy provider should review the various service components described above to ensure their staff are billing for any and all of those service components provided to the youth. As noted within the In-Home Therapy Service Definitions, time spent in supervision and time spent preparing for sessions with youth are not separately billable activities, as they are included in the rate.

Appendix N: In-Home Therapy Managed-Care Entity Authorization Parameters and Billing Codes

The Managed-Care Entities pay providers based on claims received for medically necessary services rendered to eligible youth. Each In-Home Therapy provider is responsible for monitoring eligibility and obtaining authorization from the Managed-Care Entity for the youth to whom they provide the IHT service. Providers should check the MassHealth Eligibility Verification System (EVS) every day to check the status of the youth's Managed-Care eligibility.

The authorization parameters for In-Home Therapy are generally given in three month increments. All authorization parameters are floors (minimums), not ceilings (maximums), and additional units may be requested and will be approved as long as the service is medically necessary for the member (see [Appendix D](#)). If a provider anticipates that s/he will exhaust the total number of units authorized prior to the end date of the authorization, the provider may contact the Managed-Care Entity to request additional units.

The following codes¹⁶ must be used by the In-Home Therapy provider when submitting claims to the appropriate Managed-Care Entity for reimbursement for In-Home Therapy services.

One (1) unit = 15 minutes

In-Home Therapy = the service provided by the master's-level staff	Billing Code: H2019-HO
Therapeutic Training and Support = the service provided by the bachelor's-level staff	Billing Code: H2019-HN

It is the responsibility of the IHT provider to ensure that claims are appropriately submitted to a Managed-Care Entity for reimbursement for any component of In-Home Therapy services provided by their staff, *i.e.*, using appropriate codes, ensuring Managed-Care Entity-specific claim submission requirements are met, ensuring that IHT services provided to a youth meet the In-Home Therapy Medical Necessity Criteria and are documented in the youth's medical record. If siblings within the same family each are receiving In-Home Therapy services from the same provider, the In-Home Therapy provider is responsible for ensuring that each sibling has his/her own medical record in which all services to that sibling are documented accordingly and that they meet the In-Home Therapy Medical Necessity Criteria for IHT.

Please refer to the links below for the authorization processes of each of the Managed-Care Entities.

Appendix O: Managed-Care Entities Websites

Beacon Health Strategies: www.beaconhealthstrategies.com

BMC HealthNet Plan: www.bmchp.org

Fallon Community Health Plan: www.fchp.org

Neighborhood Health Plan: www.nhp.org

Network Health: www.network-health.org

MBHP: www.masspartnership.com

Health New England: www.healthnewengland.com

¹⁶ From the Center for Health Information and Analysis www.mass.gov/chia.

Appendix P: Collaborative Helping

Excerpted from Chapter 3 of “*Collaborative Helping: A Strengths Framework for Home-Based Services.*” Authors: William C. Madsen and Kevin Gillespie. Wiley, 2014. For expanded guidance on using “mapping” and working collaboratively with families, please see the full publication.

A MAP TO GUIDE HELPING EFFORTS

The Vision: The process of helping has historically begun with two questions: “What is the problem?” and “What caused this problem?” We could instead ask, “What might a future with fewer problems look like?” and “What gets in the way of that happening?” Often our work is framed in terms of problems, but beginning with a focus on the problem often pulls people and helpers directly into a shared sense that life is filled with problems and little else. Instead, we can shift our initial focus to a vision of change which could be thought of as people’s preferred directions in life (*i.e.*, Where would you like to be headed in your life?). This line of questioning establishes a positive momentum, makes workers’ efforts more relevant to people’s lives, and builds stronger helping relationships.

The second typical question “What caused this problem?” is firmly embedded in a belief that knowing what caused a problem will help us figure out how to best address it. This may or may not be the case. In fact, most of the “answers” we have traditionally come up with have focused on deficits and are often experienced by people and families as blaming and shaming. Thinking in terms of obstacles may offer an alternative. When applied to problems in life, this idea shifts the organizing question from “What caused the problem?” to “What gets in the way of you doing things differently?” Obstacles are those things that get in the way of the people living out the lives they would prefer.

Four questions that comprise the Collaborative Helping Map in its simplest form are

1. Where would you like to be headed in your life?
2. What might help you get there?
3. What might get in the way?
4. What needs to happen next?

Graphically, the Collaborative Helping Map may be illustrated as below.

VISION	
<i>Where would you like to be headed in your life?</i>	
Obstacles / Challenges <i>What gets in the way?</i>	Supports <i>What helps you get there?</i>
Plan <i>What needs to happen next?</i>	

Of course, helping work is infinitely more complex than simply asking people these four questions, receiving their thoughtful responses, and then watching them head off to live happily ever after. These four questions represent areas to be jointly explored. The art and skill of this work lies in the ability to ask questions that are close to people’s experience, are personally meaningful to them,

and also stretch them beyond their automatic responses to go further in their own thinking and feeling.

Our work with individuals and families often goes better when organized around preferred directions in life. A focus on possibilities (what life *could* look like rather than what is *wrong* in life) can lift people out of the immediacy of problems and provide a better foundation for responding to challenges. Eliciting a vision of possibilities conveys that alternatives are possible and is a way to begin to collaboratively develop goals.

A useful vision statement is proactive, meaningful to the family, concrete, and highlights particular activities that a family will begin doing. It is much easier to pursue a goal of something you going to start doing rather than something you are going to stop doing. A goal of beginning a new behavior invites people outside the problem's influence that opens new possibilities and provides direction. People who have a clear vision for the future cope better with challenging current situations.

When we are helping people develop a vision to guide shared work, it is important to ask detailed questions that flesh out the vision. Some questions to help do that might include

- Concretely, what would that look like?
- Can you say more about that aspect you've just described?
- If we had a video of this future you're describing, what would we see on it?
- If I were a fly on the wall noticing this, what would I see?

Obstacles and Supports: Once we have an organizing vision, we can ask people about the challenges or obstacles they may encounter on the road to a preferred future as well as what might support or contribute to them getting there.

Some examples of obstacles could include behavioral health problems (e.g., depression, hyperactivity, tantrums); common feelings (e.g., sadness, anger, frustration); beliefs (e.g., my son is bad, I am worthless, there is no hope for us); interactional patterns between family members (e.g., the more a father corrects his son, the more the son rebels and the more the son rebels, the more his father corrects him); real life dilemmas (e.g., If I confront my husband about his infidelity, he will leave me penniless. If I don't, I will hate myself); unavoidable situations (e.g., generational poverty or lack education); and broader cultural forces (e.g., racism, sexism, classism, heterosexism).

We can also help people identify supports. These may include sustaining habits and practices (e.g., meditating, exercising, or counting to five before responding to one's children); sustaining beliefs (e.g., I can make a difference in my life); sustaining interactional patterns among family members (e.g., a father's validation and acknowledgment of his son leads to the son being more open and forthcoming and vice versa); intentions, purposes, values, hopes and dreams (e.g., love for one's children, a desire to be a better parent, a commitment to sobriety); supportive community members; and broader sustaining cultural expectations (e.g., a cultural value for respect and family).

The Plan: The final part of the Collaborative Helping map asks, "What needs to happen?" This section develops a meaningful, proactive, mutually agreed upon plan that draws on supports to address obstacles to achieve the vision and outlines concrete steps that each participant will take. It is important to engage people's natural communities in developing and supporting collaboratively developed plans. If we truly understand that people live in social networks and appreciate the potential of community, we must actively recruit important family and friends who are all around the people we are helping.

Appendix Q: Definition of Terms

Care Coordinator: individual who provides Intensive Care Coordination (ICC) to youth and families, using the high-fidelity Wraparound model. The role of the Care Coordinator includes facilitating the development of a Care Planning Team (CPT), including the youth and caregiver(s); convening CPT meetings; coordinating and communicating with the members of the CPT to ensure the development and implementation of the Individual Care Plan (ICP); working directly with the youth and family to implement elements of the ICP; coordinating the delivery of other services; and monitoring and reviewing progress toward ICP goals, and with the CPT, revising the ICP when necessary.

Care Planning Team (CPT): in Intensive Care Coordination, includes the youth and caregivers as well as both formal and natural support people (such as extended family, friends of the youth and family, representatives of child-serving state agencies, school personnel; and advocates who assist the family in identifying goals and developing and implementing an Individual Care Plan (ICP). A CPT must include more than the youth, caregiver, and care coordinator.

Child and Adolescent Needs and Strengths (CANS): a tool that provides a standardized way to organize information gathered during behavioral health comprehensive assessments. There are two versions of the Massachusetts CANS for two age groups: Birth through Four, and Five through Twenty. The Clinical Hub service is responsible for updating the CANS every 90 days. Hub-dependent service providers are not required to complete the CANS but should obtain the initial CANS and updates from the referring Clinical Hub provider, use information from the CANS to inform its work with the child and family, and provide feedback to the Clinical Hub provider to inform CANS updates.

Community Service Agency (CSA): provides Intensive Care Coordination using the high-fidelity Wraparound model, and provides the Family Support and Training Service (Family Partners). CSAs also are responsible for convening a local System of Care meeting to strengthen local communication and collaboration. CSAs contracted with MassHealth MCEs through a request-for-proposals (RFP) process and there are currently 29 geographically-based CSAs, as well as three CSAs specially dedicated to meeting the needs of underserved populations.

Comprehensive Assessment: a gathering of information, developed by a clinician in collaboration with a youth and his/her family, that serves to understand the youth's needs and direct the youth's treatment. An Assessment includes the youth's strengths and current concerns, organized with sufficient detail of medical, psychiatric, and substance use history, relevant developmental history, current treatment and medications, and risk factors to provide a substantive picture of the youth's mental status and functioning and a cogent clinical formulation and DSM V diagnosis. The Assessment includes a review of the child's need for care coordination and the adequacy of current care coordination services to meet this need. The Assessment includes the CANS.

The CANS is not a replacement or substitute for the complete Comprehensive Assessment but is a tool to organize the information gathered through the Comprehensive Assessment. The CANS supports communication among service providers and ensures that the child's and family's strengths and needs are identified across life domains. Providers of Hub-dependent CBHI services are expected to obtain

and use the most recent completed Comprehensive Assessment for the youth they serve. (*Please note that Assessment with a capital A is used throughout this document to refer to this specific document, in contrast to other forms of assessment or the general activity of making an assessment.*)

Emergency Services Program (ESP): provides behavioral health crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year. Each ESP/MCI provides ESP services for adults, MCI services for youth ages 0-20, and CCS services for adults ages 18 and older. Both ESP services for adults and MCI services for youth may be provided on a mobile basis in individual's homes, as well as other locations such as schools. Both ESP and MCI services may also be accessed on a walk-in or call-ahead basis at the ESP's Community-Based Location.

Family Partner: an individual with lived experience as the caregiver of a child or youth with behavioral health or special healthcare needs. Family Partners are trained to assist families in either of two MassHealth services: Family Support and Training (FS&T, a hub-dependent service through a Community Service Agency), or Mobile Crisis Intervention (MCI). Most Family Partners provide the FS&T service, and while they often pair with Care Coordinators to implement the Wraparound process with families, they can also work with families in other hubs, either In-Home Therapy or outpatient. On MCI teams, Family Partners pair with clinicians to provide support to youth in crisis and their families. The Family Partner provides emotional support for the caregiver and fosters empowerment and expression of family voice. Family Partners often share parts of their own stories as an intentional way of helping caregivers develop motivation and actionable insight.

Family Support and Training (FS&T): a hub-dependent service provided by a Family Partner to the caregiver of a youth receiving ICC, IHT or outpatient services. Building upon family strengths, the Family Partner supports the caregiver in ways that address the behavioral health needs of the youth. The Family Partner provides emotional support for the caregiver and fosters empowerment and expression of family voice. The Family Partner models, trains, and coaches the caregiver in relevant skills. FS&T may include activities such as sharing information, providing assistance in navigating the child-serving systems, assisting with linkages to parent and peer support groups, and identifying community resources. Family Partners in FS&T follow a successive process of "do for, do with, and cheer on" as caregivers become progressively able to accomplish more in support of the child.

Hub Services: Outpatient Therapy, In-Home Therapy, and Intensive Care Coordination. Hubs serve as the primary behavioral health care provider for a youth. The Hub service clinician, in concert with youth and family, assesses the youth's clinical need for services, including the youth's need for care coordination and Hub-dependent Services, and then links youth to appropriate services to meet those needs, including Hub Services providing greater levels of care coordination. Hubs collaborate with collateral supports and services to integrate interventions across treatment plans. Hubs facilitate treatment/care planning meetings as necessary for coordination of care. The Hub service with the highest level of intensity takes primary responsibility for care coordination.

Hub-Dependent Services: include Therapeutic Mentoring, In-Home Behavioral Services (except when circumstances warrant a waiver of the Hub referral), and Family Support and Training. They provide a

specialty service that augments the interventions of the Hub provider. Referrals for Hub-dependent services are made by one of the Hub services.

Individual Care Plan (ICP): developed according to *Wraparound* principles in the context of a Care Planning Team with youth enrolled in Intensive Care Coordination. The Care Plan specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family. It incorporates the strengths and needs of the youth and family. The ICP unifies multiple treatment plans into an overarching plan and serves as the primary coordination tool for behavioral health interventions, informal supports, and *Wraparound* care planning.

IHT Individualized Action Plan (IAP): also known as a treatment plan^[1], a detailed, individualized plan that is developed through collaboration between the IHT team and the youth and family. It states the youth's and family's goals and, using understanding gleaned from the Comprehensive Assessment, identifies the "prescription" for therapeutic activities that will help the youth move towards his or her goals. Hub-dependent providers work on one or more IHT IAP goals, except when ICC serves as the Clinical Hub. In this case, the Hub-dependent provider works on goals in the ICC Individualized Care Plan (ICP). The youth, parent/caregiver and IHT clinician all influence and concur with the final IHT IAP. The plan is written in nontechnical language that is understandable to the youth and family. The IHT IAP indicates who was involved in the development of the plan and who is responsible for carrying out each action on the plan.

[1]Some providers use the term Individualized Action Plan for a plan developed by a Hub-dependent service only. Here we also use IAP to refer to an IHT treatment plan, as this term is also used by providers.

In-Home Behavioral Service (IHBS): a Hub-dependent service (except when the situation warrants waiver of the Hub requirement), which addresses a youth's behaviors that interfere with successful functioning in the community. Services are delivered by one or more members of a team consisting of professional clinicians and qualified support staff via a combination of Behavior Management Therapy and Behavior Management Monitoring.

Behavior Management Therapy: a component of IHBS that includes a behavioral assessment (observing the youth's behavior, antecedents of behaviors, and identification of motivators) and the development of a highly specific behavior plan with interventions that are designed to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s). Both the assessment and the plan are created in collaboration with the youth and family. Supervision of interventions and training for other practitioners to address specific behavioral objectives are provided.

Behavior Management Monitoring: the other primary component of IHBS, which includes implementation of the behavior plan developed by the Behavior Management Therapist and the family, as well as monitoring of the youth's behavior and reinforcing implementation of the behavior plan by the parent/caregiver. Also included is reporting back to the Behavior Management Therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals, so that the behavior plan may be modified as needed.

In-Home Therapy Service (IHT): a service that provides intensive therapy in the home or community, through a master's level clinician and often incorporating a bachelor's level person providing the service of Therapeutic Training and Support (TT&S). If the youth is not enrolled in Intensive Care Coordination but is enrolled in IHT, IHT then is responsible for hub functions including treatment planning, communicating with other providers, and coordinating care. The IHT clinician develops a treatment plan and uses established psychotherapeutic techniques and intensive family therapy, working with the entire family or a subset of the family.

Intensive Care Coordination (ICC): provides care planning and care coordination using the high-fidelity *Wraparound* model. Collaborating with the family, ICC conducts an initial comprehensive assessment, facilitates the ongoing process for building a team, develops an Individual Care Plan to address the youth's needs and to support the goals identified by the youth and family, and then monitors and improves the plan until goals are met. The Intensive Care Coordinator works with the youth, caregivers, supports, providers, schools, state agencies, and others who play a key role in the youth's life to facilitate the development of a Care Planning Team for the youth. Care planning is driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

Managed-Care Entity (MCE): an organization that contracts with the Commonwealth to provide MassHealth insurance products to Massachusetts residents. The term MCE is used by EOHHS to refer to a broad category of health plans, including specialized plans that deliver particular benefits, such as Behavioral-health services only.

Mobile Crisis Intervention (MCI): the youth-serving component of an Emergency Services Program provider, the purpose of which is to support youth and their families through psychiatric emergencies in ways that leave the family safe and emotionally stable. MCI provides an immediate, short-term, face-to-face, therapeutic response to a youth experiencing a behavioral health crisis. The team is mobile, travels to where the emergency is taking place, and intervenes within one hour of contact. The MCI intervention identifies, assesses, treats, and stabilizes the situation to reduce immediate risk of danger to the youth or others, consistent with the youth's risk management/safety plan, if one exists. The MCI team helps the family develop a risk management/safety plan, if they do not already have one.

The MCI service is available 24 hours a day, seven days a week. Following a crisis, MCI can provide up to seven days of crisis stabilization services, which include face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention. The MCI team, as needed, makes referrals and builds linkages to all medically necessary behavioral health services and supports. For youth who are receiving ICC or IHT, MCI staff coordinates with the youth's Care Coordinator or In-Home Therapist throughout the duration of the MCI service. If IHT is acting as the clinical Hub, it must be available to coordinate with the MCI team before, during, and after the crisis event. MCI also coordinates with the youth's primary care physician, any other care management program, or other behavioral health providers involved with the youth.

Natural Supports: individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as extended family members, friends, neighbors, members of faith

communities, contacts at daycare, school, camp, or other community contexts that are accessible in families' daily environments. Participation of Natural Supports in the service planning process can make it friendlier to families. The purpose of joining with Natural Supports is to find sustainable, affirmative resources that will help children and families move forward in their lives long after professional involvement ends. Connecting with Natural Supports helps youth and families connect with their community and reduce isolation.

Parent/Caregiver: any biological, kinship, foster, and/or adoptive family/caregiver responsible for a parental role in the care of a youth.

Senior Care Coordinator: supervises other care coordinators and is a master's-level clinician licensed at the independent practice level.

Shared Decision Making (Informed Medical Decisions Foundation): a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's value and preference.

System of Care (SOC): a cross-system, coordinated network of services and supports organized to address the complex and changing needs of youth and families in the context of their culture, environment, and family situation. For a full discussion, see *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families*, edited by Beth A. Stroul, M.Ed., and Gary M. Blau, Ph.D.

Therapeutic Mentoring: a Hub-dependent service that offers structured, one-to-one, strength-based support services between a Therapeutic Mentor and a youth. It is dependent on the referring Hub service and guided by the Hub's Individualized Action Plan to address daily living, social, and communication needs.

Therapeutic Training & Support (TT&S): a dimension of the In-Home Therapy service, which is available to families to assist in achieving treatment goals and therapeutic objectives. The TT&S staff may coach, teach, or otherwise support the youth to develop, practice, and generalize skills to understand and manage emotional responses to family situations. He or she may assist the family in understanding the youth's emotional and mental health needs. TT&S staff may engage in skill building activities to strengthen the youth's functioning in the family and support family members in practicing concrete skills for dealing with the youth's episodes of disturbance. TT&S staff also help youth and families connect to Natural Supports. TT&S are not required to have clinical credentials for their role.

Wraparound: a well-defined planning process driven by the youth and family, which results in a unique set of community services and natural supports individualized for that youth and family to achieve a positive set of outcomes. CBHI services are designed to align with *Wraparound* principles. For a full description, see the National Wraparound Initiative website www.nwi.pdx.edu.

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