**In-Home Therapy Practice Profile**

**Appendix: Literature Review**

Core Components

Each practice profile matrix substantially aligns with the evidence, and the literature related to IHT highlights certain practice skills, theories and areas of emerging research.

**Practicing Cultural Relevance**

An overview of the practice skills related to cultural relevance[[1]](#footnote-1) can be found in several reference books, and certain selected chapters discuss the application of cultural relevance specifically to in-home therapy. Recent literature highlights the point that understanding unique cultural vulnerabilities and resilience across cultures and contexts is important to helping diverse families and refugee children and families. There are cultural and contextual differences related to resilience in children[[2]](#footnote-2), and differing parental beliefs about children’s mental health needs and treatment.[[3]](#footnote-3) Engaging and serving Hispanic and African American adolescents and families call for culturally specific interventions and strategies.[[4]](#footnote-4) Consider the specific needs of adolescents with behavior problems when they have experienced immigration-related separations.[[5]](#footnote-5)

Activities in even one early session can have a positive results (engagement, therapeutic alliance, activation) in bridging the gap between the family’s culturally influenced perspectives of their child’s behavioral and emotional responses and that of the clinician (cultural competence).[[6]](#footnote-6) Occasional examples of how practice has been culturally adapted are provided in the literature to illustrate practical applications (engagement, and interviewing skills, and new approaches to parenting and family relationships).[[7]](#footnote-7) It is helpful for clinicians to have self-awareness and to reflect on their perceptions of privilege and oppression as it may impact on the power differential between the clinician and client[[8]](#footnote-8).

**Engagement**

The engagement[[9]](#footnote-9) process, and the specific practice skills that are essential to in-home therapy are provided in selected chapters of reference books. There is a period of critical timing and focus for engaging families. Families are better engaged and retained when their service providers focus the content of their earliest contacts in a way that is responsive to a sense of urgency and priorities (as identified by the family), specifically assisting them with initial problem-solving[[10]](#footnote-10). Barriers to engagement include transference issues, such as a family’s past disappointments and negative experiences with treatment as well as other family circumstances such as stress and supports. [[11]](#footnote-11) Good engagement moves beyond the blaming of parents (attributing a lack of family commitment to treatment) and empowers parents to understand and accept their child’s diagnosis, and to actively join the treatment team[[12]](#footnote-12).

Specific IHT engagement skills (strategizing who to widely engage and involve in treatment, active listening, empathic responding, tracking and utilizing client language, recognizing and joining the family’s interaction patterns, accepting and validating, using strength-based language, adjusting to the family’s response, framing) are embedded in systems theory[[13]](#footnote-13). Some of the engagement skills, such as joining, are different when providing treatment in the family’s home, rather than in a clinic or office setting.[[14]](#footnote-14) Good results have been associated with a strong therapeutic alliance. Strong therapeutic alliance with the client (mother, father, adolescent) related to lower distress symptoms.[[15]](#footnote-15) Data reveals patterns of certain case characteristics and early terminations from treatment[[16]](#footnote-16) and distinguish between logistical and perceptual barriers[[17]](#footnote-17), which may be useful in helping agencies address their areas needing attention for engagement. Engaging foster parents in home-based services is important to developing young children’s relationship capacities and supporting them in foster care[[18]](#footnote-18).

**Assessment and Clinical Understanding**

Assessment[[19]](#footnote-19) as a process that seeks sufficient information in order to guide the IHT provider’s treatment decisions is summarized in selected chapters of reference books. The literature identifies the importance of considering various streams of information, which can be drawn from the child and family’s history as well as observations of the treatment team, information yielded from screening and standardized tools, and most importantly from details of current circumstances as described by the child and the family.

When assessing a child who is not emotionally and or behaviorally self-regulated, consider trauma and survival circuits[[20]](#footnote-20). Children’s behaviors and capacities change depending on who is present and what is the nature of their relationship with their caregiver. Assessing families includes relationship assessments (what happens when they face problems) and an assessment of caregivers’ needs and strengths.[[21]](#footnote-21) Using tools such as genograms and eco-maps can be more family friendly, while also increasing the quality of information that may be used for assessment.[[22]](#footnote-22)

While tools such as genograms and ecomaps are good conceptual tools, there is a wide range of valuable standardized instruments which can also be useful screening tools and assessment tools. Good interviewing and selective use of tools help the clinician to seek sufficient information and organize information to fulfill the purpose of assessment: formulation. For example, the CANS enlarges the scope of inquiry, a foundation of information, upon which to proceed to collaborative intervention planning.

**Risk and Safety Planning**

*Risk assessment and safety planning[[23]](#footnote-23) in IHT* is consistent with the mental health literature, and goes beyond the most common focus on suicide risk to also include a wider range of emergent situations and potential dangers such as youth arrest, parental medical emergency in addition to suicide. The steps and actions drawn from the tools and training[[24]](#footnote-24) of Kappy Madenwald.[[25]](#footnote-25) Additional MA DMH tools[[26]](#footnote-26), published online appear to have been developed for the purposes of reducing restraints and seclusions for sub-acute and inpatient settings, are also of high quality and may be useful for adaptation for the community-based work in IHT as well. It is important for clinicians to consider the distinctions between self-harm and suicidality, particularly in crisis planning[[27]](#footnote-27).

**Collaborative Intervention Planning**

*Collaborative Intervention Planning[[28]](#footnote-28)* must be developmentally informed, and understood within the context of unique characteristics of services to infants, toddlers, preschoolers, school-age youth, and transition-age youth.[[29]](#footnote-29) Shared decision-making becomes complicated in medication management, and calls for a some thinking around medication from the practitioner’s perspective of “compliance”. The therapeutic alliance supports long-term gains when clients’ preferences and decision-making processes are valued, as they learn how to use medications along with other coping strategies.[[30]](#footnote-30)

**Intensive Therapeutic Intervention**

The core component matrix emphasizes that the heart of In Home Therapy is the intensive therapeutic intervention[[31]](#footnote-31) that enhances the well-being of the child with behavioral health needs as well as the capacity of the caregivers to provide a safe and supportive environment for the child. The therapeutic intervention consists of strategies and actions that are most likely to heal, strengthen, and last. High quality interventions make every meeting count with specific purposes for each session, plans for conducting sessions, clear correlation between the session plan and the goals established in the treatment plan, and actions to practice between sessions. Intensive therapeutic interventions use strengths in real and tangible ways to address needs. Family reports of both improvements and setbacks directly inform next steps as do collateral perspectives and direct observation by the IHT team. Therapeutic intervention is a live process that responds to changes in the family’s treatment needs, including possibilities for higher as well as lower levels of intensity. IHT models may effectively use evidence-based practices[[32]](#footnote-32) as well as practice-based evidence[[33]](#footnote-33) in developing interventions.

When planning the intervention strategy, consider the appropriate intensity of services and potential concerns for each treatment option (contraindications) such dangerous situations, acute medical conditions, or repeated negative outcomes of the family’s prior experiences with similar treatment[[34]](#footnote-34). One of the anticipated downsides of EBT’s was researched, and showed that the use of manual-guided intervention did not harm the therapeutic alliance between the therapist and youth.[[35]](#footnote-35) Consider how psychotropic medications integrate within the intervention technique(s), and how the use, prescriptions, or dosages of medications may change during the sequential stages of treatment.[[36]](#footnote-36)

Parenting tasks and mental health challenges are related to child development phases and strategies for engagement, assessment, and clinical strategies for infant, toddler, and preschool children[[37]](#footnote-37). Clinical strategies must also be considered for children with difficult temperaments[[38]](#footnote-38), children who are having difficulty regulating physical and emotional experiences[[39]](#footnote-39), difficulty forming attachments[[40]](#footnote-40), and for children with particular diagnoses, such as ADHD[[41]](#footnote-41), mood disorders[[42]](#footnote-42), sensory processing challenges[[43]](#footnote-43), attachment and traumatized children[[44]](#footnote-44). Parental issues of substance abuse and parental mental health[[45]](#footnote-45) impacts on family functioning and must be incorporated into adaptations of the ongoing intervention. Tools and documents used in the clinical process of assessing and treatment planning, such as the CANS[[46]](#footnote-46) and Treatment Plan[[47]](#footnote-47) can also be used to support effective communication with families and aid in shared decision-making.

**Care Coordination and Collaboration**

The multiple perspectives of the child, family, school, community, and service providers come together in care coordination and collaboration. These perspectives help to develop the fullest picture of the strengths and challenges of the child and family, which also provides the context for how the IHT provider can accurately understand the priorities, work with the participants to set expectations, negotiate the decisions, sequences, and determine the most beneficial ways of helping. There are often competing demands in the family. Simultaneously attending to needs of the children and caregivers’ challenges when there are issues of adult mental health, substance abuse, intellectual disabilities, and teen parents is important for the purpose of strengthening attachment relationships and a supporting higher family functioning[[48]](#footnote-48). Children with serious emotional disturbance much lower graduation rates than statewide averages of all children, such as in North Carolina where the rate compared 42% to 76%[[49]](#footnote-49). The study indicates the need to keep academic progress in view during collaborative meetings, as those efforts have present day implications for learning, grades, and severity of behavior problems at school but also future graduation rates, employability and life earnings.

**Engaging Natural Supports and Community Resources**

*Engaging natural supports[[50]](#footnote-50)* is highly valued; however, more attention must be given to the tasks, time, and follow through of doing so. The research shows that the actual use of natural supports in systems of care requires further development.[[51]](#footnote-51) How, by what means, can clinicians connect families in stronger ways to 8 types of potential sources of support studied: neighbors, friends, spouse or partner, family service providers, faith community, family support groups or organizations, and coworkers. A study of rural youth looked at their help-seeking behavior and the likelihood of engaging natural supports on their own. The study described gender differences and patterns depending on what types of problems they were experiencing and the severity of their problems. It is not surprising that as they got older, they chose friends as their first choice for help and less likely to choose family members.[[52]](#footnote-52)

**Preparing for Exit**

Preparation to discharge[[53]](#footnote-53) as a process is described in selected chapters of reference books. Some studies have discovered patterns of unexpected exits from services[[54]](#footnote-54), and the research topic of preparation for change (accessibility to supportive relationships that will continue, maintaining skills and progress, planning for crisis after the transition, and future focuses) primarily focuses on discharges from hospital and residential settings. The existing research in other child mental health settings examines family members’ involvement in the transition plan, perceived readiness, the need for ongoing supports. One study discovered an unexpectedly low priority on mental health (ranked by parents and youth). Youth and parents ranked supports and services related to community involvement, family, and independent living as more important, expanding the topics beyond their immediate needs.[[55]](#footnote-55) Another set of research studies focuses on transitions to adulthood, which may coincide with age eligibility and exit from treatment or entire service systems[[56]](#footnote-56).

1. Overview of cultural relevance (Hepworth, Rooney, Strom-Gottfried, Larsen, 2013, chapter chapters 8, 10); related to serving young children (Cornett, 2014, chapter 18) [↑](#footnote-ref-1)
2. Cultural and contextual resilience (Unger, 2005) [↑](#footnote-ref-2)
3. Ethnic differences in parental beliefs about ADHD and treatment (Pham, Carlson, Kosciulek, 2010) [↑](#footnote-ref-3)
4. Culturally specific interventions and strategies (Bains, 2014; Santisteban, Mena, Abalo, 2012; Robbins, Szapocznik, Dillon, Turner, Mitrani, Feaster, 2008; Liddle, Jackson-Gilfort, Marvel, 2006; Sanisteban and Mena, 2009) [↑](#footnote-ref-4)
5. Immigration-related separations (Mitriani Sanisteban, Muir, 2004) [↑](#footnote-ref-5)
6. Culturally enhanced video feedback aids engagement and therapeutic alliance (Yasui and Henry, 2014) [↑](#footnote-ref-6)
7. An example of an EBT Parent Child Interaction Therapy (PCIT) culturally adapted to support American Indian and Alaska Native families (Bigfoot and Funderburk, 2011) [↑](#footnote-ref-7)
8. Privilege and oppression related to clinician/ client power differential (Hays, Chang, Dean, 2004) [↑](#footnote-ref-8)
9. Overview of engagement (Hepworth, Rooney, Strom-Gottfried, Larsen, 2013, chapter 5; Fraser, Grove, Lee, Greene, Solovey, 2014, chapter 3; Cornett, 2014, chapter 1)) [↑](#footnote-ref-9)
10. The critical timing and problem-solving (McKay, Nudelman, McCadam, Gonzales, 1996; McKay et.al, 2004)) [↑](#footnote-ref-10)
11. Transference, family stress, social supports as potential barriers to engagement (Dadds and McHugh, 1992; Kazden and Wassell, 2000; McKay, Pennington, McCadam, 2001) [↑](#footnote-ref-11)
12. Beyond blame (Kelleher, 2015) [↑](#footnote-ref-12)
13. Systems theory and engaging (Fraser, Grove, Lee, Greene, Solovey, 2014) [↑](#footnote-ref-13)
14. Joining and other skills differ in practice setting (Stinchfield, 2004) [↑](#footnote-ref-14)
15. Good results with strong therapeutic alliances (Johnson, Wright, Ketring, 2002) [↑](#footnote-ref-15)
16. Early terminations data (Gopalan et. al., 2010; Larsen-Rife and Brooks, 2009) [↑](#footnote-ref-16)
17. Logistical and perceived barriers to engagement (McKay and Bannon, 2004) [↑](#footnote-ref-17)
18. Importance of engaging foster parents (Cornett, 2014, chapter 20) [↑](#footnote-ref-18)
19. Overview of assessment (Hepworth, Rooney, Strom-Gottfried, Larsen, 2013, chapters 8, 9, 10; Cornett, 2011, chapters 7-12; Saxe, Ellis, Kaplow, 2007, chapter 7; Rast and Rastsmith, 2015, chapters 12, 13, 14) [↑](#footnote-ref-19)
20. Self-regulation, trauma, survival circuits (Saxe, Ellis, Kaplow, 2007) [↑](#footnote-ref-20)
21. Assessment includes relationship and caregivers’ needs and strengths (Cornett, 2014, chapters 6, 7; Anderson, Lyons, Giles et. al, 2003) [↑](#footnote-ref-21)
22. Genograms and eco-maps (Butler, 2008; Rempel and Kishner, 2007) [↑](#footnote-ref-22)
23. Overview of risk and safety planning (Cornett, 2011, chapter 16; Stanley and Brown, 2011; Stanley and Brown, 2008; Rast and Rastsmith, 2015, chapter 19) [↑](#footnote-ref-23)
24. Crisis planning tools and training (Resources such as the safety plan template, advance communication to treatment providers, and supplemental documents are accessible on the MBHP website <https://www.masspartnership.com/provider/CrisisPlanning.aspx>) [↑](#footnote-ref-24)
25. Sample of crisis planning training content (Kappy Maldenwald, 2011, accessible at the MBHP website https://www.masspartnership.com/pdf/EffectiveCrisisPlannin-April11and132011FIN.52011.pdf) [↑](#footnote-ref-25)
26. MA DMH Safety Tool 2006 (<http://www.mass.gov/eohhs/docs/dmh/rsri/safety-tool-for-kids-sample.pdf> ) [↑](#footnote-ref-26)
27. Crisis planning and discussions of non-suicidal self-harm (Fisher, 2011; Brausch and Gutierrez, 2010) [↑](#footnote-ref-27)
28. Overview of collaborative intervention planning (Rast and Rastsmith, 2015, chapters 17, 18; Cornett, 2011, chapters 13-15; Fraser, Grove, Lee, Greene, Solovey, 2014, chapter 5) [↑](#footnote-ref-28)
29. Developmentally appropriate services (Cornett, 2011), clinical strategies to support caregivers of young children (Cornett, 2014, chapter 15) [↑](#footnote-ref-29)
30. Shared decision making and medication management (Deegan and Drake, 2006) [↑](#footnote-ref-30)
31. Overview of intensive therapeutic intervention (Rast and Rastsmith, 2015, chapters 21, 22, 23; Fraser, Grove, Lee, Greene, Solovey, 2014, chapters 6, 7, 8) [↑](#footnote-ref-31)
32. A wide range of evidence based practices in IHT and home-based therapies, including FFT, MST, TST, I-FAST (Mazier, 2015, chapter 2), IFPS, MTFC (Maachi and O’Conner, 2010) ARC (Blaustein and Kinniburgh, 2010); EBP’s in infant and early childhood mental health (Cornett, 2014, chapter 17) [↑](#footnote-ref-32)
33. Common Factors Approach examples: I-FAST (Fraser, Grove, Lee, Greene, Solovey, (2014)

    MAPS, MATCH [↑](#footnote-ref-33)
34. Contraindications (Maachi and O’Conner, 2010) [↑](#footnote-ref-34)
35. EBT manuals and therapeutic alliance (Langer, McLeod, Weisz, 2011) [↑](#footnote-ref-35)
36. Integration of medications and treatments (Saxe, Ellis, Kaplow, 2007, chapter 13) [↑](#footnote-ref-36)
37. Developmental considerations for working with families with young children (Cornett, 2014) [↑](#footnote-ref-37)
38. Clinical strategies for children with difficult temperaments (Cornett, 2014, chapter 11) [↑](#footnote-ref-38)
39. Clinical strategies to help children manage regulation (Cornett, 2014, chapter 10) [↑](#footnote-ref-39)
40. Clinical strategies to support attachment relationships (Cornett, 2014, chapter 14) [↑](#footnote-ref-40)
41. Clinical strategies to support children with ADHD (Cornett, 2014, chapter 8) [↑](#footnote-ref-41)
42. Clinical strategies for children with mood disorders (Cornett, 2014, chapter 12) [↑](#footnote-ref-42)
43. Clinical strategies for children with sensory processing challenges (Cornett, 2014, chapter 13) [↑](#footnote-ref-43)
44. Clinical strategies to support traumatized children (Cornett, 2014, chapter 9) [↑](#footnote-ref-44)
45. Parental mental health (Reupert, Maybery, Nicholson, Gopfert, Seeman, 2015; Nicholson, Wolf, Wilder, Biebel, 2014; Beardslee, Martin, Gladstone, 2012) [↑](#footnote-ref-45)
46. CANS (Anderson, Lyons, Giles et. al, 2003) [↑](#footnote-ref-46)
47. The treatment plan can be downloaded at the Massachusetts Standardized Documents Project (MSDP) website abhmass.org [↑](#footnote-ref-47)
48. Attending to caregivers needs (Cornett, 2014, chapter 15) [↑](#footnote-ref-48)
49. Educational outcomes in a SOC for children with emotional disturbance (Strompolis, Vishnevsky, Reeve, Munsell, Cook, Kilmer, 2012) [↑](#footnote-ref-49)
50. Overview of engaging natural supports (Cornett, 2011, chapter 3; Rast and Rastsmith, 2015 chapters 16, 24), [↑](#footnote-ref-50)
51. Supports for families in systems of care (Cook and Kilmer, 2010) [↑](#footnote-ref-51)
52. The importance of friends as natural supports for adolescents (Sears, 2004) [↑](#footnote-ref-52)
53. Overview of preparing for exit (Walker, Bruns, Vandenberg, Rast, Osher, Miles et al, 2004; Fraser, Grove, Lee, Greene, Solovey, 2014, chapter 8, Rast and Rastsmith, 2015, chapters 22, 26) [↑](#footnote-ref-53)
54. Early and late dropouts from treatment (Kazdin, 1994; McCabe, 202) [↑](#footnote-ref-54)
55. High priority supports for youth and their parents beyond mental health services (Trout, Hoffman, Huscroft D’Angelo, Epstein, Hurley, Stevens, 2014) [↑](#footnote-ref-55)
56. Transition to adulthood (Clark and Davis, 2000; Greenen and Powers, 2006; Schulenberg, Sameroff, Cicchetti, 2004; Davis and Sondheimer, 2005; Ringeisen, Casanueva, Urato et al., 2009) [↑](#footnote-ref-56)