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Kathryn Cole
MassHealth (Medicaid) Clinicians' Perceptions of In-Home Therapy with Children and Families

ABSTRACT

This study identifies the attitudes of clinicians providing in-home therapy and related services under the umbrella of MassHealth in Massachusetts. It examines who is doing In-Home Therapy, whether these clinicians (and bachelor's level providers known as providers of therapeutic training and support) feel adequately prepared to do this work, the kinds of training these clinicians receive, what could be done in order to help them feel more successful, find job satisfaction, and want to continue providing in-home therapy.

Three hundred and four participants completed an online, anonymous survey that collected basic demographic information including gender, age, race, education, professional background, geographic location, and work experience. Participants were required to be at least 18 years of age and be providing in-home therapy or therapeutic training and support services in order to participate. Participants were then asked to rate various expectations on a Likert scale indicating if they agree or disagree with that expectation and to respond to five open-ended questions.

The findings identified that overall participants report high levels of satisfaction related to their work, specifically with regard to the population, families, children, and adolescents, with whom they work. Participants also report issues and challenges in their work. These challenges include training, productivity requirements, safety, and teamwork within their agency. Policy implications of the findings are discussed.

MASSHEALTH (MEDICAID) CLINICIANS' PERCEPTIONS OF IN-HOME THERAPY WITH CHILDREN AND FAMILIES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Kathryn Cole

Smith College School for Social Work
Northampton, Massachusetts 01063

2016

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Chapter I

Introduction

In 2001 a federal class action lawsuit was brought against the Commonwealth of Massachusetts claiming the Commonwealth was not providing adequate care to children with Medicaid suffering with serious mental illness under the EPSDT provision of the Medicaid statute (Goldberg, 2011).[1] In 2006 the United States District Court of the Western Massachusetts Division decided the case, *Rosie D. v. Patrick,* in favor of the plaintiffs. In 2007 the court issued a remedial order, which defined what the state needed to do in order to meet the needs of Medicaid-eligible children and their families statewide. This plan sought to restructure the children's mental health system by incorporating "intensive home-based services, including behavioral health screenings, assessments, case management, crisis intervention and in-home therapeutic supports" as well as other elements. (Rosie D.: Reforming the Mental Health System in Massachusetts, Litigation Overview, 2008).

Today, ten years after this landmark case, in the Commonwealth of Massachusetts, there are a great number of clinicians, working with children and families accessing their health care needs through MassHealth, the state's Medicaid program. Many of these clinicians provide In-Home Therapy, one of the new services specified in the remedial order. Many others, in Massachusetts and in other states, provide some kind of home-based family therapy, a kind of mental health treatment in which clinicians (or teams) go into families' homes to provide care.

[1] EPSDT stands for Early and Periodic Screening Diagnosis and Treatment, This section of the Medicaid law provides very strong entitlement to healthcare for Medicaid eligible individuals under the age of 21.

Despite its increasing popularity and importance, home-based therapy (including MassHealth's In-Home Therapy) is a relatively new mode of treatment and there has been little written on the experiences of clinicians doing this work.

During the first year of working towards my MSW I gained experience in providing in-home therapy in the state of Colorado while interning at a community mental health clinic.[2] I found this kind of work to be very different than the outpatient therapy I also provided and noted the unique challenges that came along with working in clients' homes rather than clients coming into an office. Anecdotally I had heard from other clinicians that morale was low in in-home therapy positions and the turnover rate was high, meaning clinicians did not stay in their role as in-home therapists for long. This led me to be curious about the nature of in-home therapy positions and I wondered if other clinicians had similar or different experiences than I did. This study examines who is doing In-Home Therapy in Massachusetts, whether these clinicians (and bachelor's level providers known as providers of Therapeutic Training and Support, or TT&S) feel adequately prepared to do this work, the kinds of training these clinicians receive, what could be done in order to help them feel more successful, find job satisfaction, and want to continue providing In-Home Therapy (IHT). Currently the Children's Behavioral Health Initiative, which is responsible for implementation of the Rosie D remedy services within MassHealth, is working to strengthen IHT services.[3] This study seeks to understand clinician's

[2] In what follows, In-Home Therapy (capitalized) refers specifically to the MassHealth service. Home-based therapy or in-home therapy refers to the broader group of home-based family therapy services in Massachusetts and elsewhere.

[3] The new or enhanced services implemented under the Rosie D remedy are often referred to in Massachusetts as "CBHI services".

experiences with IHT in order to help provide more information that could aid in improving these therapeutic services.

IHT and the Massachusetts Children's Behavioral Health Initiative

The Massachusetts Children's Behavioral Health Initiative (CBHI) provides guidelines for clinicians providing IHT and also an overview of these services for families to review when receiving this form of care. Their overview of In-Home Therapy Services states,

> The main focus of In-Home Therapy Services is to ameliorate the youth's mental health issues and strengthen the family structures and supports. In-Home Therapy Services are distinguished from traditional therapy in that services are delivered in the home and community; services include 24/7 urgent response capability on the part of the provider; the frequency and duration of a given session matches need and is not time limited; scheduling is flexible; services are expected to include the identification of natural supports and include coordination of care (CBHI; In-Home Therapy, 2009).

In Massachusetts IHT is provided by one clinician, working in the majority of cases with a trained paraprofessional who work with the child and family in their home environment in order to understand the family dynamics, possible safety concerns, and seek to teach strategies that address stressors that may arise in the process (CBHI; In-Home Therapy, 2009).

In order to meet medical necessity criteria to receive IHT in Massachusetts, a "comprehensive behavioral health assessment" must indicate 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" (CBHI; In-Home Therapy, 2009). The child or youth must also live in a family home environment and have a parent or caregiver that agrees to participate in IHT services. It must also be evaluated that outpatient services alone would not be sufficient in meeting the needs of the youth and family, and required consent must be obtained (CBHI; In-Home Therapy, 2009).

As long as the youth and family continue to meet the above criteria and the youth's clinical condition continues to warrant treatment, the family remains eligible for in-home treatment. The clinician continues to work with the youth and family to develop a treatment plan that includes obtainable objectives (CBHI; In-Home Therapy, 2009).

One potential obstacle to implementation of service expansions such as CBHI is workforce challenges. Where will all the skilled providers come from to provide these services? In 2009 The Blue Cross Shield Foundation of Massachusetts conducted a study that assessed issues related to the clinical workforce and children's mental health services in the state, referred to as, "Accessing Children's Mental Health Care in Massachusetts: Workforce Capacity Assessment" hereafter referred to as "Workforce Capacity Assessment". According to this study, "Approximately 70,000 children in Massachusetts are estimated to have a severe mental health need, while as many as 216,000 are estimated to have a diagnosable mental health disorder" (Workforce Capacity Assessment, 2009). The study found that the current mental health workforce is aging and that the majority of mental health staff is over the age of 50 (Workforce Capacity Assessment, 2009). The aging workforce, in conjunction with parity laws that expand mental health coverage and an increase in emphasis on evidenced based treatments,

which often require additional training in mental health practices, have led to several national clinical workforce challenges. These challenges include provider retention, reimbursement, and barriers in entering the workforce (Workforce Capacity Assessment, 2009, p. 8).

In my personal experience providing in-home therapy in Colorado, I found the position to be highly rewarding, yet I often felt uneasy about the unpredictability of being in my clients' homes. This study sheds light on some of the experiences of the current workforce doing IHT in Massachusetts with the hopes of providing feedback to CBHI about ways to make IHT more successful.

Chapter II

Literature Review

The following review of the literature examines a broad scope of home-based therapeutic services including IHT and home-based family therapy. This chapter is divided into five sections: the first section provides some historical context into the roots of home-based treatments. The second section outlines the benefits of home-based treatments. The third examines the evidence-based practices that are often used in home-based family therapy. The fourth outlines the challenges of home-based family therapy, and the fifth section looks into importance of the training clinicians receive to provide these treatments.

Home Based Treatment and Family Preservation

Providing mental health services in community and home settings has become an increasingly common practice of mental health professionals in community agencies (Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012; Cortes, 2004). Over the last few decades, home-based mental health services have been a growing and effective option for treating chronic mental health and behavioral health concerns for children and families. The roots of IHT started in the 1970's as an offshoot of "results-oriented" programs, which sought to keep "at-risk" kids in their homes with their families, while also working on maintaining safety (Reiter, 2008). Fuller (1991) explains that home-based services served primarily in the child welfare world as a "family preservation" intervention and safety planning first used in child abuse and foster care cases and came through the Adoption Assistance and Child Welfare Act of 1980. This act made it clear that Congress intended federal social service funding to be used, first, to maintain children in their homes as long as their safety was not compromised rather than placing children

and adolescents in out-of-home care like residential treatment facilities and hospitals (Reiter, 2008).

Wells (1995) describes family preservation services as "structured skills-building programs delivered on a short-term basis in a family's home mainly with the purpose of teaching parents new tools to manage family conflicts and stress". This concept of service places value in preserving the family as a functioning social unit. Family preservation services, now more often called *home-based family therapy, in-home therapy,* or *family-based programs*, made it more acceptable to incorporate parents as active members in interventions and treatment. This assumption introduces a different understanding of family dynamics that incorporates "systemic principles" (Cortes, 2004). Instead of blaming caregivers for a child's maladaptive behavior, the focus is on families' "interactive patterns, which moves families away from blaming, scapegoating, or looking for simple causes" (Dembo, Dudell, Livingston, & Schmeidler, 2002).

Advantages of Home Based Family Therapy

Today home-based family therapy continues to hold goals around safety planning, prevention of child placement outside of the home, and family preservation, as well as advantages from a behavioral health perspective. In some instances, different funders may pay for home-based family therapy services but with differing goals. For example, mental health goals may be linked to behavioral health outcomes for Medicaid funders, while child welfare goals such as family preservation, prevention of out of home placement, and overall improvement of the home environment may be primary concerns of child protective agencies. The literature (Eyberg, Nelson, & Boggs, 2008; Reiter, 2008; Wood, Barton, and Schroeder, 1988; Morrison Dore & Zuffante, 2015) points to the many benefits of family-based therapies. These services can more often be tailored to fit the family's unique needs because they allow

clinicians to work with families' schedules. Because of this, clinicians are often better able to gather important information about the family and their needs through observing the family members in their home setting and listening to what the family needs. Additionally, families that were previously unable to make outpatient clinic appointments are now better able to receive services (Reiter, 2008).

Cortes (2004) explains that home-based therapy services can often be a less resistant avenue to address and understand family patterns. Youth and their families may be more comfortable in their own homes because they are more likely to feel in control and safe in these familiar environments (Johnson, Wright, & Ketring, 2002). Furthermore, many clients in need of behavioral health or psychiatric services are often unable to access traditional treatment programs, which can prevent them from receiving behavioral healthcare or other mental health treatment. Home-based family therapy reduces the barriers that prevent people from accessing available programs by bringing the counseling services closer to individuals who may greatly benefit (Cortes, 2004; Reiter, 2008). Evidence suggests that because of this access, families receiving home-based instead of office-based services have higher attendance rates and are often more engaged in treatment (Mattek, Jorgenson, & Fox, 2010).

Evidence-Based Treatments and Interventions in Home-Based Family Therapy

Mental health professionals are challenged with utilizing innovative treatment models to meet the needs of diverse communities. In many mental health settings, evidenced based practices (EBPs) and treatments are being used more often to meet funding requirements and to provide high quality, research-based treatment (Lee et al., 2013). Despite this rise in the use of EBPs, there remain several barriers for community-based mental health clinics to use and implement evidence-based treatment programs (Gewirtz & August, 2008). One of the central

concerns is the lack of internal capacities and infrastructure necessary in integrating evidence-based practices into existing services (Gewirtz & August, 2008). Many of the EBPs used in family therapy are manualized treatments with many hours of training and continuing hours of education to maintain fidelity to the treatment. This can often be difficult to sustain in community-based settings (Gewirtz & August, 2008). Finally, a given EBT, or even multiple EBTs may not adequately address the wide range of co-occurring child and family problems and cultural contexts that are typically found in public-sector behavioral health clinics (Barth et al., 2012).

There are several established evidence-based approaches to family therapy, including but not limited to: Multisystemic Therapy (MST), Integrated Family and Systems Treatment (I-FAST), functional family therapy (FFT), Multidimensional Family Therapy (MDFT), and Brief Strategic Family Therapy (BSFT) (Lee et al., 2013; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009; Robbins, Szapocznik, & Pe'rez, 2007). Many of these are not specifically created or studied as home-based models but can be and often are implemented this way. Each of these treatment approaches works from a systems theory perspective, and seeks to identify and amplify family strengths (Lee et al., 2013; Saleebey, 2009).

Multisystemic Therapy (MST). According to Woodford (1999), MST is deeply rooted in strategic family therapy, family systems theory, cognitive behavioral therapy, and ecological systems theory. MST is an intensive home-based family treatment that works to enhance the way children function in their homes, schools, and neighborhoods as was originally developed for adolescents with juvenile justice system involvement and then later expanded and adapted for other populations including those with serious emotional disturbance. (Baglivio, Jackowski, Greenwald, & Wolff, 2014). It has been subject to a great deal of evaluation and has been shown

to have favorable short-term and long-term effectiveness in a variety of research settings with racially diverse populations (Baglivio, Jackowski, Greenwald, & Wolff, 2014).

MST combines intensive family therapy with individual skills training for adolescents by allowing for intervention in multiple settings. It involves helping youth, their families, and appropriate professionals understand how the youth's conduct problems are maintained by repeated patterns of interaction within the family and other social systems (Carr, 2014). It uses individual and family strengths to develop and "implement action plans" and new skills to disrupt these "problem-maintaining patterns" (Carr, 2014). Additionally, it provides support to families so that they can better follow through on these action plans, while allowing them to use new insights and skills to handle new problem situations and observes family progress in a methodical way (Carr, 2014).

Another important component of MST is the way in which those providing the intervention are trained and given the tools needed to maintain fidelity to the treatment. The MST training package is robust: it provides information on how to select staff, access to the training program, fidelity measurements, and forms used throughout treatment cycle (Schoenwald, Brown, & Henggeler, 2000).

I-FAST: Integrated Family and Systems Treatment. I-FAST is a home-based treatment model that has been developed and implemented within community based mental health systems. I-FAST treatment has four fundamental overarching beliefs about treatment: 1) effective treatment of a child or adolescent with a severe emotional or behavioral problem compels treatment of the family system; 2) all families have strengths, resilient qualities and resources that can be used in building solutions and achieving client change; 3) effective treatment includes adequate coordination among diverse organizations providing services to the

child and the family; 4) effective treatment is built upon training and retaining excellent staff with expertise in providing home-based family services (Lee et al., 2009).

Functional Family Therapy. Functional family therapy is a manualized model of systemic family therapy for adolescent conduct disorders. It involves clear stages of engagement where emphasis focuses on forming a therapeutic alliance with family members, on youth and family behavior shifts, and on facilitating competent family problem solving, in which families learn new skills and how to deal with challenges in a range of situations. Ideally, whole family sessions are conducted on a weekly basis (Baglivio, Jackowski, Greenwald, & Wolff, 2014).

Multidimensional Family Therapy (MDFT) and substance abuse problems. Multi-dimensional family therapy is the most researched family-based intervention for adolescent substance abuse concerns (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009). This treatment addresses difficult drug use and related substance abuse problems among adolescents and, instead of using a set regimen or manual, applies principles and a "therapeutic framework to the individual young person situated within a particular set of environmental influences and constraints" (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009). It can be office, home-based or both, and also can be used in a residential or non-residential setting. One of the important aspects of MDFT is that the intervention extends beyond the adolescent and family to many other social systems in which the adolescent is involved, (school, juvenile justice, etc.), and is centered according to the particular vulnerabilities and strengths of the adolescent and his or her family. Throughout treatment therapists meet alone with the adolescent, alone with the parents/caretakers, or with the child and parents/caretakers together, depending upon the specific problem being addressed (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009).

Brief Strategic Family Therapy (BSFT). BSFT is based on the overarching notion that the family is the "bedrock" of child development. This treatment modality is a research-driven family preservation and treatment approach developed over a thirty-year period in the 1970's through a clinical research initiative with Hispanic and African American adolescents in Miami, FL (Robbins, Szapocznik, & Pe'rez, 2007). The research done to create this intervention aimed to create "culturally appropriate" strategies to meet the needs of culturally, racially, and ethnically diverse populations in Miami. BSFT has clearly articulated goals such as reduction of child behavioral problems, and uses interventions detailed in a treatment manual. This treatment manual uses three central constructs: Systems (family system), Structure/Patterns of Interaction, and Strategy (how to create new patterns and behaviors). One of the major aspects of this treatment is the focus on allowing families and adolescents to practice new behaviors and behavior patterns both in and outside of therapy sessions. The use of homework is a crucial aspect of this intervention.

Challenges of Home-Based Family Therapy

Home-based family therapy also presents several unique challenges. One important challenge of home-based family therapy is the lack of knowledge and training offered in academic institutions. A study conducted by Christensen (1995) found that one of the greatest difficulties for therapists doing home-based therapies is a lack of training. Most of the training therapists receive is geared toward therapy in clinics and offices (Cortes, 2004). Another study assessing the experiences of therapists doing home-based therapy conducted by Adams and Maynard (2000) found that from therapists' perspectives crisis intervention and safety concerns were areas they are often uncertain about. The families represented in home-based caseloads often come from low-income backgrounds and often face several serious problems; the job of the

therapist can feel overwhelming and stressful for counselors (Adams & Maynard, 2000). Additionally, therapists who work in this modality often have limited involvement with other agency professionals, and the chances of debriefing, supervision, and the exchange of information are also limited (Cortes, 2004). With this lack of training and supervision, some therapists report feeling ineffective and dissatisfied in their work, often leading to lower job satisfaction, high staff turnover, and less reliability for families (Mattek, Jorgenson, & Fox, 2010).

Clinician Training of Home-Based Therapists

While many home-based family therapy providers receive professional and educational training, these often do not encompass home-based treatments. Reiter (2008) and Glebova, Foster, Cunningham, Brennan, & Whitmore (2012) explain that clinicians providing home-based family therapy need to be adequately prepared and trained to do this kind of work. Snyder and McCollum (1999) contend that training programs for home-based family services need to consider the immense differences between services provided in an office-based clinic and clients' homes. Historically, home-based therapists often receive the same or similar training to those clinicians doing office based therapy, which is often to the detriment of the treatment and of the therapists' feeling of competency (Reiter, 2008). Christensen (1995) reports that, historically, family therapy theorists and training programs have ignored the special issues raised by working in the home in favor of training in office or clinic-based work. Many studies advocate for specialized training programs for clinicians doing home-based work (Christensen, 1995; Snyder and McCollum, 1999; Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012).

At least one effort has been made at creating a formalized training for the home-based setting (Mattek, Jorgenson, & Fox, 2010), specifying a developing recognition of the need for

training standards for in-home therapy modalities. Hammond and Czyszczon (2014) posit in their article, “Home-Based Family Counseling: An Emerging Field in Need of Professionalization,” that without the same high standards in training home-based compared to traditional family therapy could potentially send a message that this profession places less value on the families served in the home than on those who receive services within a traditional outpatient office setting.

Reiter (2008) discusses the ways in which therapists who were not trained to use the home environment as an advantage were often less successful in providing this mode of treatment. Therapists who saw activities in the home "as obstacles that had to be overcome or ignored" often were less successful in building a therapeutic alliance. (Christensen, 1995; Reiter, 2008). Reiter advocates for home-based family therapy training programs that would help clinicians utilize family dynamics as a way to further the therapeutic process. While some would deem these activities as "distractions" in the home, Reiter’s study contends that using these aspects in conjunction with other elements of the home environment could increase therapeutic alliance building between clients and therapists. For Reiter, these aspects of home life dynamics for family are an important aspect of the home environment and must be addressed in therapy, thus further contributing to the working alliance.

Another important component of clinician training for IHT and home-based services is the implementation of treatment. Clinicians who receive training on how to use the home environment in ways that will benefit the family, as well as evidence-based practices and interventions that have been successful in the home, are much more likely to feel more effective in the ways in which they implement treatment, leading to greater family trust and buy-in (Reiter, 2008; Schoenwald, Brown, & Henggeler, 2000).

Summary

Significant research has been done on the efficacy and challenges of treatments used in home-based family therapy. However, many questions are still left unanswered about these interventions and treatments. Much of the literature points to the overall efficacy of home-based family therapy and the many evidence-based treatments that exist. Much of the literature dictates that what matters most is implementation of treatment, which raises crucial questions: Are home-based therapy providers getting the training and support needed to provide the most effective, ethical care for this setting? Do they feel safe and effective doing this work?

Chapter III

Methodology

Research Method and Design

The purpose of this study was to explore the experiences of clinicians providing In-Home Therapy (IHT) in Massachusetts. The study used a Web survey of these clinicians to inquire about various aspects of their work, including whether they feel adequately prepared to do this work, and what they believe could be done in order to help them feel more successful, find job satisfaction, and want to continue providing IHT, The research took place over the course of ten months, with data collection between March 22, 2016 and April 12, 2016. The Human Subjects Review (HSR) Board at the Smith College's School for Social Work approved the methodology of this study prior to beginning this research (Appendix A). After initial approval from the HSR Board, changes were made to the survey to include more depth of information for TT&S providers. Appendix A shows the HSR changes made, and approval from the board.

Data Collection

Sample. In order to participate in this survey, participants must have identified themselves as clinical staff (social workers, psychologists, paraprofessionals, etc. (known at MassHealth as TT&S) working in the state of Massachusetts who provide IHT to children and families with Medicaid coverage. Participants were contacted via email (See Appendix B) and provided information about the study for which they were being asked to participate. This was done with the help of MassHealth who, with the assistance of advisor to this study, Jack Simons, Ph.D, agreed to disseminate the survey. An email request to participate a brief explanation of the study and a link to the survey were sent to the following:

1. The mailing list of clinicians who receive training to do the Massachusetts Child and Adolescent Needs and Strengths (CANS). This includes every clinician who registered on the CANS website in order to complete training and become certified to fill out the CANS questionnaire. All master's level clinicians providing IHT are required to have CANS certification, and therefore would be on this list. There are currently 26,330 people on this list, which also includes many individuals not involved with IHT (J. Simons, Personal Communication, May 13, 2016).

2. All IHT provider organizations that are contracted through the six MassHealth Health managed care entities (MCEs). MassHealth directed the MCEs to send the survey invitation to provider organizations via email with a request that IHT/TT&S program managers disseminate the invitation to their staff, with the understanding that participation is entirely voluntary. Participants in this study were required to be at least 18 years of age and identify as a TT&S/IHT provider. The SurveyMonkey survey began with informed consent, which outlined the above inclusion criteria, purpose of the study, description of the study procedure, risks and benefits of participation, and confidentiality (See Appendix C – Informed Consent). If participants were not 18 years of age or older or they did not identify as a TT&S/IHT provider they were redirected to a disqualification page. If participants did meet these criteria, they were able to begin the survey, starting with demographic questions.

Survey. The survey for this study used SurveyMonkey, an online survey company that allows users to design their own surveys, and disseminate them using a unique URL via email and social media platforms. The survey (See Appendix D) used in this study asked a variety of questions that included twelve demographic questions, twenty-four Likert style scaling questions, and five open-ended questions. Demographic information was collected at the start of

each survey, including gender identity, age, languages, race, ethnicity, training and how far they went in school.

This study uses a Likert style rating scale to gather participants' attitudes and thoughts about their role as IHT providers and the efficacy of the work and training they received to do this work. This widely used method is most appropriate for this study because its aim is to collect participants' attitude and opinions (Page-Bucci, 2003). The Likert style questions all used a scale from 1 to 5, with "Completely Disagree" at the 1 point, and "Completely Agree" at the 5 point, as in Figure 1:

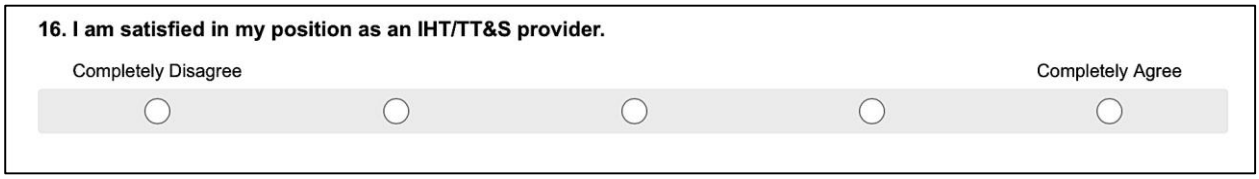


Figure 1

Intermediate levels were not labeled, in the expectation that respondents could judge where they fell in the levels between "Completely disagree" and "Completely agree".

Ethics and Safeguards

Obtaining informed consent from participants prior to them taking the survey was the most crucial ethical consideration for this study. On the informed consent page (Appendix C) participants were presented with purpose and intent of the study and what would be done with the results to be used in the researcher's Masters thesis. Participants were also provided the contact information of the researcher should they wish to review the results once the study was complete. Although the information being asked of participants was not highly sensitive and would not likely put them at any risk, participants were reminded that their participation was

anonymous and voluntary and that they could choose not to participate by navigating away from the survey at any time.

Data Analysis

Primary data collection was derived from the forty survey questions, and was analyzed using descriptive statistics and graphical displays. Confidence Intervals (CI) were calculated to identify the amount of sampling error for response percentages. Information in free text fields was analyzed thematically in order to gather more specific information about the attitudes participants hold about various aspects of their work.

Reflexivity. As the researcher in this study it is paramount to reflect on my own positionality as a white, middle class, cis-gender woman. It is also important to note, that as a current MSW student, I participated in a program that provided IHT to children and families in the state of Colorado. This experience led me to be curious about others' experiences with IHT and also may impact the lens through which I am coming to this study. Given my social location described above, I was curious about how participants' race, ethnicity, and/or culture affects their experience in providing IHT and TT&S. While data was untimely not analyzed in this way, this is something I am aware of and believe it deserves important attention. It is crucial to note the wide range of experiences clinicians hold, noting that mine is one of many and was also done in a different context, in a different state, with different trainings.

Chapter IV

Findings

Eligibility Questions

During the time the survey was open, 307 individuals responded, of whom 251 met the eligibility criteria of being a TT&S/IHT provider and 18 years of age or older.

Description of the Sample

Tables 1-11 and Graph 1 reflect the demographic information of the sample from this study. 81.8% of participants identified as female and 15.1% as male with 3.1% who chose not to self-identify (Table 1).

Table 1.

Gender Identity

Answer Options	Response Count	Response Percent	CI 95%
Female	184	80.3%	[76.2%, 86.3%][4]
Male	34	14.8%	[11.0%, 20.3%]
I choose to not self-identify	7	3.1%	[1.5%, 6.3%]
Other (please specify)	4	1.7%	[0.7%, 4.5%]
answered question	**225**		
skipped question	**26**		

A majority of participants were between the ages of 25 and 34 (Table 2) and 73% identified as white, with 7.7% who identified as Black of African American, 4.7% as Hispanic/Latino/White, and 5% as Other (Table 3).

[4] Confidence Interval of a Proportion. VassarStats. Retrieved May 31, 2016, from http://vassarstats.net/prop1.html

Table 2.

Age

Answer Options	Response Count	Response Percent	CI 95%
18-24	23	10.0%	[6.8%, 14.6%]
25-34	117	51.1%	[44.7%, 57.5]
35-44	32	14.0%	[10.1%, 19.1%]
45-54	27	11.8%	[8.2%, 16.6%]
55-64	20	8.7%	[5.7%, 13.1%]
65+	3	1.3%	[0.5%, 3.8%]
I prefer to not identify	5	2.2%	[0.9%, 5.1%]
answered question	**229**		
skipped question	**22**		

Table 3.

Race

Answer Options	Response Count	Response Percentage	CI 95%
Black or African American	18	7.7%	[4.6%, 11.9%]
Hispanic/Latino/Black	4	1.7%	[0.5%, 4.3%]
Hispanic/Latino/White	11	4.7%	[2.4%, 8.3%]
Hispanic/Latino/Other	8	3.4%	[1.5%, 6.7%]
Native Hawaiian or Pacific Islander	0	0.0%	[0.0%, 1.6%]
Native American or American Indian	0	0.0%	[0.0%, 1.6%]
American Indian/Alaska Native (Wampanoag)	0	0.0%	[0.0%, 1.6%]
American Indian/Alaska Native (Other Tribal Nation)	2	0.9%	[0.1%, 3.1%]
White	170	73.0%	[66.8%, 78.6%]
I prefer to not identify	9	3.9%	[1.8%, 7.2%]
Other (please specify)	11	4.7%	[2.4%, 8.3%]
answered question	**233**		
skipped question	**32**		

A vast majority of participants have a Master's Degree (Table 4) and 52.4% of participants are unlicensed (Table 5).

Table 4.

Education

Answer Options	Response Count	Response Percent	CI 95%
Less than a High School Diploma	0	0.0%	[0.0%, 1.8%]
High School Diploma or Equivalent	4	1.9%	[0.7%, 4.7%]
Bachelor's Degree	47	21.8%	[16.8%, 27.7%]
Master's Degree	161	74.5%	[68.3%, 79.9%]
Doctoral Degree	4	1.9%	[0.7%, 4.7%]
answered question	**216**		
skipped question	**35**		

Table 5.

Level of Licensure in Massachusetts

Answer Options	Response Count	Response Percent	CI 95%
Licensed Clinical Social Worker (LCSW)	31	12.4%	[8.6%, 17.1%]
Licensed Independent Social Worker (LICSW)	28	12.2%	[7.6%, 15.8%]
Licensed Psychologist	3	1.3%	[0.2%, 3.5%]
Licensed Marriage and Family Therapist (LMFT)	8	3.2%	[1.4%, 6.2%]
Licensed Alcohol and Drug Counselor 1 (LADC - 1)	4	1.6%	[0.4%, 4.0%]
Licensed Alcohol and Drug Counselor 2 (LADC - 2)	1	0.4%	[0.0%, 2.2%]
Certified Alcohol and Drug Counselor 1 (CADC - 1)	2	0.8%	[0.1%, 2.9%]
Certified Alcohol and Drug Counselor 2 (CADC - 2)	3	1.2%	[0.2%, 3.5%]
Not Licensed	131	52.4%	[46.0%, 58.7%]
Other (please specify)	39	15.6%	[11.3%, 20.7%]
answered question		**250**	
skipped question		**49**	

Forty one point three percent (41.3%) of participants identified themselves professionally as Social Workers and 39.2% as Psychologists, Clinical Psychologists, Counseling Psychologists, or School Psychologists (Table 6).

Table 6.

Professional Identification

Answer Options	**Response Count**	**Response Percent**	**CI 95%**
Social Work	96	41.3%	[35.0%, 48.0%]
Psychology	16	6.9%	[4.0%, 11.0%]
Clinical Psychology	17	7.3%	[4.3%, 11.5%]
Counseling Psychology	57	24.6%	[19.2%, 30.6%]
School Psychology	1	0.4%	[0.0%, 2.4%]
Marriage and Family Therapy	21	9.1%	[5.7%, 13.5%]
Addictions Counseling	3	1.3%	[0.3%, 3.7%]
Other (please specify)	21	9.1%	[5.7%, 13.5%]
answered question	**232**		
skipped question	**40**		

All fourteen counties in Massachusetts are represented (Table 7) and the sample here roughly corresponds to the overall population distribution with Middlesex having the highest number of participants, 18.3%, and Worcester, Suffolk, and Essex with the next four with the most representation (U.S. Bureau of the Census, 2014).

Table 7

County participants primarily practice

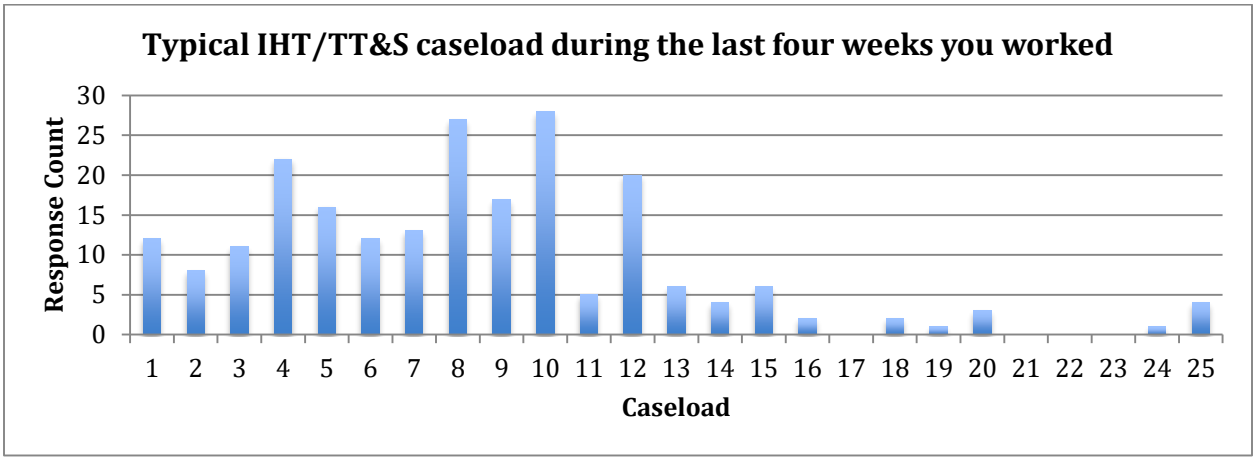
Answer Options	Response Count	Response Percent	CI 95%
Middlesex	18.0%	40	[13.5%, 23.6%]
Worcester	16.7%	37	[12.3%, 22.1%]
Suffolk	11.7%	26	[8.1%, 16.6%]
Essex	11.3%	25	[7.7%, 19.1%]
Bristol	9.9%	22	[6.6%, 14.6%]
Hampden	8.1%	18	[5.2%, 12.5%]
Barnstable	4.5%	10	[2.5, 8.1%]
Plymouth	4.5%	10	[2.5, 8.1%]
Hampshire	3.6%	8	[1.8%, 6.9%]
Norfolk	3.6%	8	[1.8%, 6.9%]
Franklin	2.7%	6	[1.2%, 5.8%]
Nantucket	1.8%	4	[1.0%, 4.5%]
Berkshire	1.4%	3	[0.5%, 3.9%]
Dukes	0.9%	2	[0.3%, 3.2%]
	answered question	**222**	
	skipped question	**29**	

A majority of participants, 71%, are employed to do IHT/TT&S between 20-40 hours a week (Table 8) and reveal a wide range of "typical" caseloads during the previous four weeks worked (Figure 2).

Table 8.

Average number of hours employed doing IHT / TT&S	**Percent**	**CI 95%**
20-40	71.00%	[64.4%, 76.7%]
Over 40	12.00%	[8.5%, 17.6%]
Under 20	18.00%	[13.9%, 24.6%]
Answered question	223	
Skipped question	28	

Figure 2.



Participants also represent a wide range of experience working in Behavioral Health (Table 9) and in doing IHT/TT&S work (Table 10).

Table 9.

How long participants have been working in behavioral health (including practicum/internship time)?

Answer Options	Response Count	Response Percent	CI 95%
Less than one year	21	9.3%	[6.2%, 13.8%]
12-23 months	26	11.5%	[8.0%, 16.3%]
24-35 months	29	12.8%	[9.1%, 17.8%]
3-5 years	65	28.8%	[23.3%, 35.0%]
6-7 years	30	13.3%	[9.5%, 18.3%]
8-9 years	13	5.8%	[3.4%, 9.6%]
10+ years	42	18.6%	[14.1%, 24.2%]
	answered question	**226**	
	skipped question	**25**	

Table 10.

How long participants have been doing IHT/TT&S or an equivalent service?

Answer Options	Response Count	Response Percent	CI 95%
Less than one year	51	22.7%	[17.7%, 28.6%]
1 year but less than 2 years	38	16.9%	[12.6%, 22.3%]
2 years but less than 3 years	33	14.7%	[10.6%, 19.9%]
3-5 years	60	26.7%	[21.3%, 32.8%]
6-7 years	18	8.0%	[5.1%, 12.3%]
8-9 years	7	3.1%	[1.5%, 6.3%]
10+ years	18	8.0%	[5.1%, 12.3%]
	answered question		**225**
	skipped question		**26**

Table 11.

How long have you been doing IHT/TT&S or an equivalent service in this organization/agency?

Answer Options	Response Count	Response Percent	CI 95%
Less than one year	68	30.1%	[24.5%, 36.4%]
1 year but less than 2 years	49	21.7%	[16.8%, 27.5%]
2 years but less than 3 years	32	14.2%	[10.2%, 19.3%]
3-5 years	50	22.1%	[17.2%, 28.0%]
6-7 years	15	6.6%	[4.1%, 10.7%]
8-9 years	4	1.8%	[0.7%, 4.5%]
10+ years	8	3.5%	[1.8%, 6.8%]
	answered question	**226**	
	skipped question	**25**	

Table 12 and Figure 2 show participants' responses to the 23 Likert-style scaling questions. One of the core questions motivating the survey had to do with their level of satisfaction in doing this work. Sixty-three percent of participants report agreeing or strongly agreeing with the statement "I am satisfied in my position as an IHT/TT&S provider," and 16% indicated they strongly disagree or disagree with this statement, while 21% report a neutral attitude.

Several questions asked participants to reflect on how effective they felt in different aspects of their work providing IHT. Overall participants reported high effectiveness rates with 75% or more of participants responding that they agree or strongly agree with all four statements (questions 6-9 in Table 12) about effectiveness. Participants reported feeling most effective in creating a therapeutic alliance with youth: 90.8% of participants stating they strong agreed or agreed with the statement.

Other questions were centered on what participants need (resources, training, supervision) in order to feel more successful in their work. A majority of participants reported feeling as though they do not need more hours of supervision to feel more successful. More than half (55.1%) of participants disagreed or strongly disagreed the statement, "I would be more successful if my organization provided more hours of supervision." However, a majority of participants *did* express a need for more training. Similarly, 54.3% of participants marked that they strongly agreed or agreed with the statement, "I would be more successful if my organization provided more training."

Table 12 -- Responses to Attitude questions

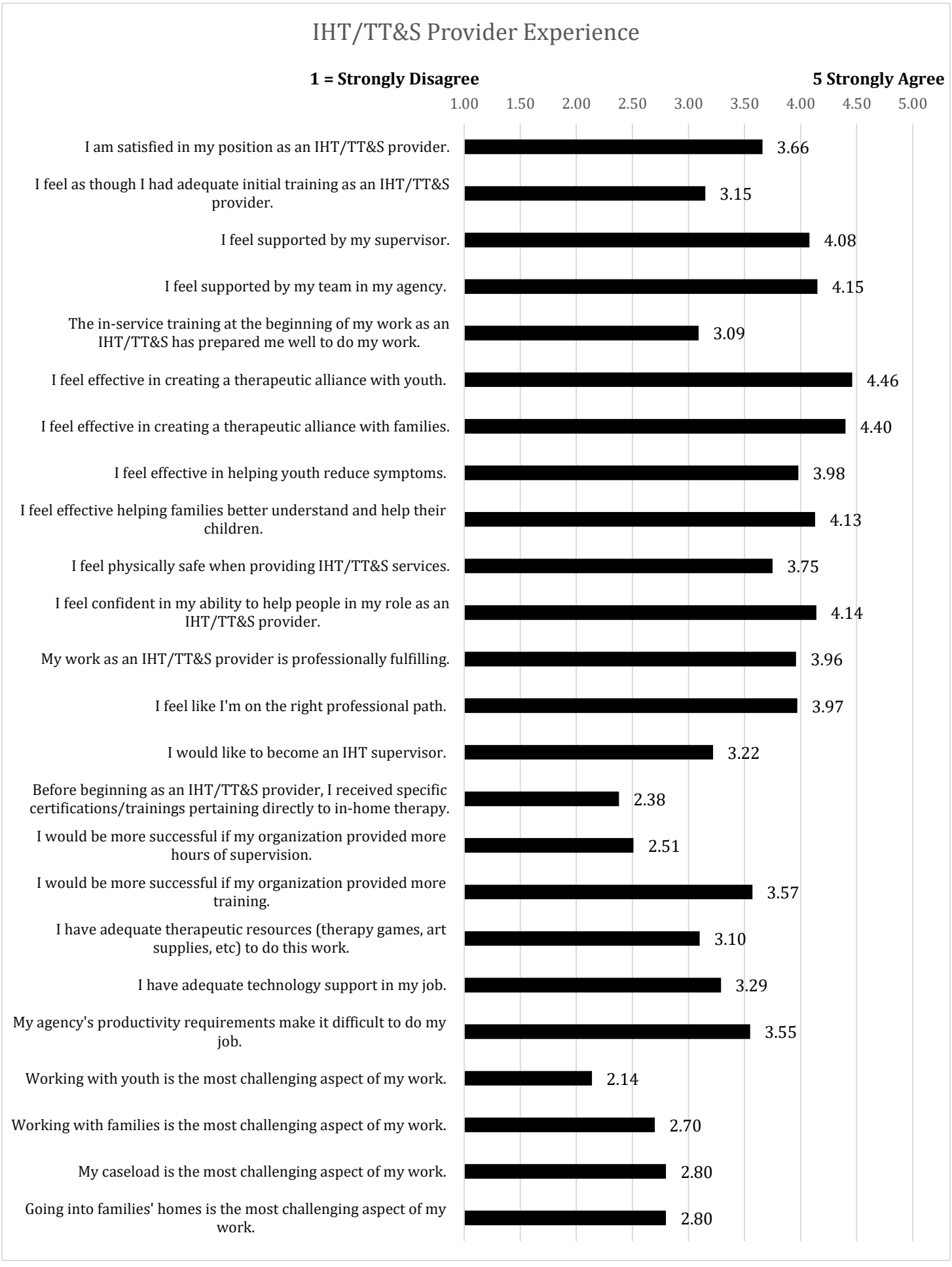
Question	1 Strongly Disagree	2	3	4	5 Strongly Agree	Average	Count
1. I am satisfied in my position as an IHT/TT&S provider.	6 (2.9%) [1.1%, 6.2%]	27 (13%) [8.8%, 18.4%]	44 (21.3%) [15.9%, 27.5%]	84 (40.6%) [33.8%, 47.6%]	46 (22.2%) [16.8%, 28.5%]	3.66	207
2. I feel as though I had adequate initial training as an IHT/TT&S provider.	27 (12.9%) [8.6%, 18.2%]	40 (19%) [14%, 25%]	48 (22.9%) [17.4%, 29.1%]	65 (31%) [24.8%, 37.3%]	30 (14.3%) [9.9%, 19.8%]	3.15	210
3. I feel supported by my supervisor.	10 (4.8%) [2.3%, 8.6%]	14 (6.7%) [3.7%, 10.9%]	29 (13.8%) [9.4%, 19.2%]	53 (25.2%) [19.5%, 31.7%]	104 (49.5%) [42.6%, 56.5%]	4.08	210
4. I feel supported by my team in my agency.	7 (3.3%) [1.4%, 6.7%]	13 (6.2%) [3.3%, 10.4%]	24 (11.4%) [7.5%, 16.5%]	64 (30.5%) [24.3%, 37.2%]	102 (48.6%) [41.6, 55.5%]	4.15	210
5. The in-service training at the beginning of my work as an IHT/TT&S has prepared me well to do my work.	28 (13.4%) [9.1%, 18.8%]	39 (18.7%) [13.6%, 24.6%]	57 (27.3%) [21.4%, 33.8%]	57 (27.3%) [21.4%, 33.8%]	28 (13.4%) [9.1%, 18.8%]	3.09	209

6. I feel effective in creating a therapeutic alliance with youth.	1 (0.5%) [0.0%, 2.6%]	3 (1.4%) [0.3%, 4.2%]	15 (7.2%) [4.1%, 11.6%]	70 (33.7%) [27.3%, 40.5%]	119 (57.2%) [50.2%, 64.0%]	4.46	208
7. I feel effective in creating a therapeutic alliance with families.	0 (0.0%) [0.0%, 1.7%]	4 (1.9%) [0.5%, 4.8%]	16 (7.7%) [4.4%, 12.1%]	81 (38.8%) [32.1%, 45.7%]	108 (51.7%) [44.7%, 58.6%]	4.40	209
8. I feel effective in helping youth reduce symptoms.	3 (1.4%) [0.3%, 4.1%]	9 (4.3%) [2.0%, 8.0%]	40 (19.1%) [14.0%, 25.1%]	94 (45%) [38.1%, 52.0%]	63 (30.1%) [24.0%, 36.9%]	3.98	209
9. I feel effective helping families better understand and help their children.	2 (1.0%) [0.1%, 3.4%]	5 (2.4%) [0.8%, 5.5%]	29 (13.9%) [9.5%, 19.4%]	99 (47.6%) [40.6%, 54.6%]	73 (35.1%) [28.6%, 42.0%]	4.13	208
10. I feel physically safe when providing IHT/TT&S services.	6 (2.9%) [1.1%, 6.1%]	13 (6.2%) [3.4%, 10.4%]	56 (26.8%) [20.9%, 33.3%]	86 (41.1%) [34.4%, 48.1%]	48 (23%) [17.4%, 29.3%]	3.75	209
11. I feel confident in my ability to help people in my role as an IHT/TT&S provider.	3 (1.4%) [0.3%, 4.2%]	9 (4.3%) [2.0%, 8.2%]	25 (12.1%) [8.0%, 17.3%]	88 (42.5%) [35.7%, 49.6%]	82 (39.6%) [32.9%, 46.6%]	4.14	207
12. My work as an IHT/TT&S provider is professionally fulfilling.	9 (4.3%) [2.0%, 8.1%]	10 (4.8%) [2.3%, 8.7%]	33 (15.9%) [11.2%, 21.6%]	84 (40.4%) [33.7%, 47.4%]	72 (34.6%) [28.2%, 41.5%]	3.96	208

13. I feel like I'm on the right professional path.	6 (2.9%) [1.1%, 6.1%]	20 (9.6%) [6.0%, 14.5%]	29 (13.9%) [9.5%, 19.4%]	72 (34.6%) [28.2%, 41.5%]	81 (38.9%) [32.3%, 45.9%]	3.97	208
14. I would like to become an IHT supervisor.	35 (16.8%) [12.0%, 22.6%]	41 (19.7%) [14.5%, 25.8%]	34 (16.3%) [11.6%, 22.1%]	39 (18.8%) [13.7%, 24.7%]	59 (28.3%) [22.3%, 35.0%]	3.22	208
15. I would be more successful if my organization provided more hours of supervision.	46 (22.2%) [16.8%, 28.5%]	68 (32.9%) [26.5%, 39.7%]	51 (24.6%) [18.9%, 33.1%]	25 (12.1%) [8.0%, 17.3%]	17 (8.2%) [4.9%, 12.8%]	2.51	207
16. I would be more successful if my organization provided more training.	14 (6.8%) [3.8%, 11.1%]	26 (12.6%) [8.4%, 17.9%]	54 (26.2%) [20.3%, 32.8%]	52 (25.2%) [19.5%, 31.7%]	60 (29.1%) [23.0%, 35.8%]	3.57	206
17. I have adequate therapeutic resources (therapy games, art supplies, etc) to do this work.	30 (14.4%) [9.9%, 19.9%]	44 (21.2%) [15.8%, 27.3%]	40 (19.2%) [14.1, 25.3%]	63 (30.3%) [24.1%, 37.0%]	31 (14.9%) [10.4%, 20.5%]	3.10	208
18. I have adequate technology support in my job.	26 (12.6%) [8.4%, 17.9%]	35 (16.9%) [12.1%, 22.7%]	40 (19.3%) [14.2%, 25.4%]	65 (31.4%) [25.1%, 38.2%]	41 (19.8%) [14.6%, 25.9%]	3.29	207
19. My agency's productivity requirements make it difficult to do my job.	11 (5.4%) [2.7%, 9.4%]	38 (18.6%) [13.5%, 24.7%]	47 (23.5%) [17.4%, 29.4%]	43 (21.1%) [15.7%, 27.3%	65 (31.9%) [25.5%, 38.7%]	3.55	204

20. Working with youth is the most challenging aspect of my work.	73 (35.1%) [28.6%, 42.0%]	62 (29.8%) [23.7%, 36.5%]	49 (23.6%) [18.0%, 29.9%]	18 (8.7%) [5.2%, 13.3%]	6 (2.9%) [1.1%, 6.2%]	2.14	208
21. Working with families is the most challenging aspect of my work.	47 (22.6%) [17.1%, 28.9%]	49 (23.6%) [18.0%, 29.9%]	50 (24.0%) [18.4%, 30.4%]	43 (20.7%) [15.4%, 26.8%]	19 (9.1%) [5.6%, 13.9%]	2.70	208
22. My caseload is the most challenging aspect of my work.	36 (17.3%) [12.4%, 23.1%]	47 (22.6%) [17.1%, 28.9%]	64 (30.8%) [24.6%, 37.5%]	45 (26.4%) [16.2%, 27.9%]	16 (7.7%) [4.5%, 12.2%]	2.80	208
23. Going into families' homes is the most challenging aspect of my work.	58 (27.9%) [21.6%, 34.0%]	64 (30.8%) [24.2%. 37.0%]	43 (20.7%) [15.1%, 26.5%]	32 (15.4%) [10.6%, 20.7%]	14 (6.7%) [3.7%, 10.9%]	2.43	211

Figure 3


IHT/TT&S Provider Experience
1 = Strongly Disagree
5 Strongly Agree
1.00
1.50
2.00
2.50
3.00
3.50
4.00
4.50
5.00
I am satisfied in my position as an IHT/TT&S provider.
3.66
I feel as though I had adequate initial training as an IHT/TT&S provider.
3.15
I feel supported by my supervisor.
4.08
I feel supported by my team in my agency.
4.15
The in-service training at the beginning of my work as an IHT/TT&S has prepared me well to do my work.
3.09
I feel effective in creating a therapeutic alliance with youth.
4.46
I feel effective in creating a therapeutic alliance with families.
4.40
I feel effective in helping youth reduce symptoms.
3.98
I feel effective helping families better understand and help their children.
4.13
I feel physically safe when providing IHT/TT&S services.
3.75
I feel confident in my ability to help people in my role as an IHT/TT&S provider.
4.14
My work as an IHT/TT&S provider is professionally fulfilling.
3.96
I feel like I'm on the right professional path.
3.97
I would like to become an IHT supervisor.
3.22
Before beginning as an IHT/TT&S provider, I received specific certifications/trainings pertaining directly to in-home therapy.
2.38
I would be more successful if my organization provided more hours of supervision.
2.51
I would be more successful if my organization provided more training.
3.57
I have adequate therapeutic resources (therapy games, art supplies, etc) to do this work.
3.10
I have adequate technology support in my job.
3.29
My agency's productivity requirements make it difficult to do my job.
3.55
Working with youth is the most challenging aspect of my work.
2.14
Working with families is the most challenging aspect of my work.
2.70
My caseload is the most challenging aspect of my work.
2.80
Going into families' homes is the most challenging aspect of my work.
2.80

Open-Ended Responses

Five opened ended questions were asked at the end of the survey. The first question asked participants to reflect on the challenges they face in their role in IHT/TT&S (see Appendix E for examples). For this question, 166 participants responded. Themes that arose included frustrations with the population participants serve, anger at the systems at play in which participants felt they did not have any ability to change, including productivity requirements, and irritations around paperwork/ documentation, compensation/ salary, and scheduling. Many participants also wrote about the lack of training they received to do this work and reported feeling unprepared for the tasks being asked of them. A few participants noted frustrations with their IHT/TT&S teams and safety concerns when going into clients' homes. One participant wrote, "Most of the challenges that I face in this job is the CBHI (Children's Behavioral Health Initiative) system as a whole. I think we need to really consider the providers doing this job, and rework the amount of paperwork that is expected of us. I also think we need to look at each agency and make sure all people in their given position is adequately trained to work with the population that they are working with" (Survey, Question 40).

The next open-ended question asked participants to write about aspects of their work they found fulfilling and enjoyable (see Appendix E for examples). For this question, 167 participants responded. An overwhelming majority of participants discussed the fulfillment they feel when working with this population, especially when positive change occurs for families. One participant shared, "I love working with families and children in the home. CBHI services allow

for such incredible flexibility - we can support families in many environments and have a unique ability to step into their worlds to better understand the challenges they are facing." (Survey, Question 41). Participants also wrote about their team, supervisors, and IHT/TT&S staff in general. A few participants wrote they liked the flexibility in their schedule and enjoyed working out of an office environment.

The third opened-ended question asked participants their thoughts about optimal productivity requirements (see Appendix E for examples). While services can be billed in a variety of ways, MassHealth requires providers to bill for IHT and TT&S in 15 minute "units". Many participants expressed a desire for fewer units to be required to meet productivity numbers, or for driving and travel time to be considered when looking at these requirements. Other participants discussed productivity in terms of hours, and also expressed a desire for there to be less hours of direct client contact in order to have time for things like paperwork, training, travel, and supervision. Many participants reported frustration with productivity requirements in general and feel it is unfair for "no-shows" or when families fail to attend a session, to count against them in their productivity. One participant wrote,

> I truly think we need to get rid of this term and come up with a new system. Putting a label on the beautiful work and care we provide our families shouldn't be considered "productivity" This word naturally brings stress to very compassionate and talented people who give their heart and soul to do this job. This word is shaming when people to do not

meet their requirement and when families cancel on us due to daily life struggles.

The next question asked participants the following question, “If you are considering leaving IHT/TT&S work, what might sway you to stay?” For this question, 167 participants responded (see Appendix E for examples). They listed increasing salary/compensation, more training, travel reimbursement, change in paperwork requirements, and a more predictable schedule with less evening hours as changes that could be made to help them stay in their positions. One participant answered the question saying, “Less productivity requirements with no reduction in pay, more opportunities to be among coworkers, more groups/workshops/trainings about self care as a clinician and agency becoming trauma informed in order to provide best support from the top down (admin, supervisors, clinicians, clients etc)” (Survey, Question 41).

The last open-ended question asked participants to provide any additional information they wished (see Appendix E for examples). For this question, 97 participants responded. Many reflected on the overarching systems at play and their feelings of helplessness and frustration with aspects of this work they cannot change. Some continued to write about their wish for more and better training and others wrote about their love of this work and the clients/families they work with.

Chapter V

Discussion

This chapter interprets the study findings, discusses its strengths and limitations, and provides suggestions for further research and possible policy implications. It is my hope that this study will spark conversations around the nature of IHT and ways in which providers can feel supported and prepared to do this important work.

Demographic and training questions in the survey shed some light, not only on who responded, but also on who provides IHT, or the master's level component of the service, and TT&S, the bachelor's level component, in Massachusetts. Anecdotally, I had heard that these positions tended to be filled by early-career, unlicensed clinicians with a few years of experience. The sample shows that this is largely true: 62% of participants have been working five years or less and 51.8% have been providing IHT in their agency for two years or less. A majority of participants were also unlicensed clinicians (52.4%) with Master's Degrees (74.5%). In Massachusetts, many of these positions do not require clinicians to be licensed, which could mean that many of these early career clinicians are currently working on accruing hours in order to become independently licensed in the state. On the other hand, over 18% reported working in IHT or a similar role for ten or more years; it is important not to overlook this segment of experienced clinicians, and to not ignore their needs and their contribution to the service.

While there was a variety of a professional backgrounds represented in this sample, 45.5% of participants identified themselves professionally as Social Workers and 39.2% identify themselves as trained in some area of psychology. 21.8% reported they have a Bachelor's Degree, indicating they are TT&S providers and a majority, 74.5%, of participants reported they have a Master's Degree, indicating they are IHT clinicians. Since the IHT model is designed to pair a master's level IHT clinician with a bachelor's level TT&S practitioner, one might expect TT&S to make up about half of the IHT workforce, and this suggests that TT&S staffs are underrepresented in this survey. Their lower response rate in conjunction with the comments, taken from the open-ended questions, from many TT&S about their lack of training specific to their role, indicates that more attention is needed specifically with regard to this role in IHT.

Central questions this study asked were whether clinicians feel adequately prepared to do this work, the kinds of training these clinicians receive, what aspects of their work they find fulfilling and which aspects they find challenging. The study also looked into what could be done in order to help them feel more successful, find job satisfaction, and want to continue providing IHT. The literature (Cortes, 2004; Mattek, Jorgenson, & Fox, 2010; Christensen, 1995; Snyder and McCollum, 1999; Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012) pointed to a lack of adequate training specific to IHT and support in IHT settings as common source of frustration. Survey responses indicated that training, productivity requirements, and compensation were the most prominent overarching themes for participants' responses to the survey. 54.3% of participants responded stating they would feel more successful if their

organization provided more training, and 53% of participants responded that the productivity requirements at their agency made it more difficult for them to do their job. While salary and compensation were themes not covered in the closed-ended questions of the survey, this theme emerged clearly in the open-ended questions at the end of the survey. One participant wrote,

> The biggest challenge is financial; the pay is not enough to live on, but the work is so rewarding. So in order to continue doing this important work, most providers require a second job (or more), this takes energy away from doing the therapeutic work and provides the biggest challenge against burnout.

While this theme regarding salary and compensation did arise in this study, this is not unique to IHT and home-based services; salary and compensation issues in mental health settings are common (England, Budig, & Folbre, 2002). Issues related to compensation and salary are likely to interact with other important factors relating to overall job satisfaction which contributes to concerns related to productivity requirements, training, and teamwork.

Productivity Requirements, Training, and Teamwork

For many participants it seemed there were two different kinds of stress related to their work as IHT/TT&S providers. The first was related to the actual clinical work they provide to families in their area, the interventions they use, care coordination, and time spent with clients. The second kind of stress relates to the productivity requirements placed upon IHT/TT&S providers. Although the survey questions did not separate these issues cleanly, one can make the case that (a) tracking their work and documenting justification for interventions used is a

different strain, and for many participants a more tedious kind of stress than (b) many hours of clinical work. One participant wrote, “Spending so much time on making sure I have enough billable hours takes away time from actually working on planning the best treatment approaches with families.” While training was an issue in my own experience, and review of the literature had indicated would be an important topic for participants, issues related to productivity requirements was not a topic I had spent much time considering. These issues, however, ended up being just as important and relevant for participants. Frustrations related to productivity, paperwork, documentation, and billing were the most common responses in the open-ended questions about challenges participants face in this role and also the most salient data in the closed-ended questions as well.

Another important aspect of this work, which also deeply affects the care families receive, is the kind of training clinicians receive. My own personal experience in home-based treatment, the literature reviewed, and other anecdotal stories led me to have my own suspicions that training would be a crucial aspect of IHT clinician satisfaction. This turned out to be accurate: training issues came up for participants over and over again. One TT&S participant wrote that because of the lack of adequate training, they turned to fellow team members to get information needed to do their job. They wrote,

> I do not believe I was properly trained, and had to learn a lot from fellow co workers. When confronted about something I ‘did wrong’ I always want to respond with ‘I wasn't trained on that.’ But it would be a bit awkward to say

that to your supervisor in a meeting.

Many participants reference training in multiple facets of practice and stated they hoped for more training about a variety of topics including interventions, the populations they serve, resources available to families in their area, and parenting strategies.

While a majority of participants responded positively to questions about feeling supported by their supervisor and IHT/TT&S team, several participants wrote of the challenges they feel with team cohesion and the ways in which their IHT/TT&S teamwork directly affect the care they provide to families. One participant wrote, "Collaborating and staying unified as a TT&S / IHT team when two workers are going into the home can be challenging when there are power struggles and perceived hierarchies between the clinician and [TT&S] support, and the workers have different goals and interventions." Given the wide variety of educational and professional backgrounds participants represent, this points to the need for further policy considerations about the ways in which teams are formed, managed, and function because, as the participant quoted above points out, this teamwork has profound implications on the care families receive.

TT&S and IHT Provider Attitudes

One of the core questions motivating the survey had to do with participants' level of satisfaction in providing IHT/TT&S services. Sixty-three percent of participants report agreeing or strongly agreeing with the statement "I am satisfied in my position as an IHT/TT&S provider," and 75% of participants report agreeing or strongly agreeing the with statement, "My

work as an IHT/TT&S provider is professionally fulfilling." While participants had a lot to say about the immense challenges they face in their roles, it became clear through their responses about the most enjoyable aspects of their work that working with children, adolescents, and families is highly rewarding work. Many participants spoke specifically about their feelings of achievement and pride when they see positive changes occur within family systems and dynamics. One participant wrote, "I take pleasure in the family's enlightening moments, when suddenly they realize something that has been in front of them all along. I also rather enjoy when a family can all sit through a family meeting and openly communicate with one another."

Given that a majority of participants (54.3%) have been doing IHT/TT&S work for less than three years, another aspect of job satisfaction may be tied to mastery and the feelings of accomplishment that can arise after noticing progress that has been made. Some of the participants wrote that they didn't feel they received adequate training but that after doing IHT/TT&S work for some time they noticed how much they had improved. One participant wrote, "I didn't feel prepared for this job when I started. I'm only a month into it, and I am feeling more confident."

Some participants wrote about their frustrations with realities of going into their clients' homes. They wrote of bed bugs, lice, dirty living conditions, pets, time spent driving, and feeling unsafe in areas with which they were less familiar. One participant wrote of these challenges, "Many houses are very dirty and unsafe to be at. Traveling is harsh. I travel 37 miles for my caseloads every day." While IHT/TT&S providers report high levels of satisfaction in the closed-

ended questions of this survey, the challenges faced in this role have important implications that could have long-term effects for providers.

Policy Implications

Many of the above emerging themes such as support, teamwork, training, and productivity requirements affect the ways in which clinicians provide care to children, adolescents, and families and relates to overall job satisfaction for providers. This leads to some relevant policy implications and questions for further study.

Keeping in mind the experience levels of many of the clinicians providing IHT/TT&S care, one important policy consideration is tied to training, or perhaps more generally, the various processes that develop and enhance provider competencies. Participants who responded to this survey work at a wide variety of organizations and agencies around Massachusetts and apparently receive different amounts of training. Each agency has a process by which they select their employees and then provide them with orientations, in-service trainings, supervision and evaluations. If agencies differ greatly in how they provide these aspects of orienting and training their IHT/TT&S providers, it might be useful to look into the ways in which these practices do differ and the results that come from the variety of approaches. Bringing provider agencies together in a problem-solving format such as a learning collaborative might be a good way to identify and share best practices.

It would also be useful to know if there are particular agencies providing IHT who provide specific training about the nature of working in home environments, and if they have

different kinds of outcomes. The literature pointed to the importance of providing environment specific training and the implications of providing better care when care providers are able to use the home environment to their advantage (Reiter, 2008). While this study was primarily exploratory and did not ask clinicians to specify about the training they received directly related to IHT, this could be an important avenue to take for future studies. State policy makers may wish to look at potential benefits of developing uniform training materials for provider agencies to use in in-service training. Collaboration with graduate training programs might also be helpful in finding ways to enhance the preparation of future IHT clinicians.

TT&S provider responses in particular provide insight into their unique experience and this suggests their experience may differ significantly from IHT clinician experiences. TT&S providers commented about being undertrained, in some cases wrote of having difficulties working with IHTs, and consequently, if some TT&S may potentially wish to become future IHT providers, the implications of employee retention and job satisfaction are important. This is a particularly salient policy consideration: TT&S providers need specific attention.

Findings regarding training and teamwork between TT&S and IHT providers suggest that strengthening support for these positions in knowing how to work together, while also keeping in mind compensation issues mentioned above, might have a significant impact on satisfaction, employee turnover, and quality of care.

It is also crucial to note policy considerations for changes in productivity requirements. Current requirements seem to be overwhelming and burdensome for many of the participants in

this study. Productivity levels that practitioners suggest in the open-ended question portion of the survey varied considerably (Appendix E), and the survey design did not allow respondents to indicate the relative burden they felt due to amount of clinical work versus production of billable units. When asked about what might sway providers to stay in their current role, one participant wrote with regard to productivity,

> Less productivity requirements with no reduction in pay, more opportunities to be among coworkers, more groups/workshops/trainings about self care as a clinician and agency becoming trauma informed in order to provide best support from the top down (admin, supervisors, clinicians, clients etc).

This participant speaks to the ways in which these issues are not isolated and, instead, work in conjunction with one another.

Today there is a powerful movement within healthcare to replace fee-for-service payments with payments that are more reflective of value and quality of care (Barnes, 2012). Many IHT and TT&S providers expressed some interest in being compensated in a way that reflects clinical value of their work. MassHealth's Managed Care Entities (MCEs) are currently engaged in a pilot study in which they are examining the use of a day rate for billing for another service (Intensive Care Coordination); early anecdotal evidence suggests a positive impact on practitioner morale and on enhancing clinically appropriate activities (J. Simons, Personal Communication, June 9, 2016). Lessons from this alternative payment pilot may be relevant for IHT, too.

Limitations and Future Research

This research indicates a need for further research on a variety of aspects related to IHT in Massachusetts as well as in other states and agencies. There were several important limitations of this study. This study was conducted with participants from one state Medicaid behavioral health program and may not hold in other jurisdictions, or in services focused on different populations. Another limitation of this study is probable selection bias in the sample. As noted above, probably about half of the IHT workers are TT&S providers and yet make they up only 21.8% of the sample. In addition, it is quite possible that those who chose to respond to the survey were motivated in some different ways from non-respondents, so the survey may not be entirely representative of the target population.

Upon completing this study, there are several important questions I would have asked differently and topics that would have been useful to include. With regard to productivity requirements, I asked participants to reflect on what they thought were appropriate requirements but did not ask for specific data pertaining to a particular unit of measure (i.e. units, hours, percent of work week). This meant that I received a variety of responses that were difficult to discern into a more coherent and specific understanding. In future research related to productivity it would be useful to ask participants to use the same unit of productivity measurements in order to draw a more cohesive conclusion.

Another topic that could have been addressed differently in the survey questions has to do with training. While it seems apparent from the responses that participants feel as though they do

not receive adequate training, it would be important to know that if participants had received training specific to IHT, what that training was and how useful it felt. Finally, it also would have been beneficial to ask more closed-ended questions about participants' attitudes related to compensation and salary. This came up over and over again in the open-ended responses from participants but is not something I was able to gain quantitative data on. This would have been useful to include in this study.

Conclusion

In summation, agency supports for providers, teamwork, training, and productivity requirements affect IHT and TT&S providers deeply. One participant wrote the following reflection,

> The nature of the IHT work draws in young, minimally trained, and newly-graduated clinicians. These (relatively) unskilled clinicians are serving the most vulnerable families in the level of care system (IHT is the service in between outpatient and out-of-home care). They then earn great experience working with families, dealing with the system, and developing their skills and then move onto other services for better paying positions. So, IHT - in general – constantly has the least experienced clinicians working with the most vulnerable clients. Also, the coworker turnover is detrimental to community building and a sense of attachment to the organization which decreases job satisfaction and leads to more turnover and inexperienced supervisors.

Each of the issues this participant raises has profound impacts on the ways in which agencies are able to provide adequate care to children, adolescents, and families.

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Appendix A

HSR Approval and Change Form

School for Social Work
Smith College
Northampton, Massachusetts 01063

February 19, 2016

Dear Katy,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,
Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jack Simons, Research Advisor

2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

«Project_Name»
Katy Cole
Jack Simons, PhD

……

Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. I am requesting a change related to my survey document. Training and Support (TT&S) providers working under In-home therapy (IHT) providers may need more explicit instruction indicating that they are included in the survey questions referring to IHT providers. Attached is a revised copy of my survey. I have added TT&S to each question that directly asks about the experience as an IHT provider.

……

__X__I understand that these proposed changes in protocol will be reviewed by the Committee.
__X__I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
_X__I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: __Kathryn Cole_____

……

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 10, 2016

Katy Cole

Dear Katy,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jack Simons, Research Advisor

Appendix B

Invitation to Participate

Dear IHT/TT&S Provider,

What is it like to do in-home therapy?

I am an MSW student at Smith College. Last year, as part of my practicum, I gained experience doing in-home therapy. Doing this challenging, yet rewarding work made me want to know about others' experiences. I am conducting a thesis project examining In-Home Therapy (or "IHT")/ Therapeutic Training & Support (or "TT&S") and the experiences of the staff who provide these services.

I'd like to invite you to participate in this *anonymous* survey, which would help us better understand the experience of in-home therapists in Massachusetts and learn about ways to improve the experience of IHT for providers and clients alike. This short survey will take about 20 minutes to complete, and provides space (if you choose) to share your thoughts and opinions in written form.

https://www.surveymonkey.com/r/XKW579X

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Your experiences are very important and the findings of this study will be shared with MassHealth. In this way your views may influence future policy. Once the project is complete, I'd be happy to share my findings. If you would like to receive them, please email me at _____.

Many thanks,

Katy Cole

Appendix C

Informed Consent

Investigator(s): Katy Cole, Smith College SSW MSW Student
Advisor: Jack Simons, Ph.D, Director of the Children's Behavioral Health Initiative

Thank you for your interest in this study. Please review the information below before agreeing to participate.

THIS STUDY PROTOCOL HAS BEEN REVIEWED AND APPROVED BY THE SMITH COLLEGE SCHOOL FOR SOCIAL WORK HUMAN SUBJECTS REVIEW COMMITTEE (HSRC).

Introduction
• You are being asked to participate in a research study which seeks to examine whether clinicians providing In-Home Therapy (IHT) feel adequately prepared to do this work, what the Commonwealth of Massachusetts could do in order to help them feel more successful, find job satisfaction, and want to continue providing IHT.

• You were selected as a possible participant because of your position as a TT&S/ IHT provider.

Purpose of Study
• The purpose of the study is to better understand the experiences of clinicians providing IHT/ TT&S in Massachusetts.

• This study is being conducted as a research requirement for my master's in social work degree.

• Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
• If you agree to be in this study, you will be asked to do the following things: read and answer the following survey about your experiences as a TT&S/IHT provider. You may stop taking the survey at any time.

Risks/Discomforts of Being in this Study
• The study has the following risks. First, completing this survey may bring up feelings of frustration or distress related to your job. Should you need support or counseling here is a link to several resources you may contact:

http://www.healthyplace.com/other-info/resources/mental-health-hotline-numbers-and-referral-resources/

Benefits of Participating in the Survey

• By participating in this survey, you have the opportunity to affect change in your profession. In sharing your experiences and viewpoints related to this work, your voices can be heard. This research will be compiled, analyzed and given to the office of the Children's Behavioral Health Initiative and may have an impact on policy.

• While home-based therapies have been around for quite some time, and there is some evidence into the efficacy of this modality, there seems to be a need for a deeper look into the experiences of clinicians doing this work. Anecdotally this work presents with many challenges, including feelings of safety, and there is little research on clinicians' experiences. This project has the potential to create institutional change in agencies in Massachusetts that provide these services.

Confidentiality

• This survey is anonymous. We will not be collecting or retaining any information about your identity. SurveyMonkey's software encodes data collected so that the data is unidentifiable to the researcher. This means that while the researcher will have access to this data, she will only be able to see answers to the survey without any identifying information from participants.

Payments/gift

• You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

• The decision to participate or not in this study is entirely up to you will have no effect on your employment. You may refuse to take part in the study at any time.

Right to Ask Questions and Report Concerns

• You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Katy Cole at_____. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

fl

* 3. Consent:

I agree to participate in this survey, and that have read and understood the information provided above. Please print a copy of this page for your records.

- o Yes
- o No

Appendix D

Survey

1. Gender Identity:
Female
Male
Other_____
I prefer not to self identify

2. Age:
18-24
25-34
35-44
45-54
55-64
65+
I prefer not to identify

3. Race:
Black or African American
Hispanic/Latino/Black
Hispanic/Latino/White
Hispanic/Latino/Other
Native Hawaiian or Pacific Islander
Native American or American Indian
American Indian/Alaska Native (Wampanoag)
American Indian/Alaska Native (Other Tribal Nation)
White
Other_____
I prefer not to identify

4. Education:
Less than a High School Diploma
High School Diploma or Equivalent
Bachelor's Degree
Master's Degree
Doctoral Degree

5. Professional Identification (choose one):
Social Work
Psychology
Clinical Psychology
Counseling Psychology
School Psychology
Marriage and Family Therapy
Addictions Counseling
Other_____

6. Level of Licensure in Massachusetts:
Licensed Clinical Social Worker (LCSW)
Licensed Independent Social Worker (LICSW)
Licensed Psychologist
Licensed Marriage and Family Therapist (LMFT)
Licensed Alcohol and Drug Counselor 1(LADC – 1)
Licensed Alcohol and Drug Counselor 2 (LADC – 2)
Certified Alcohol and Drug Counselor 1 (CADC – 1)
Certified Alcohol and Drug Counselor 2 (CADC – 2)
Other_____
Not Licensed

7. County where you practice primarily:

Barnstable	Franklin	Norfolk
Berkshire	Hampden	Plymouth
Bristol	Hampshire	Suffolk
Dukes	Middlesex	Worcester
Essex	Nantucket	

8. Average number of hours per week you are employed doing IHT?
(Participants will enter a number between 1-40)

9. Typical IHT Caseload during the last four weeks you worked:
(Enter a number between 1-25)

10. How long have you been working in behavioral health (include any practicum/internship time)?
Less than one year
12-23 months

24-35 months
3-5 years
6-7 years
8-9 years
10+ years

11. How long have you been doing IHT or an equivalent service?
Less than one year
1 year but less than 2 years
2 years but less than 3 years
3-5 year
6-7 years
8-9 years
10+ years

12. How long have you been doing IHT or an equivalent service in this organization?
Less than one year
1 year but less than 2 years
2 years but less than 3 years
3-5 year
6-7 years
8-9 years
10+ years

Provider Experience

Please express the extent to which you agree with the following statements

0 – Completely Disagree
5- Completely Agree

13. I am satisfied in my position as an IHT provider.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

14. I feel as though I had adequate initial training and/or preparation to be successful providing IHT.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

15. I feel supported by my supervisor.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

16. I feel supported by my team at my agency.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

17. The in-service training at the beginning of my work as an IHT has prepared me well to do my work.

0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

18. I feel effective in creating a therapeutic alliance with youth.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

19. I feel effective in creating a therapeutic alliance with families.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

20. I feel effective in helping youth reduce symptoms.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

21. I feel effective in helping families better understand and help their children.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

22. I feel physically safe when providing IHT services.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

23. I feel confident in my ability to help people in my role as an IHT provider.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

24. My work as an IHT provider is professionally fulfilling.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

25.I feel like I'm on the right professional path.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

26.I would like to become an IHT supervisor.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

27. Before beginning as an IHT provider, I received specific certifications/trainings pertaining directly to in-home therapy.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

28.I would be more successful if my organization provided more hours of supervision.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

29.I would be more successful if my organization provided more training.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

30. I have adequate therapeutic resources (therapy games, art supplies, etc) to do this work.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

31. I have adequate technology support in my job.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

32. My agency's productivity requirements make it difficult to do my job.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

33. Working with youth is the most challenging aspect of my work.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

34. Working with families is the most challenging aspect of my work.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

35. My caseload is the most challenging aspect of my work.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

36. Going into families' homes is the most challenging aspect of my work.
0 – Completely Disagree ----------5- Completely Agree
(Drop Down 1-5)

Open-Ended Questions

37. Please provide any other information about the challenges you face in this role.

38. What aspects of your job do you find most fulfilling / enjoyable?

38. What would be the optimal productivity requirements for IHT?

39. If you are considering leaving IHT work, what might sway you to stay?

40. Any other information you would like to share.

Appendix E

Open-Ended Question Responses

Below find a representative sample of verbatim responses from participants for each of the five open-ended questions.

In some instances, editorial comments are added for clarity.

1. Please provide any other information about the challenges you face in this role.

Collaborating within systems - or trying to. Working with problem-saturated narratives about kids and families, having blame put on kids and families by other providers, schools, courts, and working within that system to support something else.

I work with several chronically disabled people who make their progress very slowly. It takes a lot of patience to persevere.

The paperwork requirements and time-lines while managing time on the road.

I didn't feel prepared for this job when I started. I'm only a month into it, and i am feeling more confident. I am concerned about being able to manage my caseload as it continues to grows.

Keeping current with documentation.

Working in a two-clinician model and lack of training to do so; working within the constraints of the system and working with collaterals (primarily DCF and large issues with communication with DCF); supporting multi-stressed families to reach stability to then move forward, in particular services providing effective care (housing support, other levels of mental health care, other CBHI services, etc) which then furthers the family's distrust and belief in the usefulness of services; insufficient salary to motivate me and others to stay in the position so then there is high turnover in the agency.

Not enough training / insufficient information provided about the specific activities this worker can do with youth / the constant traveling around the state - which increases the amount of time worked per week without adding to productivity

The biggest challenge is financial, the pay is not enough to live on, but the work is so rewarding. So in order to continue doing this important work, most providers require a second job (or more),

this takes energy away from doing the therapeutic work and provides the biggest challenge against burnout.

Getting families to acknowledge their child's concerns as well as needs.

I do not believe I was properly trained, and had to learn a lot from fellow co workers. When confronted about something I "did wrong" I always want to respond with "I wasn't trained on that." But it would be a bit awkward to say that to your supervisor in a meeting.

Collaborating and staying unified as a TT&S / IHT team when two workers are going into the home can be challenging when there are power struggles and perceived hierarchies between the clinician and support, and the workers have different goals and interventions. Caregivers can be very avoidant and often are not on board, and sometimes even counteract or contradict the work being done in session, and this can be very frustrating and challenging.

Most of the challenges that I face in this job is the CBHI system as a whole. I think we need to really consider the provider doing this job, and rework the amount of paperwork that is expected of us. I also think we need to look at each agency and make sure all people in their given position is adequately trained to work with the population that they are working with.

There are no supports for TT&S. Clinicians at least have clinical experiences from previous jobs and higher certifications and educational titles. There is a CBHI course for Family Partners and Therapeutic Mentors, but there are not any for TT&S. *[The respondent may be referring to a workforce collaborative in which some provider agencies participated.]* Part of our role is to do case management, but there is no training in such. There is no training in how the MASS. services work, like food stamps. We constantly rely on our co-workers' knowledge because there are no trainings. It is very unreliable. There are also arguments as to why TT&S are qualified to visit families by themselves in person but not do clinical documentation. TT&S do not have the same experiences as Clinicians yet TT&S are expected to act as such. This is applicable to new TT&S. There should be training on parenting skills and case management. Sometimes I feel that my only job is case-management since I am told that if there are not any case-management needs in a family, I should leave the case while Clinician stays. I have heard of agencies who do not have many TT&S, and usually have Clinicians be by themselves.

Lack of community resources to support our work, such as addictions treatment for family members and positive activities for youth is this catchment area.

Lack of safety while in the neighborhoods. Many houses are very dirty and unsafe to be at. Traveling is harsh I travel 37 miles for my caseloads every day. DCF, doctors and school make our work very difficult as they don't accept or respect our jobs.

The challenges that I face is not having a consistent schedule and having it affect my family and my personal life in where it has me not being able to do self-care on a daily basis for myself. I know it is part of the job to meet needs of family but it is a challenge for me.

We were never trained for this type of work. Neither at school, nor at job. It is always complex super deep trauma and we know nothing about that. Safety is another big concern. Once I almost got killed in a dark and half empty garage. Nobody gave a damn. And last but not least, our salary is just a shame.

I am limited by insurance companies not being willing to pay for these services. Often I know I could provide better care for someone if I could meet with them at home but many insurance companies will not allow it." *[Not clear what the respondent is referring to here, but possible the fact commercial insurance may not pay for IHT. All MassHealth managed care entities pay for IHT.]*

I am limited by insurance companies not being willing to pay for these services. Often I know I could provide better care for someone if I could meet with them at home but many insurance companies will not allow it. *[See prior comment]*

Pressure to meet productivity hours, when often cancellations and no-shows cannot be controlled. I did not feel as though I received training for the role; supervision helped, but this was when I was already on the cases. I learned by doing. As a TT&S, we are not required to do any intake paperwork. While this makes it "easy" for us, it does not give us a good start when working with the families. We hop onto the case and can only read supporting documents from our HUB. We will talk with the parents about their needs, but not as much is gained. Because we cannot bill for a consult with the IHT clinician, sometimes we are not on the same page or have no idea how it is going with the other person because we don't see each other to talk about it.

2. What aspects of your job do you find most fulfilling / enjoyable?

Connecting with kids and families. Therapeutic relationships.

Clients that are able to recognize they can use my help and make visible progress.

Interacting with families and youth and the high level of collaboration with other professionals involved in the youth's life.

Working with youth and families.

Developing relationships, engaging in discourse with families about relationships.

Being with the family in their environment and seeing them in the setting in which they need support; the flexibility of support we can give families (in schools, during Doctor appointments, at court, in home, etc); the schedule flexibility; getting to know the families so well.

Wonderful supportive staff, working with the families 1-on-1.

The small (and large) progress that families make towards their goals. It is really rewarding to see a family communicate effectively and better understand each other.

Working with the youth in community and having the ability to do some of the clinical work inside the homes.

Working with my partner, team, supervisor and agency. I also enjoy working with most families.

Spending time with the kids and being out of the office

My team is incredible and so supportive and I am very encouraged in supervision. Also, when a family is on board and wants to work with the clinician / support person to impact the home environment, it can be really outstanding.

Progress of the youth and families.

My most favorite part of this job is the children and families with whom I work. I truly believe in the in-home therapy model and how each time I come to a family's home, in naturally providing care, support, and empathy to people who are vulnerable and who wouldn't have received support without IHT. I bring these families the gift of art therapy, and work with them to take internal conflict and create empowerment, communication and collaboration. Most enjoyable part of this job is watching the magic of therapeutic healing, and the sincere gratefulness of these families for being the one to both see and hear them at their worst.

Giving support to families, specially mothers and youth that usually are discriminated.

I love seeing results and the families being really thankful of the outcomes. The reason I am still working here is because of this. I know families need the services I provide.

Witnessing improved communication within families.

Informing Parent(s)/Guardian(s) about their child's mental health and how it may be displayed through the youth's actions or behaviors. In addition, observing the youth actively utilizing effective coping strategies to reduce negative behaviors and/or interactions.

Working one on one with youth, building rapport and trust with the youth. Seeing the youth improve over time and be proud of themselves.

I take pleasure in the family's enlightening moments, when suddenly they realize something that has been in front of them all along. I also rather enjoy when a family can all sit through a family meeting and communicate with one another.

3. What would be the optimal productivity requirements for IHT/TT&S?

[The question was not clear about how productivity should be measured. Despite the difficulty of interpreting some responses, I felt it was important to report them. Where respondents refer to "units" they are probably referring to units of 15 minutes, probably per week. Staff productivity requirements are set by the provider agency, not by MassHealth or its managed care entities, although productivity requirements will obviously be influenced by rates paid to the provider agencies.]

Closer to 90 units, rather than 105, since we can't bill for all the driving we do.

Not sure, I do about 25% outreach and 75% in offices or day programs. I'm not sure anyone does their best work after about 5 sessions per day combined in or out of the office.

23 hours billable to allow for a 40 hour work week with travel times to homes
Hard to say, I think the 120 units we have is reasonable. Getting productivity "units" has been an incentive to complete paperwork in a timely manner. It's kind of like a game that way. I'm only a months in, so the novelty could wear off.

105 units/week

Not completely sure - maybe 23 billable hours

I think contract work would be best honestly. Productivity requirements measure quantity, not the quality of services. *[Not clear what the respondent means by "contract work" but she or he may be referring to state agency contracts which use a case rate.]*

Not having to follow units of production.

I'm fee for service, so this does not impact me.

I truly think we need to get rid of this term and come up with a new system. Putting a label on the beautiful work and care we provide our families shouldn't be considered "productivity" This word naturally brings stress to very compassionate and talented people who give their heart and soul to do this job. This word is shaming when people to do not meet their requirement and when families cancel on us due to daily life struggles. The fact that we need to justify why units may be low or why we haven't seen a client should be honored by managed care and supervisors as it should be reported. Working with families inside their home can be quite complex and takes complete flexibility and creativity about where therapy can take place. Families with whom I work are often struggling with poverty and often do not have documentation, making matters highly stressful. Meeting clients where they are at is crucial, yet this system doesn't account for that and instead sees what has been produced.... Therapy takes time and IHT shouldn't be short term services when outpatient provides are far and few between. *[Note that MassHealth does not define IHT as a "short term service" or impose time limits on enrollment.]*

I believe that working with productivity makes no sense in the type of job we do. However, if there is not option, 60 units would be enough for a TT&S, considering that we can bill only for around a 20% of the job we do.

It really depends since not all families have as much case management needs or therapeutic needs as others. From my experience, I would say 7-8 cases (95-98 units). TT&S should be able to work on paperwork since it will help them think in a clinical way and help them develop professionally. At this point, Clinicians have so much work-load and are allowed to do anything, while TT&S are very limited as to what they are allowed to do by the insurances, and struggle to meet the weekly productivity.

Not to work with units and instead set up an hourly rate measured by the families response to services as positive or negative.

Smaller caseloads in order to strengthen therapeutic strategies and treatments with each youth and/or family.

Many IHT providers hold 2-3 jobs serving in the same capacity in different agencies, which makes it impossible for them to service the families in the manner that the model was designed to do. They do not see the damage they do to the families and maybe they just do not care. IHT providers should be required to limit their service in the field to only one agency and if they need

to seek a second job, it should be in a different role and or field. Additionally more emphasis should be focused on the actual work done with the family and not so much on paperwork.

Do really understand this question - My time is more valued and almost everything I do for my IHT clients is counted towards my productivity (the agency can bill for my time - to do CANS, IAP, [Comprehensive Assessments]) where it is not billable in outpatient therapy.

Some agencies cover larger rural areas which leads to more driving (less billable time) than urban agencies. I feel that the idea requirement should be no more than 25-27 hours of billable time.

Full time work is 113 hours a month.. almost 30 hours a week.. that does not include office time, travel time, supervision meeting etc. instead of 28.75 hours a week, it should be 20 hours a week total, there are times where I have traveled 15 hours a week due to where my caseloads lived that time.

50-60% of the work week, especially as we cover three counties in Mass. and spend significant amounts of time driving to and from appointments. Also high cancellation rate by caregivers negatively impacts ability to maintain expected minimum productivity quota of current 70%

I don't know what to say here, but I feel like CBHI should be more practical and logical on figuring out what is realistic if a person carries X amount of caseload and X amount of hours spent for each family--considering all documentation, traveling, lack of benefits, etc.

4. If you are considering leaving IHT/TT&S work, what might sway you to stay?

Increase in salary.

I'm not considering leaving, but more time off, better pay, better mileage rates, better benefits and a new car would help.

Increased salary to a comfortable wage living in MA.

Increased salary / more training around specific activities TTS / TM *[therapeutic mentor]* can engage in with clients.

As I mentioned before, the work is rewarding, it is the money that is the issue, particularly with the cost of living and paying back student loans. It would also be nice to have more understanding if clients cancel due to illness, the weather or because they have gone on vacation.

Pay increases, and bonuses for production.

I have stayed for 6 plus years due to pay raises and the people I work with as well as great supervision and peers.

More trainings, certifications, and more billable hours.

I will be leaving this position come June. It is partially to the negative environment of my agency, and the other part is more personal in that I would like to continue a group I am running using expressive therapies for unaccompanied minors from Central America. I think ultimately what could sway me to stay was a major overhaul in the CBHI system, especially a revamp of the paperwork needed by MCE's *[Managed Care Entities]*. A great majority is redundant and it would be easier on the lives of clinicians if we could use the support of the TT&S role to help clinicians more with documentation so we can truly work as a team.

Working without productivity.

This is a very inconsistent job in many ways, families who are not willing to do their part might cancel frequently or are just in denial for a long time, which is part of the process. The hours are very tiring. We are supposed to be available 8am-8pm, and the schedule is inconsistent. One has to be very flexible in many ways, and this part is also exhausting, but at the same time the nature of the job. Personally, the expectations of my job do not match my previous experiences. There are many times I wonder why I was admitted to work here since my previous experiences do not match what is really required to be a productive TT&S.

Pay, better working conditions. Everything I hear CBHI workers complain about are not agency related policies rather CBHI mandated expectations.
Better pay and supervisors that are licensed to supervise.

Change in hours, child care options

TRAINING!

Better training for direct supervisors, in terms of the CBHI model, more consideration for the amount of excessive driving done by clinicians, which is not accounted for. Higher, competitive salary.

Productivity, more support, more incentives and raises.

Better compensation (salary, mileage, compensation for car repairs, oil changes).

Higher pay, better hours (reduce late nights).

Bill for travel to and from appointments, as with other disciplines (e.g., as with those working with the deaf and hard of hearing)

A flexible scheduling system.

Less focus on productivity, more resources for family and funding.

5. Any other information you would like to share?

More safety training and resources about community violence is needed. High turnover is such an issue in IHT. The nature of the IHT work draws in young, minimally trained, and newly-graduated clinicians. These (relatively) unskilled clinicians are serving the most vulnerable families in the level of care system (IHT is the service in between outpatient and out-of-home care). They then earn great experience working with families, dealing with the system, and developing their skills and then move onto other services for better paying positions. So, IHT - in general - constantly has the least experienced clinicians working with the most vulnerable clients. Also, the coworker turnover is detrimental to community building and a sense of attachment to the organization, which decreases job satisfaction and leads to more turnover and inexperienced supervisors.

I just want to say thank you for considering those who work in this field, as I've spent much time brainstorming how this system can be better, and more supportive of the person doing this very tough job. When we see clinician as people and not machines, we will inevitably be providing better, wrap-around care that IHT should be doing.

I think that IHT clinicians and TT&S must receive more training with a sociological focus. Big part of our job is social work and understanding not only the particular cultures of the families but also the whole system in the US. Some people does not even know how to situate in a map the neighborhoods in which they are working. Regarding safety, we do not need general trainings we need specific crisis plans coordinated with the agencies and coordination with the police. Agencies should provide information regarding the activity of the gangs in the city.

I am very thankful you are conducting this survey. I hope to really see positive changes. Many of my IHT co-workers are very miserable in this department and NONE of them are planning to stay, including myself. It breaks my heart because I believe these services are needed but the system and structure of CBHI make it difficult for people to stay working under it. If agencies keep hiring new people who have to adapt over again to the IHT system, how well will the service be for the families? On the other hand, I am thankful because I have learn SO MUCH in such a short time but it has been super stressful as well.

Staying here another year will kill me.

CBHI needs to change things around. This service is meant to support the most needy youth and families. However, if the people serving these families are over worked, underpaid (it's a CBHI issue given rates), then the quality of service is at risk (very low retention).

I get why IHT is important to provide but overall it doesn't feel like it is working on a large scale. The major benefit is we get to see parents in action vs 'fix my child' in a once a week/ 45 min session. Here we can provide prompts, education, redirection to facilitate attunement and build healthy attachments.

There are unaddressed training needs that require attention. Atmosphere in office could be more 'therapeutic.'

There appears to be a fairly wide spectrum of IHT/TT&S job expectations for productivity, pay rate and schedule of weekly work hours between the numerous agencies in the state providing CBHI services. More uniformity may be good.

Keeping up with paperwork and case coordination is the worst part about this job. I would much rather put my energy into spending time with the families.

Lack of resources and difficult scheduling make this job difficult. Also insurance companies have taken more and more things away that are billable services although same amount of work is required to provide quality service to families.

More funding for therapy supplies and training for IHT/TT&S is needed. I have started to build my own selection of games, but this is very expensive.

Please use this also to monitor the agencies; there's a lot of ethics and [HIPAA] violations. Supervisors are in for the productivity and not for the families' well fare.
I wish I had done something else with my life.

We work very hard, sometimes long hours with the most multi-stressed families and are compensated poorly even as we gain more experience and skill. We often have to collaborate with state agencies who simply have no clue that mental health issues are always part of what creates a crisis or charges of "neglect" for a parent. There is no money or services other than IHT to support these families and no place for kids with severe and persistent mental health illnesses to receive appropriate treatment. The legislature and/or judges who created CBHI have no business making decisions without talking to the clinicians who are really doing the WORK.

Wonderful questions! Thank you for focusing on IHT! Wicked awesome of you to get this question in the CANS newsletter!

Flexibility of IHT services allow providers to collaborate with other providers; go school meetings, psyhe [psych?]appointment, WRAP around and other collaterals meetings.

Fully train new clinicians about family therapy, especially regarding the paperwork. Everything must be written to the auditors or it is at risk of having the billing reversed.

This is a very tough but rewarding job, more outcome studies need to be done to establish effectiveness and ways to improve services.

At my current job, I noticed a lack of training, I created a training manual, and now complete all trainings.

I already left....the system is not conducive to supporting social workers and helping families...creativity is stifled for 'meeting productivity requirements and other paperwork requirements'. Prior to managed care, there was an ability to engage in meaningful team meetings, expanding critical thinking skills and allowing for agency based and outside trainings, dialogue and intelligence...it (clinicians) has now become a 'puppet' to answering and 'passing' the requirement by insurance managed care entities....one's degree and intelligence is disparaged and devalued....this is work that can be done without MSW's or advanced education, as it has become....DBT and other 'standard' treatments are being pushed by insurances and agencies, as the correct way to proceed, despite a clinician's determination of needed other modalities and treatment approaches. Advanced education makes little sense and a waste to working with families in need.