Intensive In-Home Behavioral Health Treatment (IIBHT)
Program Standards

Clinical Program Categories	Description
A program that provides high-quality in-home behavioral health services for children and youth with serious emotional and behavioral needs and their families includes:	
1) Competent staff	**1.1** *Role clarity*: Regardless of approach to practice adopted by IIBHT programs (i.e., use of solo practitioners; two or three-person teams), there are clear roles and responsibilities for each IIBHT practitioner, including detailed job descriptions for each role [e.g., therapists, other qualified mental health professionals (QMHPs), peer support workers, supervisors]. **1.2** *Practitioner credentials:* All IIBHT practitioners (i.e., therapists, QMHPs, peer support workers, supervisors) have a clear set of credentials (i.e., relevant degree, training, and experience) appropriate to their role. IIBHT teams as a whole have credentials that allow them to provide the complete array of services included in IIBHT (i.e., if the program utilizes a single practitioner model, staff need to have the necessary credentials to provide the full continuum of services). **1.3** *Rigorous and Reflective hiring processes:* The IIBHT provider organization has written interviewing and hiring protocols for each of the relevant positions. Protocols are rigorous and aimed at recruiting and hiring staff who are ideal for the position (e.g., presentation of scenarios that allow candidates to demonstrate skills/value base). The IIBHT program undertakes all steps possible to ensure staff recruitment and hiring reflects the racial, cultural, and linguistic diversity of the population(s) served. **1.4** *Effective orientation:* IIBHT practitioners with little to no previous experience in IIBHT will shadow or team with a more experienced practitioner or supervisor and practice under observation with feedback until they demonstrate competence prior to being assigned a caseload. **1.5** *Effective training:* IIBHT staff and supervisors are required to participate in training delivered using written training protocols that include behavioral rehearsal and direct observation of skills-based practice. **1.6** *Skills-based coaching:* IIBHT practitioners receive regular coaching by supervisor or consultant of IIBHT skills and receive feedback based on observation of practice and review of plans of care and other documentation. **1.7** *Intensive supervision:* Supervisor to practitioner ratio meets relevant guidelines (ideally, no higher than 1:8) and supervisors allocate adequate time to the IIBHT team (ideally, 50% FTE for up to 4-person team; and 100% for 5 to 8 person team). Supervisors provide weekly supervision and are available for additional supervision as needed, including field supervision. In addition, the IIBHT supervisor convenes weekly team meetings/group supervision to coordinate treatment, supports, review safety plans, and coordinate crisis on-call between team members. **1.8** *On-call support:* IIBHT supervisors provide 24/7 on-call support and backup to their staff. **1.9** *IIBHT Quality Management:* Supervisors review initial and updated IIBHT treatment plans, treatment notes, and progress for each youth and caregiver as part of the process of overseeing IIBHT implementation.
2) Defined Practice Model	**2.1** *Clear eligibility criteria:* Population of focus is limited to youth with intensive behavioral health needs (e.g., multiple diagnoses, multiple action items on a standardized assessment, and/or significant safety or risk concerns) and who are at risk of out-of-home placement or transitioning home from an out-of-home placement due to their behavioral health needs. **2.2** *Practice protocol(s):* A standardized protocol is used by program staff with all youth and caregivers that guides an individualized selection of IIBHT interventions to be provided relative to youth and caregiver strengths, needs, goals, and preferences. **2.3** *Service coordination:* IIBHT programs include a well-operationalized approach to cross-system communication, planning, and coordination of services and supports for the benefit of the youth and family. In the absence of an identified care coordination program or provider, the IIBHT provider is responsible for and integrates case/care management into the practice model. **2.4** *24/7 availability:* Ideally, crisis response is available at all times by IIBHT program staff, with rotating on-call coverage as needed. IIBHT supervisor(s) provide on-call support and backup to their staff. Agency has policies that describe the on-call coverage protocols, as well as a description of when and how to access external crisis support in the community (e.g. mobile response and stabilization), if necessary. **2.5** *Commitment to flexibility and accessibility:* IIBHT sessions are scheduled at times and in locations that are flexible, accessible, and convenient to youth and caregivers, including evening and weekend appointment times, at the location of the youth and caregiver's choice. **2.6** *Ecological focus:* IIBHT is based on a holistic and comprehensive assessment of youth and caregiver needs. Treatment planning conceptualizes the youth and caregivers as part of an ecological system (i.e., individuals within families within communities within the broader cultural context).

		2.7	*Comprehensiveness of intervention:* Whether delivered via one individual or by teams, youth and caregivers have access to comprehensive behavioral health treatment, including, but not limited to: behavioral management training, skills-enhancement, individual therapy, family therapy, 24/7 crisis response, and care coordination.
		2.8	*Safety planning:* IIBHT program policies establish an expectation for safety planning for each youth and delineate required safety planning components and processes, youth and caregiver involvement, and plan dissemination. Program policies also establish frequency of safety plan review, which should be no less than quarterly.
		2.9	*Small caseloads:* The number of youth and caregivers per practitioner/team is appropriate to the practice model and intensity (ideally, 6:1, 8:1, and 12:1 for one, two, and three-person teams respectively).
		2.10	*Intensity of intervention:* Frequency and hours of intervention match the level of need for support of youth and caregivers and where they are in the intervention process. Average intensity for youth and their caregivers, however, should be no less than 3-6 hours per week. In some cases, factors such as phase of treatment may warrant flexibility.
		2.11	*Focused treatment duration:* Youth and caregivers are engaged in IIBHT until intervention goals are met and progress has been documented via ongoing assessment. However, the intervention should aim to address youth and caregiver priority needs and transition out of formal IIBHT within 6 months. IIBHT provider organizations' average length of treatment should be 3-6 months.
3)	**Accountability mechanisms**	**3.1**	*Outcome monitoring:* Baseline and repeated measurement of outcomes including: emotional and behavioral functioning of the youth, living situation, school outcomes, juvenile justice and/or child welfare involvement, and progress toward individualized goals for youth and caregivers is routinely and reliably monitored and shared with youth and caregivers. Youth and caregiver satisfaction with the IIBHT team and process is also assessed.
		3.2	*Quality monitoring:* IIBHT practice adherence and quality of care is measured routinely and reliably with the goal of providing feedback and opportunity for skill development for the practitioner as well as continuous program improvement.
		3.3	*Effective data management:* The IIBHT provider organization uses information systems that serve as a mechanism for maintaining information for each youth and caregiver. Data systems can generate reports that are used routinely to monitor individual youth and caregiver progress, guide supervision, and manage the IIBHT program.
		3.4	*Review of care plans:* Each youth and caregiver's initial treatment plan is reviewed by an expert (i.e. supervisor) in the IIBHT practice model. Updated treatment plans should also be regularly reviewed.
4)	**Leadership**	**4.1**	*Comprehensive system collaboration:* The IIBHT provider establishes and maintains effective partnerships with community partners including representatives of all child serving systems, caregiver- and youth-run organizations, and other provider organizations. IIBHT providers advocate on behalf of youth and caregivers with child serving systems and providers.
		4.2	*Positive work environment:* IIBHT supervisor and program administrators monitor and address staff morale and encourage a high sense of collective mission, open communication, and cohesion among all staff.
		4.3	*Effective Leadership:* Supervisors and higher-level leadership are receptive to the ideas and concerns of staff, have well-defined organizational performance goals, and effectively address barriers to effectively implementing IIBHT.
5)	**Facilitative organizational support**	**5.1**	*Adequate compensation and resources:* IIBHT practitioners and supervisors are adequately compensated and given the required physical and technical resources (e.g., office space, laptops, secure electronic record systems, transportation support) to do the job effectively.
		5.2	*Supportive workforce policies:* The organization will take specific steps to adopt policies supportive of IIBHT practitioners, including worker safety protocols, crisis coverage protocols, supervisory availability and support, and flexible work schedules.
		5.3	*Monitoring and addressing turnover:* The organization will monitor staffing and undertake efforts to ensure that turnover among staff is maintained at a level that does not negatively impact youth and caregivers (ideally, less than 25% annually), including ensuring the adequacy of compensation and benefits, organizational climate, and policies (such as those described in 5.2 above).
		5.4	*Routine oversight of key operations:* The IIBHT organization has individuals responsible for (1) overseeing human resources (i.e., recruitment, training, coaching, performance assessment, staff retention); (2) data collection and use; and (3) IIBHT implementation, including review of youth and caregiver enrollment patterns and plans of care.