Best Practices in Children's Mental Health:

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Report #12
"Attendant Care For Children and Youth with EBD/SED"

PART II:
ATTENDANT CARE IN KANSAS

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Attendant Care for Children and Youth with EBD/SED
Part II: Attendant Care in Kansas

EXECUTIVE SUMMARY

Rationale

Generally speaking, attendant care services consist of individualized, one-on-one personal assistance, supervision and support for young people provided in community settings to maintain youth in the least restrictive environment.

Recent reports and initiatives in the State of Kansas for Children's Mental Health (Hospital Taskforce Report 2003, Crisis Response Evaluation 2001), have identified Attendant Care (AC) as a resource to maintain functioning, stabilize as well as prevent and reduce higher level care. To enhance the array of the community based services within the state system, state level policy makers refined the service definition of AC in 2001 adding Individual Community Support (ICS). ICS is a more intensive service that is reimbursed at a higher rate than attendant care, whose reimbursement rate was also raised significantly to encourage higher utilization of the service. (See Appendix C for definitions of AC and ICS). Since 2001, there has been a large increase in the utilization of AC/ICS services. In a recent survey of 2421 Medicaid consumers in Kansas, whose children received mental health services at some point between August 2003 and February 2004, 43% (or a total of 1041) families reported that they had received attendant care services (Martin & Petr, 2004). With this amount of service provided, questions have naturally been raised about how AC/ICS workers are being recruited, trained, supervised, and evaluated. Some of these questions derive from some stakeholders' discomfort with having the least trained and least educated member of the treatment team being the one who spends the most time with this vulnerable and complex population. Although there is no evidence indicating that training or credentials are essential to managing effective interventions, agencies experience ambiguity in providing the service. A national literature review on Attendant Care (Walter & Petr, 2004) identified "no empirical or conceptual literature" published on the use of Attendant Care for children with emotional and behavioral disorders. The following report is a follow-up to the literature review seeking to identify how attendant care is utilized in the Kansas Children's Mental Health System.

Method

The study is a Qualitative Utilization Focused Evaluation (Patton, 1997) in which primary stakeholders are interviewed, paying particular attention to how the findings and results of the process may be utilized in the "real world." Primary stakeholders interviewed for this study were consumers (27), AC/ICS workers (61), and AC/ICS program administrators (17) from seven rural and urban mental health centers representing a range of AC/ICS utilization. All interviews were taped and transcribed, then analyzed using Atlas.ti version 5.0, a visual qualitative analysis data software program (Muhr, 1997).

Results-Answers to Three Research Questions

1. What is the standard of practice for Children's Attendant Care (AC) and Individual Community Support (ICS) within the Public Children's Mental Health System in Kansas?

Overall the study found that AC and ICS are provided within the spirit and scope of the State's definitions. AC is provided in the home, school, and community, and is generally seen as providing crisis stabilization and support while ICS is seen as an active "hands on" intervention. The tasks of AC/ICS workers are individualized and goal specific and

incorporate a range of activities. Workers provide a "therapeutic presence" in crisis stabilization programs, give "one on one behavior management" in classrooms, assist with "activities of daily living" in homes and help children "learn skills" to negotiate in community settings such as "grocery stores" and "libraries." The most common recipient was reported to be a pre-teen male. The agencies report trends toward serving younger children (ages 2 and up) as well as more clients who are dually diagnosed. Parents often did not know about the service until a provider referred them. The assignment of workers is typically determined by the availability of provider.

Providers were typically young females, many of whom are pursuing college degrees. Part-time AC/ICS workers were more common than full-time. Some AC/ICS workers also had other roles within the agency, such as case managers. On-line training was seen as easy to access and a good basic foundation, but incomplete without the "hands on" training at the agency.

Two factors influencing perceived effectiveness of supervision appeared to be regular, consistent structure and the open, knowledgeable approach of the supervisor. Administrators relayed that professional/client relationship concerns occur with AC/ICS workers mostly because they have the least professional training and spend the most time with youth in their natural environments. Open communication about the issues along with clear, structured, and accessible supervision are helpful to address these concerns. All stakeholder groups identified turnover as a problem, however concerted efforts to recruit with a staff member dedicated to this task made a difference. In addition all stakeholder groups said workers stay longer in the position because they like helping and leave due to low pay.

Administrative challenges include responding to the need for AC/ICS while recognizing limited staffing resources and budget constraints. In rural sites, relatively low demand presents staffing challenges that are different from urban centers where high demand requires hiring, training and supervising many staff (e.g. 70 AC/ICS workers at one site).

2. How valuable and useful are AC/ICS to various stakeholders (consumers, staff, and administrators)? What makes the service valuable and useful to the key stakeholders?

All stakeholders expressed that AC/ICS services were effective, with families being the most enthusiastic. In addition to preventing hospitalization or foster care placement, outcomes cited included keeping kids safe, improving their self esteem, providing them with "normal" experiences in the community, and generally providing support to the child, family, and team. Factors that were reported to influence outcome were level of parental involvement, AC/ICS training, teamwork, and turnover.

The service is valuable to treatment teams as AC/ICS workers spend the most time with youth and families and may provide valuable insight into treatment. Case managers tend to value AC/ICS workers as a supplement to the community based work they are trying to achieve. In turn AC/ICS workers appreciate the guidance and support from case managers. Agencies that utilize attendant care workers in crisis stabilization programs view these programs as valuable resources to other systems.

3. What accounts for the AC/ICS integration into the system of care in Kansas? What policies or practices at the state level or agency level support AC/ICS as a part of the system of care?

Integration of the service begins at the agency level with policies and procedures that support the administration of the service. The service was more integrated in agencies with

frequent structured access to supervision, a team approach, access to peers, and contact with clinical staff. To assist with integration of AC/ICS within the state system respondents thought that more work could be done to refine the definition of AC and ICS, making the differences in the two services clearer. In-house trainings where state level administrators or trainers are accessible to answer questions would help with understanding how the service is to be implemented in agencies. Program administrators from two sites and one family respondent group identified funding for AC/ICS services as a barrier to providing the services.

Recommendations

1. Recognition and support for the valuable work performed by AC/ICS workers, including full inclusion and integration on treatment teams. Consideration could also be given to developing a statewide support organization similar to the one recently developed for the parent support specialists.
2. In collaboration with other state agencies, explore options and opportunities for work force development that would enhance the consistency and quality of basic education and training for potential attendant care personnel.
3. Additional training on diagnoses, medications, liability questions, how to motivate youth, behavior management, hands-on experiential training, shadowing, and safety in the community.
4. Weekly individual and group supervision as well as ready access to supervisors in crisis situations.
5. Opportunities for AC/ICS workers to advance within the program and the agency.
6. Developing successful mechanisms for the recruitment of males and persons of color to be AC/ICS workers.
7. Outreach efforts by the state to clarify the differences between AC and ICS.
8. Research efforts to establish the evidence base for AC/ICS services, to confirm the wide and strong perception among staff and families that it is a valuable and effective service.

Attendant Care for Children and Youth with EBD/SED
Part II: Attendant Care in Kansas

Background

Attendant care for children and youth with SED has received increased attention in the continuum of community-based services in Kansas (Rast, 1999). The *Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program* (SAMHSA, 1999), reviewed Milwaukee's service patterns for three years (1996-1998), and found that along with case management and wraparound services, attendant care was the one of the most consistently utilized services. Half of all children received attendant care, a percentage that remained constant over all three years reviewed. As part of the continuum of care, attendant care is one of the means to provide mental health services in children's natural environments and prevent unnecessary out-of-home placements of children with Serious Emotional Disturbance (SED).

In Kansas, Medicaid policy defines attendant care (AC) as:

> One on one support or supervision with the goal of maintaining an individual with severe and persistent mental illness or child with SED in natural community locations, such as where the person lives, works or socializes. All supports provided must relate to the specific goals set forth in the consumer's treatment plan and must be provided under the supervision of a qualified mental health professional. Service may include providing direct support and supervision in accomplishing activities of daily living and supporting the consumer and or the family in maintaining daily routines critical to a stable lifestyle (See Appendix C).

Experienced Attendant Care workers in Kansas can also provide another, higher level service called Individual Community Support (ICS). Medicaid defines ICS as:

> Face to face interventions in a community setting. This includes activities which assist persons to function more independently in natural community settings of their choice. The need and level of this service is determined by the treatment team in collaboration with the consumer and family. Services include the following:
>
> 1) Personal support, which shall have as its objective assistance with daily activities necessary to maintain personal stability in a community setting.
> 2) Support provided to an individual adult or child, which shall include education and in-home consultation and shall have as its objective the delivery of specific training in daily living to an individual, which will be needed to provide natural supports, maintain the family support system, improve self-help skills, interpret policies, procedures and regulations that impact the individual living in the community, and monitor progress with treatment plan goals and objectives.
> 3) Under supervision, personal support provided to individuals in crisis situations. (See Appendix C).

Rationale for the Study

Despite the widespread existence of attendant care, or some otherwise named equivalents, in various fields, few guidelines and scant research has been published to describe or substantiate the specific role, effect, and necessary training of attendant care services (Riggs, 2001; Marks, Schrader, & Levine, 1999; Wolery, Werts, Caldwell, Snyder, & Lisowski, 1995). Due to "budgetary constraints, managed care and scarcity of available professionals" training initiatives are underway in some states (Illinois, Texas, Florida, Colorado, and Lousiana) to increase the availability of direct care service providers. As of yet, nothing has been published on the evaluations and program successes of these initiatives (Backs-Edwards, Gilfort, McCraken, & Corrigan, 2001).

The lack of research focused on attendant care may in part be a function of its position in between formal and informal supports: that is, attendant care often lies somewhere between clear categories of formal and informal support. Its unclear position may contribute to the confusion and disagreement about how "professional" an attendant ought to be, and whether the service is "worthy" of formal study.

In Kansas, the SRS Statewide Children's Hospital Task Force has identified attendant care as an essential service to avoid unnecessary hospitalization (Kansas Social and Rehabilitation Services, 2001). In a recent survey of 2421 Medicaid consumers in Kansas, whose children received mental health services at some point between August 2003 and February 2004, 43% (or a total of 1041) families reported that they had received attendant care services (Martin & Petr, 2004). Parents of SED children frequently request the service, and when they do receive it, parents are generally satisfied with service, giving the service an average grade of 3.24 on 4 point scale on most recent Consumer Satisfaction Survey (Martin & Petr, 2004). Despite more use statewide, utilization of attendant care varies widely among mental health centers. Informal conversations with consumers and CMHC administrators have indicated that underutilization may occur due to difficulties in the recruitment, training, and retention of attendant care workers, to confusion about their function and role, and to misunderstanding about the two different levels of reimbursement for the service, and to the definition of "medical necessity".

Research Questions

1. What is the standard of practice for Children's Attendant Care (AC) and Individual Community Support (ICS) within the Public Children's Mental Health System in Kansas? That is, how are AC/ICS workers recruited, trained, supervised, and evaluated? What are the roles and responsibilities, and how do these vary across the state? What are the characteristics of those who are typically served?
2. How valuable and useful are AC/ICS to various stakeholders (consumers, staff, administrators) what makes the service valuable and useful to the key stakeholders?
3. What accounts for the integration of AC/ICS into the system of care in Kansas? What policies or practices at the state level or agency level support AC/ICS as a part of the system of care?

Method

<u>Research Design</u>

A Qualitative Utilization-Focused Evaluation Method (Patton, 1997) was applied, in which evaluators are mindful of the process used to gather data from participants and pay

particular attention to how the findings may be applied in the "real world." This approach acknowledges that no evaluator is "value free." For this reason the approach focuses on choosing clearly identified "primary intended users" or "stakeholders" who will "apply evaluation findings and implement recommendations" (Patton, 1997, p. 20). The intended users of the Evaluation of Attendant in the Children's Mental Health System are the research participants and state level policy makers. Intended users were engaged in the process of evaluation by frequent contacts with the project manager by phone and member checks on summaries prepared upon completion of each data collection site visit.

The areas of interest to evaluate in the study were derived from themes identified in a national literature review conducted as Part I of this study (Walter & Petr, 2004) and refined with consultation from individuals with experience working in the Children's Mental Health system. Study questions were developed to guide data collection (see Appendix B). Specifically, the areas of interest that were questioned are:

1) Definition of Attendant Care and Individual Community Support. In 2001, the State Medicaid Department added Individual Community Support (ICS) services to the array of community-based services. ICS was intended to be a more intensive level of service than Attendant Care (AC) (see Appendix C). This study is seeking to understand how these services are defined and implemented locally.

2) Characteristics of the recipients of the AC/ICS services.

3) Characteristics of providers of the AC/ICS services.

4) Administration of the AC and ICS services. The literature review highlighted many aspects of managing and providing the service that helped guide the structure of questions within this broad domain. The sub-headings in this domain include: matching, supervision, integration of service within the mental health service delivery system, monitoring professional boundaries, recruiting, retention, training, role definition and actual tasks conducted.

5) Effectiveness of the AC/ICS service. Respondents are asked to rate the effectiveness of the service on a 5 point scale (1 being the least effective, 2 not effective, 3 neutral, 4 effective and 5 very effective). The participants explain their answers to the scale.

6) Medical Necessity has been identified as a conceptual barrier to providing AC/ICS by state administrators. Respondents in the study were asked to respond to the definition of medical necessity and how they been able to articulate when AC/ICS is medically necessary.

7) Barriers to providing the AC/ICS service are explored to gather additional information about how providers have overcome these.

8) Systems feedback to the state and the agency is also explored to assess ongoing issues or those that need to be addressed by state and agency level administrators regarding the AC/ICS services.

9) A Pre-service Training Program is explored to get respondents ideas about the benefits or drawbacks to this and if it would be feasible and/or attractive to future AC/ICS workers.

Sample

Evaluation studies typically draw on individual, local programs or on demonstration and other atypical service delivery situations, generalizability of study findings does not usually rely on sampling logic (or statistical representativeness). "Rather, evaluation research relies on theory and on replication or accumulation of evidence across settings and situations" (Anastas, 2004, p. 60).

For these reasons a "purposive sample" was constructed of seven Community Mental Health Centers (CMHCs). Purposive samples are utilized to obtain the most comprehensive understanding of a subject that focuses on "reflection" of knowledge of the subject being studied and an "intuitive feel" for the best representative sample (Rubin & Babbie, 2000, p. 401).

Site Selection

Utilization rates of Medicaid data from each CMHC over a three month period (January to March 2003) were reviewed to select sites for data collection. Amount of attendant care (AC) and individual community support (ICS) utilized per youth was determined by dividing the number of units billed by the number of youth who received the service at each CMHC. This variable was defined as the units of AC/ICS per youth. Sites were chosen that appeared to show different patterns of AC and ICS service utilization while being mindful of their rural and urban characteristics. Special characteristics such as organization of satellite offices in multi-county CMHCs were also contemplated while selecting the rural sites. The following table depicts the attributes of the seven sites selected.

Table 1: Attributes of CMHCs providing AC/ICS

CMHC	Rural	Urban	High AC/ICS	Low AC/ High ICS	High AC /Low ICS	Low AC/ICS
1	x		x			
2	x			x		
3		x		x		
4	x				x	
5	x					x
6	x					x (low AC and no ICS)
7		x	x			

Research Participants

Data was collected at the seven mental health centers across three stakeholder groups (families receiving the services, administrators of the service, and providers of the service). Overall 27 recipients, 17 administrators and 61 AC/ICS workers were interviewed. Table II summarizes numbers of study participants from each CMHC. One parent consent was

retrieved from agency 2 and numerous attempts to contact the recipient of service by phone were not successful. No parent consents were obtained from agency 3 administrators.

Table II: Study Participants

CMHC	# recipients of the service	# of administrators interviewed	# of AC/ICS workers interviewed
1	3	2	8
2	0	3	15
3	0	2	12
4	4	2	16
5	1	2	3
6	4	4	2
7	15	3	5
Totals = 7	27 (25 %)	18 (17%)	61 (57%)

Data Collection

Site visits were made in the Spring of 2004. All interviews were taped with verbal permission of the service providers and written consent of the recipients of the service. Two research assistants conducted the interviews (one completed two agencies and the other five agencies). Depending on the availability of the participants and structure of the agency, interviews were conducted in focus groups, by phone and/or during the time frames that were most convenient for the respondents. Some interviews occurred in the evening when AC/ICS workers and parents were available. Special accommodations, such as childcare and food were provided when the interviews took place during meal times. Access was gained to these groups through the administrative contacts at each respective CMHC.

Upon completion, all interviews were summarized utilizing the "focused qualitative evaluation" method (Patton, 1996, as cited in Padget & Freundlich, 2004). The transcription followed the "template method of domain focused transcribing" (Padget & Freundlich, 2004). The original interviewer became the first reviewer taking detailed notes during the interview under each area of interest described above. The detailed summary was then used while listening to the tape for illustrative quotes. The summary with illustrative quotes was given to an objective reviewer who "spot checked" the tape and transcript for accuracy. If a disagreement occurred in key themes noted, the reviewers reached a consensus and the process to reached consensus was noted. This method of transcription was chosen for it's time sensitive nature with the interest of getting the summaries back out to research participants for member checks and feedback before the preparation of a state report. Themes noted in previous interviews were used in subsequent interviews to gather additional information about the discovered theme. Additional questions are dated and noted in Appendix B. In addition, disagreements in member checks on summaries of research participants are noted and worked through until consensus is achieved.

Data Analysis

Atlas.ti, a visual qualitative analysis data software program (Muhr, 1997) was used to refine coding and analysis of themes across recipients, administrators, and providers of the AC/ICS service. All the project staff received specialized training and consultation using Atlas.ti version 5.0 on the project.

Codes were discussed based on interviewers' knowledge of emerging findings from the seven agency transcripts. Consensus was then achieved with all project staff on what codes to use in analyzing the transcripts. The research assistants coded the transcripts and discussed discrepencies or emerging findings as needed.

Drafts of individual agency summaries were then prepared and sent out to each agency and their participants for member checks. In addition, a draft report was prepared for state policy makers for review and comment prior to dissemination.

Overall Results

[Note: See Appendix A for individual agency results]

1) Definition of Attendant Care and Individual Community Support.

Although there is some variation among sites in how they define the purpose and role of AC and ICS workers, administrators seemed very conscientious about providing AC and ICS within the spirit and scope of the State's definitions. Although some reported that AC can be perceived as "babysitting", respondents knew that is not the intent or purpose. Both AC and ICS are seen as supports to the case manager, family, and treatment team to help kids function within the community in as "normal" ways as possible. In differentiating between AC and ICS, the purpose of AC is generally seen as crisis stabilization and supervision to prevent a crisis, while ICS is more focused on "active intervention" and specific goal attainment. However, there was also a general sense that the distinctions were not that clear at the State level, so local implementation varied somewhat, based on local interpretation of State guidelines. AC was provided exclusively at one site due to uncertainty about what ICS would do that is different than what AC does. Administrators at this site conveyed an understanding that the policy definitions were written with "a certain vagueness" so that providers had more freedom and flexibility to utilize the service. At the same time, the "vagueness" contributed to this agencies' fear of future medicaid audits for failing to meet some "unknown expectation." Another site perceived they were "meeting the need" providing mostly ICS and would like "latitude" to determine what services should be provided within the "context of their community." Still another site perceived the lack of clarity in definition made AC/ICS a "catchall" in the system of care. The participants asked, "Is this an appropriate use of the service?"

2) Characteristics of the recipients of the AC/ICS services.

Although few hard statistics were provided about the **recipients** of service, all reported an age range from preschool (as young as 3) to 21. The prototypical recipient was reported to be a male pre-teen.

3) Characteristics of providers of the AC/ICS services.

The **providers** of AC/ICS services tend to be young persons with high school educations, many of whom are enrolled in college majoring in education or social service professions. Some are "stay at home Moms" who are older, and some are substitute teachers

or other school employees who double as AC workers at the schools. The vast majority are white females. In two rural sites and one urban, some case managers also provide AC/ICS. "Passion, flexibility, patience, dedication" were traits that administrators and families used to describe quality AC/ICS workers.

4) Administration of the AC and ICS services. The sub-headings in this domain include: recruiting, training, supervision, monitoring professional boundaries, role definition, actual tasks conducted, integration of the service within the mental health service delivery system (this includes where the services are delivered in homes, schools and community places), retention, administration of services (activation, termination and monitoring medical necessity) and matching.

Providers are **recruited** through traditional means such as newspaper advertisements and speaking to college classes and to religious and community groups. Perhaps the most effective means is word of mouth and referrals from existing AC workers who recommend friends. One site pays a bonus of $50 to staff that make successful referrals.

Once hired, all AC/ICS workers complete the on-line **training** provided by the State through Wichita State University (although one small rural site reported that no one had yet passed the test without tutoring from the supervisor). Most workers reported that the on-line training was useful and easy to access, but incomplete. Topics for improvement of training included hands-on training, shadowing of AC workers, more information on diagnoses and medications, liability questions, how to motivate youth, and behavior management. In addition to the on-line training, some sites provide additional structured training of up to two weeks covering CPR, First Aid, Management of Aggressive Behavior (MAB), HIPPA, cultural diversity, safety in the community, and internal policies and procedures, and shadowing. One site trains ICS workers in a model of intervention called Parent Child Interactional Therapy (see Appendix D-3).

Ongoing **supervision** of AC/ICS workers is provided in a variety of ways. Most sites (four) had an AC coordinator who is in charge of supervision, and all of these except one provided regular weekly supervision, either in group or individually. The exception provided "on-call accessibility" about which workers expressed dissatisfaction. The other three centers (all small and rural) used either the Children's Director or psychosocial group leaders to provide supervision. While most staff reported satisfaction and appreciation for regular supervision, some lamented that supervisors were not readily available to help in crisis situations. There was acknowledgment and concern on the part of administrators that AC/ICS workers are "on their own" when delivering the service and there is no way to monitor what they do every minute. A common issue in supervision was **relationship boundaries** between workers and clients. AC/ICS workers are expected to adhere to the same professional and ethical standards as other clinical staff, so behaviors such as meeting with youth at the AC worker's home are typically prohibited. In rural areas where personal and professional relationships can co-exist, this can be a problem. Also, the insistence on professional standards can hurt recruitment when other similar jobs at other agencies do not emphasize the same standards. Staff works to keep the boundaries from becoming too rigid, and no parents reported any major issues or concerns in this area.

Concrete **roles and concrete tasks** were typically defined in the "plan of care" or "treatment plans." In addition team meetings with supervisors, case managers and therapists

help to define **specific tasks** AC/ICS workers are to do. Most sites, five, relayed that tasks are "individualized" and based on "goals" from the treatment plan. Two AC/ICS participant groups were not as clear about their role and how it was different from Case Managers (CM). The other five, relayed that CMs see AC/ICS as an "extension" of the community based work "picking up" where the CMs "left off" and using it when a youth needs "extra support."

Actual tasks conducted by AC/ICS workers varied widely. AC/ICS workers were reported to be utilized in the context of psychosocial groups, crisis intervention programs, homes, schools and community locations such as grocery stores, libraries, recreation centers, and restaurants.

AC/ICS workers assist in crisis intervention as part of crisis resolution programs "listening to youth" and "processing a traumatic event" or just "being there" while a youth can "sleep safely." AC was used to provide "a presence and oversight" while ICS was used while staff were "interacting with the youth in someway."

AC/ICS workers served in the context of psyschosocial groups to "maintain a child" in the group setting by providing "redirection" to complete activities the group was engaged in or to help "prevent conflict" with other group members. In one case, an AC/ICS worker was assigned to work with a youth when the rest of the group was "taking a nap" as this young child had behavior problems during this time.

All sites in the study utilized **AC/ICS in schools**. The consensus at four sites was that the "structure" of a school setting made it easier for workers to know what they were supposed to be doing with a youth as the "ultimate goal" is to keep a youth in the school setting. Examples given of actual tasks in the school setting were sitting with youth at lunch "to make her feel special," working with teachers on behalf of youth explaining behavior and letting the teacher "vent," "giving immediate positive feedback" and making sure medications were taken at the right time (dispensed by the school nurse). One worker said, " We're not tutors, but if I can sit there and help somebody with their school work a little bit, I'm going to that because AC is so broad and the kid will feel better about the class and be better behaved if they can understand the work."

Five of the seven sites provide the service in their communities (including homes). Workers assist with activities of daily living at specific times when the child and family needs additional help. For instance one worker was assigned to work with a youth three days a week in the morning to get dressed, brush teeth, eat breakfast and comb hair before riding in the car with the parent to the youth's school. Another worker helps a youth complete his chores at home before "an activity" the family reported "he really looks forward to." Another family relies on the AC worker at the grocery store to help the youth spend their "allowance" helping problem solve through choices spending "as much time as they need." Workers take youth to events such as school carnivals or restaurants as a reward for goal attainment and to the zoo when school is out as a "chance to work on how to act in public setting." Community "hot spots" include libraries, coffee shops, and city parks. One worker expressed enjoyment learning about the community while teaching the youth he was working with how to "use" library resources and make "small talk at coffee shops."

Two of the five sites do not provide Attendant Care and Individual Community Support in the homes. One site does not due to safety and level of training they perceive the AC/ICS worker needs. Another site does not because "the need has not been identified" by parents or treatment providers.

Providers and administrators report that **staff turnover** was an ongoing issue. A variety of factors were reported to influence **retention,** including quality of support and supervision, flexibility of hours, opportunity to advance, and satisfaction with being able to help youth and their families. Although barriers to recruitment and retention (such as low pay), exist, most sites reported that focused and concerted efforts can overcome these barriers.

Activation of service tended to be on referral from the case manager, and occasionally the family or teacher, when there is a need to keep the SED child in the community or classroom. The **medical necessity** typically involves this need coupled with diagnosis and SED determination. At some sites, provision of AC was also linked to participation in a pyscho-social group. Some parents reported that AC is a hard service to obtain and that they had to advocate for it. Typically, the referral is staffed in a team before assignment.

As far as **matching** the child with a worker, staff reported that attempts were made to match according to gender and personality and interests, but that assignment was often based on availability, due to limited staff resources. At most sites, the continuing need for AC/ICS services, and possible **termination,** is reviewed at regular intervals ranging from every three months to after each eight hours of service provided. Parents at one site unanimously voiced the opinion that funding, rather than goal attainment, determined termination of service.

In addition to the administrative challenges inherent in the above, an additional challenge is **integration** of the service within the agency. AC workers are the lowest on the "totem pole" of the professional hierarchy and are usually not at the office, but serving kids out in the community, school, and home environments. Sometimes workers feel isolated, communication is strained, or clinical staff are ill-informed or uncertain about the value of the service. Strategies to deal with this challenge included a team approach in which AC/ICS workers attend wraparound and plan of care meetings, as well as regular team meetings of AC/ICS workers, case managers, therapists, and psychiatrists. Another administrative challenge is **responding to the demands and the need,** while being conscientious about the limited staff resources and funding issues. This relates to the initial plan of care in trying to provide adequate amount of service without overutilizing the service, which could result in overdependence and/or using staff resources that could be better used on another child and family. This issue is especially difficult in the large, urban centers, who reported employing 40 and 70 workers respectively, of which as many as half worked full-time. But the issue is also extensive in rural areas, where the low and irregular demand makes for different issues in trying to keep AC/ICS staff optimally engaged.

Safety of workers in the community, especially client homes, is addressed through training, close supervision, pagers and cell phones, and utilization of police. As previously mentioned, one site did not provide in-home services due to these concerns, but were in process of developing plans to meet the challenges.

5) Effectiveness of the AC/ICS service

Respondents were asked about the **perceived effectiveness of the AC/ICS service.** While all respondent groups responded positively, the parents' responses were the most enthusiastic. A number of specific situations were cited by parents and staff to support that AC/ICS had been the key service to prevent hospitalization or foster care placement. Other outcomes cited included keeping kids safe, improving their self esteem, providing them with "normal" experiences in the community, and generally providing support to the child, family,

and team. Across all stakeholder groups, factors that were reported to influence outcome were level of parental involvement, AC/ICS training, teamwork, and turnover. These factors were also identified as barriers as well and are discussed further in number seven below.

6) Medical Neccessity in the analysis was found to be tied to administration of the service in particular activation, so the results regarding this question are addressed in section number four above.

7) Barriers to providing the AC/ICS service are explored to gather additional information about how providers have overcome these.

Strategies to overcome these barriers included utilizing parent support to engage parents (at two sites), increasing "shadow time training" or implementing shadowing into the training program (at three sites), and increasing knowledge within the CMHC about what AC/ICS can do at one site. Turnover was identified as a barrier and agencies, especially four administrators were clear in saying that this is part of the "nature of the beast." One strategy identified to address turnover was to conduct an analysis of characteristics of workers who stayed over time. This agency identified that single mothers tended to stay in the position due to the flexibility the position provides. The agency then targeted this demographic when recruiting. Flexibility was also noted in another agency as a reason other workers tended to stay and they encouraged the agency to market the position this way to new hires. Two agencies noted that they encourage seasoned AC/ICS workers to refer potential employees and one agency pays a bonus (fifty dollars) to the referring worker if the new hire stays on for three months.

8) Systems feedback to the state and the agency was also explored to assess ongoing issues or those that need to be addressed by state and agency level administrators regarding the AC/ICS services.

Many of the comments about **agency-level improvements** were specific to that agency (these are reviewed in Appendix A) but a few themes were applicable to more than one. These included the desire for better in-house training and the need for better communication, respect, and integration of the AC/ICS services within the treatment teams. At the **state level,** several ideas were suggested at more than one site. Chief among these was the request for more clarity about the definitions of AC/ICS service and the different expectations for each. One site administrator was unsure about the "limits of hours they could provide." Another agency was concerned about the vague definition that has lead to AC becoming a "catchall" in their system of care and posed the question, "Is this ok?" Another comment to state level administrators was centered on the need to refine the definition with respect to preschoolers and dually diagnosed children. Four administrators (from different agencies) expressed that the level of funding was barely adequate while three did not mention funding and one administrator said "thank you for raising the reimbursement rates..we at least break even." Two agency administrators identified that it is not cost effective to pay AC/ICS workers to attend meetings and do lots of paperwork. Parents, administrators and workers had the shared suggestion to keep the service because it is valued and effective.

9) Pre-service Training Program is explored to get respondents ideas about the benefits or drawbacks to this and if it would be feasible and/or attractive to future AC/ICS workers.

Three administrators from two sites said this was a good idea and would be helpful to "have a pool of workers to hire from" as well as being able to focus on "more agency, program specific training" once AC/ICS are hired. Five administrators from four sites said no because one site already had an extensive training program for workers, and two administrators said it would be hard to recruit people to train to eventually end up with a "job that pays eight dollars an hour." One parent group suggested making AC/ICS work part of a degree training program while administrators from one agency expected the basic training of AC/ICS workers to come from "schools of social work."

Overall Results (Family Perspective)

1) Definition of Attendant Care and Individual Community Support.

Many parents reported that AC services were inadequately explained to them, and that they, therefore, were unable to provide a clear definition of AC. However, generally speaking, most of the parent responses support the view shared by administrators that AC is a "supplemental resource" to case management. Parents stated that AC helps to normalize their children's life experience by helping them to dispel their SED label while "mainstreaming" them into society.

2) Characteristics of the recipients of the AC/ICS services.

Parents shared their child's diagnosis as a way to describe the demographics of the youth served by the AC programs. Anxiety, Depression, and Conduct Disorders were among the most common diagnoses mentioned.

3) Characteristics of providers of the AC/ICS services.

AC workers were seen as companions to youth suffering from "brain disorders". Parents reported they want the mental health center to recruit workers who are mature, reliable, passionate, trustworthy, dedicated, supportive, and caring. They also want AC workers to have some real life experience and common sense.

4) Administration of the AC and ICS services:

Matching. Due to a shortage of AC workers, parents "have no say so" regarding how their child is assigned to an AC worker. Several parents said that they would like to be able to request a new AC worker if they are dissatisfied with the services that their child is receiving. However, they often times are hesitant to make such a request due to the fear of their child being placed on a waiting list. One parent said she has been waiting for "nine months" to get a new worker.

Supervision was not discussed with family respondents.

Integration of AC services within the Community. All of the families reported satisfaction with the AC workers ability to integrate their children successfully into the community.

Integration of services in the School Setting. Many parents reported feeling grateful for their children's school successes, which they attributed to ongoing AC worker involvement in the school setting.

Integration into the Family Setting. In stark contrast, parents complained that AC workers often times do not integrate well into their family systems citing a few explanations: infrequent contact, poor communication, high turnover, and the inability of workers to provide in-home services. Several parents also complained that they had never been introduced to their child's AC worker**.** Higher levels of parent satisfaction may be related to AC better integration within the families served.

Integration of service within the Mental Health Setting. In regard to the agency setting, many families felt that their children were not permitted to contribute to their plan of care. According to one parent, this often times resulted in the child's resistance to the "boring" and "repetitive" AC program. One parent said that her child who suffers from ADHD wanted to quit the program because he was required to sit for long periods of time playing "UNO everyday for months".

Monitoring professional boundaries. Parents stated that they would like to be informed of their children's whereabouts and activities at all times. One parent was submitted a bill by their worker for activities, the agency was contacted and the worker was terminated. Parents at one site described workers as "absolutely a part of our family."

Recruiting. Several parents conveyed an interest in serving as an AC volunteer or employee but then noted that their respective mental health centers discouraged that involvement due to conflicts of interest related to confidentiality.

Retention. Parents suggested paying AC workers more to prevent turnover.

Training. Parents also would like AC workers to be trained more comprehensively in order to be able to manage "explosions, hitting, kicking, biting, and throwing" incidents more effectively. Trainings according to parents should include "hands-on" shadowing of more seasoned workers in addition to information regarding different diagnoses and medications used to help "brain disordered children". Parents reported that they often feared that workers would not feel equipped to deal with their child's out of control behavior. They need "solid training related to mental illness: how to talk children down and how to diffuse a crisis".

Role definition. Two family groups compared AC and CM roles. One site talked about the interchangeable role that CM and AC workers have, "but the good thing is, is that if you guys got good case managers, they'll step in and take your kids out and do the stuff your attendant care worker would do." The other site said that a AC worker is different because they "spend more time with the family."

Actual tasks. Parents were quick to articulate AC worker tasks: homework assistance, life skills acquisition and maintenance, modeling appropriate behavior, solution finding in times of crisis, and companionship.

5) Effectiveness of the AC/ICS service. Respondents are asked to rate the effectiveness of the service on a 5 point scale.

Two parents used the term "life saver" to describe the AC services that they have been receiving. Parents reported that AC increases self esteem, helps kids feel normal, teaches better anger control, gives children chances and opportunities that they otherwise would not have, and prevents suicidal in addition to homicidal behavior. Several parents reported being "grateful" for AC because it allows them to spend time with their other children who they reported are often times "angry and resentful" toward their special needs sibling because they require most of the parent's undivided attention. Most of the parents interviewed seemed satisfied with the AC services that they receive. Overall, parents feel that AC is a "great service".

6) Medical Necessity

Parents report that AC prevents intrusive SRS and Law Enforcement involvement in addition to serving as an alternative to hospitalization and or other unwarranted out of home placement. Parents found that AC services help to keep their children in the home while also helping them to function more normally in society.

7) Barriers to providing the AC/ICS service.

One family identified multiple workers as a barrier, "We had different workers…it was trial and error. Reasons were that the CMHC could not pay enough to get a good one. We went quite a while without the service. We were willing to wait for the right one. The worker has to love the job. We had one worker that didn't and she left quickly."

8) Systems feedback

Agency level. AC services are the mental health center's "best kept secret" according to one parent whom suggested that AC services be made more accessible as a preventative rather than a reactive service for families in crisis. Many parents stated that they were unaware of AC services until their families experienced a crisis. Poor communication was also identified as the primary area of concern for most parents. Parents stated that they get frustrated with unreliable workers who no-show and cancel appointments at a moments notice. They also complained about the failure of AC workers to inform them of the whereabouts of their children while they are participating in AC activities. In conclusion, to engage youth more effectively in AC services, parents suggested that their children be given a voice in the process.

State level. Parents requested that the state establish the funds necessary to implement transition to adulthood programs. These programs according to many parents would assist their children to effectively pursue independent living opportunities. One parent was disappointed that her son's AC services had been discontinued when he turned 19. Apparently, her son had been admitted to a local college and impulsively dropped out of his classes when his meds ran out. Had her son continued to receive the support and encouragement from his former AC worker, his mother thinks he would have been able to stay enrolled in his classes. Parents also strongly urged the state to fund more programs to keep their children from being

placed out of the home. Parents also want more funding to encourage the implementation of more parent support groups. Many parents requested that AC services be made more readily available and accessible on a more consistent basis. Some mental health centers only provided two hours of service per child per week while others provided up to thirty-six hours per child per week. AC services appear to help stabilize and maintain children in their natural home environments while at the same time reducing intrusive interventions leading to unnecessary hospitalization.

9) Pre-service Training Program feedback from respondents

One parent said in response to this question, "One thing is why couldn't we set up something with the college. If you put so many hours in here and work with the child and get to learn this, why couldn't that be a credit?"

Conclusions and Recommendations

Before discussing the conclusions and recommendations of this study, it is important to acknowledge the study's **limitations.** Although the sampling method was designed to represent a range of sites and utilization patterns, only seven of the twenty-eight provider sites were included in the sample due to time and resource constraints, so that important aspects of service provision may have been inadvertently excluded. Second, repeated attempts to interview parents and youth at each site were not always successful. Parents and youth to be interviewed were nominated by local providers, and those who participated elected to do so, which likely resulted in a parent and youth sample of comparatively satisfied consumers. Third, program changes at different sites may well have occurred after the interviews and prior to the writing and distribution of this report.

Based on these interviews at seven sites, the following conclusions can be made. The **strengths** of the AC/ICS services are numerous. All respondents felt that the AC/ICS service was valuable and effective, especially parent respondents. Despite some confusion about the distinctions between AC and ICS, administrators and staff are conscientious about implementing the services within the spirit and guidelines of the state. The AC/ICS program provides a valuable service to families, schools and community agencies such as juvenile intake. Sites have developed innovative, determined, and largely successful efforts to recruit, train, and retain AC/ICS workers. Many sites have organized and structured programs for training and supervision that are valued by AC/ICS workers.

Some **areas for improvement** were also identified**.** When dissatisfaction was expressed by AC/ICS workers, they tended to focus on the need for training beyond the initial required on-line training, more regular as well as on-call supervision, and better integration within the team and agency. Administrators felt stretched by the demand for the service and were confused and unsure about the official definitions. Four administrators (from different agencies) and two family respondents (from different agencies) expressed that the level of funding was barely adequate. Families tended to want more involvement, more information about the role of the AC/ICS worker, and easier access to the service.

It must be recognized that the AC/ICS worker is the treatment team member who often spends the most time with the child and family, yet is the least paid, trained, and educated member of the team. Thus, it is timely that the state and local CMHCs work to strengthen this important service. This report supports attention to the following issues:

1. Recognition and support for the valuable work performed by AC/ICS workers, including full inclusion and integration on treatment teams. Consideration could also be given to developing a statewide support organization similar to the one recently developed for the parent support specialists.
2. In collaboration with other state agencies, explore options and opportunities for work force development that would enhance the consistency and quality of basic education and training for potential attendant care personnel.
3. Additional training on diagnoses, medications, liability questions, how to motivate youth, behavior management, hands-on experiential training, shadowing, and safety in the community.
4. Weekly individual and group supervision as well as ready access to supervisors and consultation in crisis situations.
5. Opportunities for AC/ICS workers to advance within the program and the agency.

6. Developing successful mechanisms for the recruitment of males and persons of color to be AC/ICS workers.
7. Outreach efforts by the state to clarify the differences between AC and ICS.
8. Research efforts to establish the evidence base for AC/ICS services to confirm the wide and strong perception among staff and families that it is a valuable and effective service. These efforts should include youth and family input about what outcomes to measure.

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Appendix A

Individual Agency Summaries

APPENDIX A – INDIVIDUAL AGENCY SUMMARIES

Agency 1

Agency #1 was chosen as a site for data collection due to its rural location, equal low utilization of both AC and ICS. Respondents were 2 administrators of the service, 8 AC/ICS workers and 3 recipients of the service.

1) Definition of AC and ICS

- AC services as *"respite care"*
- ICS was identified as a service to address ***"goal attainment off the treatment plan"***
- Tutoring
- Not functioning as a para while in the school setting
- ***"Around the clock crisis and stabilization services"***
- ***"CM's work with kids on specifics"***
- ***"AC comes in to pick up the slack"***
- ***"Case workers focus on one thing: something wrong in the home-finding dangers this and that whereas AC is concerned with the future of the child…they utilize me and the grandparents as a team …I'm more impressed with AC than CM"***

2) Demographics of providers of the AC/ICS services

- Minimum high school education
- Many have some college
- 24 workers: 6 are African American Males & 7 are Hispanic Females
- Parents were unclear about worker qualifications

3) Demographics of the recipients of the AC/ICS services

- AC workers serve both adults with SPMI and SED kids ***"Serve all populations all problems"***

4) Administration of the AC and ICS services

Activation of AC/ICS

- Referrals directly from CM to Team Leader then to AC Coordinator for scheduling
- At risk of out of home placement
- When family needs respite

Ending of AC/ICS

- Review following every eight hours of service provided
- Progress toward goal attainment
- One parent reported that eventually in the future he would like to stop services based on his son's progress

- One parent stated that they would never be able to terminate services due to the urgency of AC service implementation to prevent her son from "***burning down the house"*** or ***"harming his siblings"***

Matching

- Agency requested the state to grant an exception to the gender specific pairing mandate
- Small town with not many choices
- All parents said that they had no say in choosing their AC worker however, one parent requested to have the gender specific rule amended because he reported that his son liked working with female AC workers.

Supervision

- None provided regularly : ***"on-call accessibility of supervisor"***
    - AC workers go directly to executive director if they have a problem
- Needs identified
    - Better communication between other agency staff and AC workers
    - More feedback, guidelines and training from supervisor
    - Structured regular individual and group supervision
    - AC workers often call police when supervision is not readily available ***"We need more information on what we are dealing with we don't get enough information regarding the kids…wrestle them down and call the cops" "We call the cops and just sit there"***

Integration of Service within Agency, Families, and Community

- Families
    - AC's report that the CMs talk to the families
    - Two parents reported reliability (punctuality) and communication problems between themselves and their child's AC workers
    - Parents discussed the need to be introduced to their child's AC worker
    - Two parents complained about their child having numerous AC workers ***"Who do you listen to the parent or case manager?"*** ***"No contact (with AC worker) …just sign paper to pick him up…secretary opens the door…don't see workers till pick up…secretary calls me not the worker"*** ***Like to be informed sooner if there's gonna be no AC for tomorrow", "Work around me and my schedule", "AC workers are very patient with me and hours of availability"***
- Agency
    - Many communication problem examples were cited during the interviews
    - Workers discussed a need for cohesion between CMs and ACs
    - AC workers feel that they are identified as the ***"bottom of the totem pole"*** ***"We don't have the support from case managers or therapists"***

Monitoring Professional Boundaries-Strategies

- Have had difficulties in the past with staff spending their own money on youth
- One of the parents reported that she had more contact with the secretary than the direct care staff as the secretary called the parent to ask questions
- Boundaries are reviewed and policies enforced
- AC workers are prohibited from taking youth to their homes

Recruiting and Retention

- Strategies
  - Word of mouth
  - Newspaper Ads
  - Recruit at community colleges and at local schools
  - Recruiting from Big Brother and Big Sisters
  - Parents volunteering part-time
    "I would even offer two hours to take them to the park to get up and give them something to do"
- Why Stay?
  - Bonus yearly
  - Youth improvements
  - Flexibility
  - Get paid well
- Why Leave?
  - Poor communication
  - Liability concerns
  - Unclear about responsibilities
  - Way things are supervised
  - Career advancement limited

Training

- AC workers are trained to serve both adults and children
- WSU on-line training: ***"Can't prepare you to do the job"***
- Mandt, CPR, First Aid
- Two weeks on the job training (according to supervisors not employees)
- Parents requested that the staff have more training related to each individual child's particular diagnosis in order to be able to handle their ***"fits***" and or possible ***"seizures"*** more effectively
- ***"Need more shadowing: one or two trips", "I was just thrown in there", Need mandated trainings", "More person to person contact training", "More role plays"***

5) Effectiveness of the AC/ICS service

- AC serves as a mechanism to divert hospitalization
- ***"It's more effective than a session with a case manager or therapist"***
- ***"Good for working parents and kids"***
- ***"Glad it's available when I need services"***
- ***"Supportive…better ways to address issues…great teamwork"***
- ***"Understanding…helpful to me being a single parent"***
- **Least Effective**
  - Intrusive responses to crisis: police involvement
  - Poor communication with other treatment team providers
  - Complaints about numerous workers and high turnover as it relates to youth bonding and attachment issues
  - ***"More respect for AC workers"***
  - ***Call us when they are desperate and don't want to deal with it"***
  - ***"A fifteen minute briefing at least"***
  - ***"My thing they (AC) don't communicate the best"***

6) Medical Necessity

- Diverts youth from hospitalization and or other out of home placement
- Maintains youth in school setting (ADA Requirements upheld)

7) Barriers to providing AC/ICS service

- Staff cited a lack of collaboration among treatment team
- Intrusive interventions such as police involvement to manage child's behavior
- Absence of regularly scheduled individual and or group supervision
- Lack of sufficient ***"hands on training"***
- Staff not appreciated or recognized for contributions to the team ***"Low man on the totem pole"***
- Parents complained about short notice cancellations and no shows in addition to not knowing their child's workers

8) Systems Feedback

Agency

- More respect for AC workers
- Better communication
- AC inclusion in the treatment team
- More ***"hands on training"***
- Role clarification needed
- Regularly scheduled individual and group supervision

State

- Limited support from agency and the state
- AC definition to vague
- AC not considered part of the team
- Transportation issues related to reimbursement for client transport
- Information needed regarding ***"how to bill appropriately"***
- AC workers ***"give medications"*** according to one parent interviewed

CONCLUSION

<u>Strengths</u>
Overall, generally speaking the staff and administrators feel that AC is effective in that it serves as a diversion mechanism to prevent out of home placement.
<u>Needs</u>
Staff and administrators both stated that a more structured method of supervision needs to be built into their AC program. Staff also reported utilizing intrusive police intervention as a means to mediate crisis due to the inability to consult with case managers, therapists, and supervisors during times of crisis. Staff consistently throughout the interview cited the need for more hands on and other mandated trainings.

Agency 2

Agency #2 was chosen as a site for data collection due to rural location and high utilization of ICS and no utilization of AC. Respondents were 1 public school teacher, 3 administrators, 15 ICS workers, and contact information for one parent was retrieved. Four attempts to reach the parent were not successful.

1) Definition of Attendant Care and Individual Community Support

- AC is infrequently utilized as the agency does not identify the need for workers to provide this lower level intervention
- ICS is…..
  - providing a specialized evidenced based intervention intended to carry out the goals on a treatment plan
  - teaching transferable skills
  - giving immediate positive feedback to maintain children in the least restrictive environment
  - provided in psycho-social group, in school classrooms, in agency's juvenile offender/substance abuse program
  - rarely provided in home because the program is new and providers need a higher skill level to be able to be effective providing in home support added during member check ***"and families are often reluctant to allow this service in their home."***

2) Demographics of providers of the AC/ICS services

- 15 ICS for psycho-social and school based work
  - Majority are college students majoring in Social Work, Psychology, Education and Sociology
  - Ages 19-22
  - One middle age provider certified as a high school teacher/librarian
  - Duration of employment with agency ranges from 1 month to 2 years
- 7 ICS for juvenile justice psycho-social treatment program
  - ICS are "middle age" including one substitute teacher, a nursing student, psychology, early childhood and criminal justice majors.

3) Demographics of the recipients of the AC/ICS services

- Number of kids receiving service was approximately 40
- Caucasian, 75% male
- All male in the pre-kindergarten classroom

4) Administration of the AC and ICS services

Activation of ICS

- Service starts when there is a risk for disruption from school environment
- Teachers usually request it
- Clinicians or case managers refer
- Implement service at the most needed times in limited amount

Ending of AC/ICS Service

- When goal on the treatment plan is achieved
- When youth is stable at school by teacher report
- When youth doesn't need help to participate in psycho-social group

Matching

- Children's Services Director (CSD) coordinates
- Most severe youth get ICS service first
- Consider gender of provider and recipient, developmental issues, sexual abuse issues as well as personality compatibility of match

Supervision

- Structure
  - Psycho-social group facilitators act as supervisors meeting with ICS weekly
  - Monthly staff meetings with CSD where administrative issues are addressed
  - ICS workers meet with teams working with their client in agency every 2 weeks.
- Staff Feedback about Supervision Process
  - Staff relayed that they feel supported and supervisors are approachable

Integration of Service within the Agency, Families, and Community

- Families
  - Do not have families perspective
  - Agency relayed difficulties engaging parents and having them involved in treatment
- Community
  - Service is utilized in some schools and not in others, acceptance depends upon administrative support within the school
  - Juvenile court judge makes referral to Juvenile intake program
  - Most staff in the agency do not live in the county they work in
  - Pre-kindergarten teacher has been cross trained in the approach ICS workers use and uses the techniques in classroom setting
- Agency
  - Some clinical staff refer and support the service others do not

Monitoring Professional Boundaries-Strategies

- ICS do not go into client homes so these issues don't come up that often
- Administrators say that the closer the age between ICS worker and client, the more professional relationship issues come up
- Team meetings helps monitor the relationships…***"workers are not in there alone"***

Recruiting and Retention

- Strategies
  - Advertise in the local paper
  - Referral from agency staff
- Why leave? Life circumstances such as marriage and graduation

- Why Stay?
    - Workers stay through college and if they stay beyond that it is because they take a different role within the agency
    - The workers like helping kids

Training

- ICS workers are also trained in a specific model of intervention “Parent Child Interactional Therapy” (Kigin and McNeil, see Appendix D-3)
- ICS workers are also trained specific techniques outlined by Dr. Dennis Embry Ph.D who specializes in translating research into practical interventions (see Appendix D-3)
- 16 hours of training
    - Online training
    - a week of observing group
    - practicing some of the interventions in group
    - review of the children’s service manual with CSD
- Online training feedback
    - Was a good foundation for the more thorough training on specific interventions the agency provides with ICS workers

5) Effectiveness of the AC/ICS service (rating on a 5 point scale 1, least effective to 5 most effective)

- Administrators all say 5, ***“if it is not effective one day…come back the next and it will be.”*** Lack of parental involvement affects effectiveness. “***We are in the business of parent enhancement not parent replacement.”***
- Teacher respondent said 5 ***“rewards and consequences are immediate”***
- Workers all say 4.5 ***“we see the results of the work, get good reports from teachers,”*** not a 5 because parents are not always willing to be involved

6) Medical Neccessity

- Workers did not know what Medical Necessity meant.
- Clinicians at the agency on the treatment teams determine medical necessity
- Reviewed every 90 days by clinicians on the treatment teams

7) Barriers to providing the AC/ICS service

- Providing AC is difficult. The agency’s perspective is that they are meeting the need with ICS. AC is not an intervention. Workers called it ***“boring.”***
- Reasons for not providing ICS in home services
    - Difficult, primarily due to lack of parental involvement
    - The program is new and will be providing more in home services in the future
    - It takes a different level of skill to provide the service in the homes
    - Safety. Administrators report a high level of criminality that is "tolerated" in the county (sexual abuse and household violence). Interviewees referred to an ethnography of the county which validates their perspective

8) Systems feedback.

Agency

- Workers want the rest of the agency to know what they do and how effective ICS is
- Business staff need to know that toys and meals are used as rewards for targeted interventions
- Program is excited about recent move to the new building so the rest of the agency can learn about the program
- Teacher relayed that ICS has allowed her to teach and maintain a positive educational experience for 5 year olds
- Teacher said the service is ***"non invasive"*** and ***"effective."***

State

- The Center feels like they are meeting the need providing ICS to the severest youth
- Agency would like more latitude with determining what services best fit for the needs of the community they are serving
- Staff said, ***"The program is successful and we want to keep it!"***
- ***"Come see what we do."***

9) Pre-service Training Program

- The agency does not see any need for a pre-service program as staff are highly trained in ICS interventions they provide
- Offered to be a training site for other ICS

CONCLUSION

Strengths

The ICS program has a clear statement of program principles, structure for supervision, training and recruitment of quality providers. The providers also appear to have investment in the program, taking pride in the services they provide. The ICS service is visible to clinical staff within the agency and steps are being taken to educate and coordinate about its use. There is an indication the service is integrated within the community's juvenile justice system as the agency has established a grant funded juvenile offender/substance abuse program and established successful partnerships with some school administrators/teachers. The system will benefit from the specialized training the psycho-social program uses to help children and youth. During member check, an agency administrator wrote, ***"The ICS program has developed into a highly skilled, intensive, successful program that allows children to succeed in multiple environments."***

Needs

Parent involvement was identified as a reason that the service was ineffective many times. Strategies to increase parental involvement may be helpful as well as looking at what other agencies have done to prepare workers to manage professional relationships while going into homes. Workers appear to be wary of working with children and youth outside of the safety of the school and psychosocial group settings. The agency may benefit from talking to other agencies and implementing strategies for workers to access additional supervision in the course of providing more community based work and utilizing more seasoned workers to pave the way. During Member check the agency

noted that "***Lack of"*** parent involvement ***"or reluctance to accept service"*** was a reason that the service was ineffective or ***"not accepted at"*** times. ***"The agency and parent support is working on improving and increasing parent involvement."***

Agency 3

Agency #3 was chosen as a site for data collection due to its urban location, low utilization of AC and high utilization of ICS. Respondents were 2 administrators of the service, 12 AC/ICS workers. No recipients of the service were available to be interviewed. Note: Between the time of interview and the preparation of this report, the program has a new coordinator.

AC/ICS is provided in the community and also within the grant funded Crisis Resolution Program (CRP).

CRP is….

- Monitored by the AC Coordinator
- Respite for the youth and family
- Part of crisis response team (on call therapist screens youth in)
- Co-located with multiple agencies
- A room where a youth is allowed to stay up to 72 hours, typically they stay 48
- Temporary placement before court for LEO (Law Enforcement Placements)
- CRP takes referrals from Juvenile Intake and Assessment and within the agency
- CRP is not a placement for fostercare kids
- Bills AC while sleeping and ICS at other times
- Funded by
  - Contract with Juvenile Intake and Assessment
  - Medicaid reimbursements
  - United Way grant
  - State grant for mobile crisis response

1) **Definition of Attendant Care and Individual Community Support**

- An adjunct CBS service, extra support for the treatment team
- Providing goal based activities and skill building
- Outlet for a child
- Teaching skills about how to handle situations
- Provided in homes, schools, and in CRP

- **Differences between ICS and AC**

  ICS is active 1 on 1 intervention
  Bill ICS when they have to actively intervene
  Workers say ICS is more personal and goal directed

  AC is supervision and support
  Bill AC when they are a presence but do not need to intervene

2) Demographics of providers of the AC/ICS services

Crisis Resolution Program	**AC/ICS Community Staff**
8 female and 1 male	40 workers
5 Stay at home moms	Some staff work overtime (time and a half) as AC
3 college students	College students pursuing human service degrees
Ages 20s to early 30s	Ages (20's to early 30's), a few mid 40s' and above
Caucasian and one African American	Most are part-time a few full-time
	Most are female working on getting more males
Workers with agency 10 months to 7 years	Most have been with the agency 4 to 8 months

3) Demographics of the recipients of the AC/ICS services

- Age range from preschool to 22
- Preschool age receive in therapeutic preschool in a psycho-social group
- Serving more males than female across all age ranges

4) Administration of the AC and ICS services

Financial Considerations

- Financial department monitors the program budget and gives reports to ACC and Director of Clinical Programs
- Aspects of the program that are not cost efficient are monitored closely
  - Overtime workers
  - High mileage checks
  - Reimbursements that are questionable, such as expensive meals

Activation of AC/ICS

- Child is at risk of a more restrictive residential, educational, program placement
- Usually identified by the case manager
- Assess if the family and child is willing to cooperate
- Treatment team asks ***"Will family benefit in the long run from receiving the service?"***

Administrative Challenges

- ***"Getting referrals and not being able to get everyone covered."***
- Demand for service and limited ability to staff results in limited availablility
- Balancing clinical considerations (changing a match) with financial (keeping an time and a half AC worker matched with the youth)
- Being available to supervise 40 staff, conduct matching process and manage CRP

Ending of AC/ICS Service

- Continued need is assessed by the team, if disagreement, err on the side of parents
- Service ends in CRP when the pre-determined time frame is up or in 48 hours

Matching

- No specialized matching with CRP on call person comes in
- AC coordinator facilitates and operates from referral form (see Appendix D-2)
  - Qualifying criteria
  - Referral Data
  - Length of service requested, days, times and location
  - Disposition

    - Service Block (2 goals and their objectives derived off the treatment plan)
- All referrals are managed in a database
- 1st criteria ***"Who would be good for this kid?"***, 2nd ***"Who is available?"***
- Questionable matches are discussed with the referral sources
- Timeframe for match is tied to funding sources and agency contractual agreements
- Difficult to find matches for…
    - Hours requested during the school day due to limited availability
    - Preschool age who need one worker from 8-3

Supervision

- Structure
    - ACC is supervised by Crisis Team Leader (Qualified Mental Health Professional)
    - ACC also communicates with the Director of Clinical Programs as well as the Financial Director regarding specific program issues
    - Regular monthly meetings with ACC for at least an hour and 1 on 1 as needed
    - Community ACC meet with case manager weekly face to face
- Approach
    - Open door policy ACC accessible when anything ***"feels uncomfortable"***
    - CMs are ***"protective of AC"*** as an additional support for challenging cases
    - ACC establishes rapport in initial 2 weeks of AC training ***"I am constantly in contact with them…..so they don't get overwhelmed."***
    - Workers said they appreciate knowledge and qualities of AC coordinator (patience, sense of humor, creativity, listening skills, goal setting skills, compassionate, background in CBS)

Integration of Service within the Agency, Families, and Community

- Families
    - Interviewer unable to access recipients perspective
- Community
    - Co-located CRP has established connections with judicial system
    - Some schools are easier to work with than others
- Agency
    - Approach is team oriented, AC come when requested and available
    - Clinical staff see program as a resource on difficult cases
    - CM respect AC and staff work well together
    - AC input in treatment planning is respected by psychiatrists
    - ACC attends CM administrative meeting to improve program relations

Monitoring Professional Boundaries-Strategies

- AC coordinator developed a "Sticky Situations Scenerio" worksheet (see Appendix D1) that is used in monthly supervision
- Discusses worker comfort level as a indicator of a boundary problem
- Encourage the AC to talk to agency staff
- Reinforce faith in AC worker's good judgement

Recruiting and Retention

- Strategies

- Agency has a policy that family members can not be AC/ICS workers
- HR does background and reference checks
- AC coordinator goes over the job description, being candid about difficulties of the position
- Majority of CRP staff recruited through friends
- Agency looks for staff that…..
  - are patient
  - nurturing
  - positive
  - care about the outcome
  - have writing ability
  - are reliable
  - have good decision making skills
  - have a sense of humor
  - have a strong will
  - are confident
  - have a high energy level
- Hire individuals with degrees if possible
- Background checks show patterns of misdemeanor behavior that would not be suitable for an AC
- Run add in local school district newsletter
- AC coordinator recruits at local colleges
- Workers suggested recruiting at local churches

- Why Stay?

CRP AC/ICS	Community AC/ICS
-Flexible schedules (allow for time with families)	-Attachment to kids
-Pay while on call	-Flexible schedules
-Stay in profession while being a mom	-Easy (only work 1-2 times a week)
-Do personal stuff (fold laundry, pay bills) while working	-Good supervision
	-Get to know the community
	-Good money for time and ½ workers

- Why Leave?

CRP AC/ICS	Community AC/ICS
-No breaks on 8 hour shifts	-Pay
-Is hard to be on call	-Burned out
-Pay is poor	-No benefits
	-Hours are not guaranteed

Training

- Two weeks of training
  - Online training
  - MAB (Management of Aggressive Behavior), CPR, First Aid, HIPPA training
  - Documentation training with ACC
- Probation for 6 months
- No formalized feedback process
- Shadowing a more experienced AC
- Feedback about online training
  - Some parts are vague (not clear what the medical model is)
  - Need more information regarding maintaining professional relationships
  - Good foundation knowledge of mental health system

    - Workers score lower on the legal responsibility section of test
    - AC staff like the dos and don'ts section
- Staff said MAB and shadowing were helpful
- Some staff would like more shadowing and observations of interventions in group contexts

5) Effectiveness of the AC/ICS service (rating on a 5 point scale 1, least effective to 5 most effective)

- CRP (5) Always achieve the short-term goal of keeping a kid safe, (4) repeat kids seem to be missing something
- Community AC give a 5 (gives kids an outlet away from home)
- Administrators give 4
    - Adds a support as part of the whole treatment, youth often see the AC as there for them which is a different role than a CM
    - If it is used for it's intended purpose is ***"very effective"***

6) Medical Neccessity

- All CBS staff are trained in a documentation training about medical necessity
- High numbers of hours requested are hard to justify

7) Barriers to providing the AC/ICS service

- The program makes no money for the agency
- Difficult to keep a supply of workers to provide the services

8) Systems feedback

Agency

- ACC has established integrity of the AC/ICS services with clinical staff
- Matching takes time
- Part-time person to assist with recruiting will improve the program
- Help accessing new places to take youth in the community
- CRP workers are concerned about potentially volatile males

State

- Workers would like information from the state on programs similar to CRP to improve their program
- CRP is seen as a resource in the by the judicial system
- Better hands on training
- Solutions for how to meet the demand for service with minimal resources?
- Keep the service it "is valuable" to families

9) Pre-service Training Program

- Good idea
- Would provide a group of trained workers the agency could hire from
- May be hard to recruit workers to get training and be paid the current wage AC make at this agency
- ***"Would be easy to find trainers and providers"***

CONCLUSION

Strengths

The program appears to be integrated within the agency and supported within the community. The current fulltime coordinator has implemented an organized process for recruitment, hiring, training and matching. These efforts appear to have improved the integrity of the program within the agency. Staff feel supported and like the work they do. Staff and administrators understand medical necessity and have made this a part of documentation training for the workers. The structure of supervision is clear for the workers and agency staff are always accessible while encouraging workers to function autonomously in their community based work.

Needs

As the program grows to meet the demand, additional support may be needed to maintain contractual obligations for accessing the service. A more formalized feedback process about training will enable the program to focus on what workers need.

Agency 4

Agency #4 was chosen as a site for data collection due to rural location and high utilization of both AC and low utilization of ICS. Respondents were 2 administrators of the service, 16 AC/ICS workers and 4 recipients of the service.

1). Definition of AC and ICS

Defined AC as a supplemental resource to the case manager. ICS was defined as a service based on helping kids to acquire new skills. 20-25% of youth receiving AC also receive ICS.

- Management/Maintenance of newly acquired skills
- Ongoing assessment of role based on individual client need
- Achieve goals stated in plan of care
- Diversion mechanism to prevent hospitalization and or other out of home placement
- Ethical responsibility to involve the community in the treatment plan
- Address activities of daily living, normalize child's life
- Effectively integrating youth into their community
- Provide service in home, school, and community

2) . Demographics of Providers

- 7 Females 4 Males
- 3 FTE home office, 1 FTE Satellite office, 7 PTE, and PRN staff
- 5 college students, 3 bachelors degreed, 3 some college

3). Demographics of Recipients

- AC services serve on the average between 50-70 clients at a time
- Age range 4-20

4). Administration of Services

Activation of AC/ICS

- Determined by therapist and or case manager
- Decisions made using an integrative approach: teams, wraparounds, plan of care meetings
- Eligibility is determined by SED designation

Ending of AC/ICS

- Determined during 90 day review

Matching

- Gender specific
- Can parents request new workers if dissatisfied with services?

Supervision

- Regular weekly group supervision with AC Coordinator
- As needed individual supervision with both the AC Coordinator and youth therapist
- Do workers get enough assistance when confronting a crisis?
- A good rapport is essential

Integration of Service

- Families

    - Integration of child wishes in plan of care
    - Worker diligence regarding integrating concept of community based provision of AC service (In-Home, In-School)
- Agency
    - Integrative team approach to practice based decision making
    - Regular required participation by AC/ICS in wraparounds and plan of care meetings

Monitoring Professional Boundaries-Strategies

- Regular check-ins with case manager in addition to group and individual supervision weekly by AC Coordinator and youth therapists
- AC workers are held to the same ethical standards as case managers
- Boundaries are determined and assessed by the nature of the relationship in addition to the goals set forth in the treatment team
- No restraint policy
- Youth are prohibited from going into the AC workers home

Recruiting and Retention

- Strategies
    - Word of mouth from internal staff
    - Community college nearby serves as a resource for summer employment
    - Out of area satellite office regularly advertises due to difficulty recruiting an AC worker
    - Recruit empty nesters, daycare providers, siblings of child with SED, and foster parents
    - Recruit people with experience in the field
    - Training regarding "brain disordered children" (effective intervention strategies, medication, diagnosis, and crisis)
    - Preferred provider characteristics: reliable, positive, solid, mature, and caring.

Why Leave?

- Financial constraints regarding not enough money to engage youth in interesting activities
- Transportation issues related to use of personal vehicle for group transport
    - Career and educational opportunities outside of the agency
    - Raises haven't been provided

Why Stay?

- Altruistic reasons
- Career advancement: AC- CM, PTE- FTE

Training

- "On-Line training is psych babble" not effective in helping workers to serve children and their families
- Workers question liability issues related to lack of knowledge about what they can and can't say and do with youth
- Staff would like more experiential training (shadowing) from seasoned workers
- Role model
- Friend???

- Plan of care drives action

5) Effectiveness of the AC/ICS service

- Increases child's self esteem
- Provides an opportunity for the child to feel normal in the world relating to others
- Enhances the child's hope and capabilities
- Diverts the youth from unnecessary hospitalization and or other out of home placement
- Turnover
- Unreliable: no-shows and short notice cancellations

6) Medical Neccessity

- Determined by the case manager and the therapist
- Never presents a barrier to providing AC/ICS

7) Barriers to providing the AC/ICS service

- Lack of adequate finances to support the program from the state
- Availability of quality staff year round with the exception of summer

8) Systems feedback

Agency

- Need a transition to adulthood program to support youth 18 and over (vocational, educational, and housing assistance)
- Redundant paperwork requirements

State

- Need better definition from state regarding AC guidelines

CONCLUSION

Strengths

Overall, generally speaking, parents, staff, and administrators were pleased with Attendant Care services. Parents reported being extremely satisfied when their children were effectively matched with an AC worker also noting the relationship between the AC worker and the child helps to normalize the child's life experience. Staff reported remaining at the center for altruistic versus financial reasons. Staff felt that their jobs were valued by the families they serve in addition to the team at the center. Staff also seemed very satisfied with the weekly group and individual supervision that they receive which is provided by the AC Coordinator as well as the child's individual therapist. Administrators support the use of an integrative team approach to practice using teams, wraparounds, and plan of care meetings inclusive of all involved parties. Overall, the AC program seemed to function extremely well due to the agency's commitment to identify AC workers as a critical component to the treatment team. AC is seen as a medical necessity in that it serves to divert children from state hospitalization and or other out of home placement.

Needs

Inappropriate matching and poor funding for the program were the main concerns reported during the interviews. Parents stated that they would like to be able to request a

new worker if they are dissatisfied with the services they are receiving. Staff reported that they would like to see the program receive more funding in order to engage the youth in more challenging activities. Administrators identified “pitifully poor” reimbursement rates to be the main problem with the service.

<u>**Agency 5**</u>

Agency #5 was chosen as a site for data collection due to rural location and higher utilization of AC and low utilization of ICS. Respondents were 3 providers of the AC/ICS service, 2 administrators, and 1 parent.

1) Definition of AC and ICS services

- AC is used as a crisis stabilization service which serves as a diversion mechanism to prevent out of home placement.
- Role Definition
  - Role of AC in each case is defined by the supervisor
  - Parent seemed confused about AC service role

  "Maybe to explain the service a little better……….they don't let you know a whole lot…………they just kind of do their own thing and don't keep you up on what is going on" "Letting families know more about it and who is doing what"
- Medical Necessity
  - Diagnosis determines medical necessity

  "It's a way to stabilize them in the setting they are in"
- 1:1 attention in an attempt to help manage behavior
- ICS is active intervention AC is a presence in case someone needs to intervene to keep youth in the natural environment

2) Demographics of providers

- Two AC workers are employed at the agency
- 1FTE AC and 1 PTE AC
- CMs also provide AC
- All are Caucasian females in their 20's
- AC workers have bachelors degrees with some holding Masters degrees

  "There are only two workers that just provide AC and the rest are CMs that provide AC on the side in the course of psychosocial group or after hours as needed and as availability allows."

3) Demographics of Recipients

- All Caucasian
- Ages from 5-15
- Number served at the time of interview was 3

4) Administration of AC/ICS

Activation of AC/ICS

- Therapists coordinate emergency AC implementation
- Determined during weekly supervision

  "It doesn't take a lot for us to get AC in place. We don't have to go through a channel or chain of command to get it done. It is very informal. We have as many trained AC workers in this rural center as a lot of the bigger ones."

- If a child is involved in the psychosocial after school group they are often times referred to receive AC services

Ending of AC/ICS

- AC staff reports ***"backing off"*** when kids evidence success in their environment

Matching

- Small team, CMs often times provide AC

Supervision

- Regular weekly individual and group supervision is scheduled

Integration of Service

- Family
  - CBS philosophy: services provided In-Home when needed
- Community
  - Services are considered community based: In-Home, and In-School.
- Agency
  - Integrative service delivery
  - Workers reciprocate respite for each other when needed

Monitoring Professional Boundaries-Strategies

- AC workers are required to adhere to the same ethical standards as other agency staff
- AC workers are discouraged from working with youth AC worker's own homes
- Clearly defined roles between babysitting and AC services

"That cross over line between a parent wanting a break or babysitter…where the child's not really out of control they are just wanting someone to watch the kid, they can't get back from work on time……….we have steered clear of that."

Recruiting and Retention

- Strategies
  - Friends, family, and peers would need to go through the same protocols as staff if hired
  - Advertise in newspaper
  - Use pre-existing community based services staff
- Why Stay?
  - Workers like the flexibility and teamwork of community based services
  - Opportunity for promotion
- Why Leave?
  - Workers said they don't want to leave, like their jobs.

Training

- All community based services staff members are cross trained CM/AC
- Most trainings occur during group supervision
- Need more peer training (shadowing)
- AC workers would like more training regarding diagnoses

"Most all of CBS staff are trained and able to provide the service if it is needed, all CBS have done it at one time or another."

"Training programs are often set up for master's level people ………but I think it would be beneficial for AC to have some training in what the diagnosis is and what the effects are………ongoing trainings happen through supervision."

- Online training is sufficient and always improving

5) Effectiveness of the AC/ICS service (rating on a 5 point scale 1, least effective to 5 most effective)

- Staff, administrators say 5 ***"We have had some high risk kids who were at risk for hospitalization or foster care….everyone was at the end of their rope and we have been able to plug AC in.. in order to prevent that and it has worked"***
- Parent said 5 but said she/he was not sure what the agency did to help

6) Medical Neccessity

- The agency's ***"loose interpretation"*** is if a youth needs support based on their mental health diagnosis to maintain in the community, the service is medically necessary.

7) Barriers to providing the AC/ICS service

- A barrier could be lack of team support in providing the service according to staff

8) Systems feedback.

Agency

- Parent need more information about the service

State

- With other CBS services there are limits, are there any limits to the amount of AC/ICS an agency can provide?

9) Pre-service Training Program

- Wound not benefit this agency as Case management training as well as the online training are ample for their AC/ICS workers

CONCLUSION:

<u>Strengths</u>

This rural mental health center has a supportive team noting that other workers in the agency "want to get into this group." The mutual respect for all members of the team is evident in the responses to the interview questions "supervisors are always accessible…staff said many times how supported they feel in the work they do. The added support of AC/ICS is usually short term and implemented when youth are at risk of going to the hospital or can not maintain in psycho-social group.

<u>Needs</u>

Staff would like to see more training for AC, specifically regarding diagnosis. The family respondent did not understand what AC/ICS services were, how they were used and when they were implemented with his/her child. The distinctions between AC and ICS are vague and agency staff did not articulate differences. The capabilities of the AC/ICS service appear to be relatively unknown to some of the upper level management

within the agency and with the one parent available for interview. Providing more information to agency staff outside the CBS group and to parents may increase the awareness of the service as well as identify more of a need for the service.

Agency 6

Agency #6 was chosen as a site for data collection due to its rural location, low utilization of AC and no utilization of ICS. Respondents were 4 recipients of service (1 father, 2 mothers, and 1 youth and a sibling), 4 administrators and 2 AC/ICS workers. Note: Since the time of the site visit this agency has doubled its capacity (5FTE) to provide the service and expanded hours available to include evenings, overnights and weekends. In addition a part-time coordinator is available for matching and scheduling.

1) Definition of Attendant Care and Individual Community Support

- State definition is vague
  - Concrete tasks for AC/ICS are hard to define
  - Difference between two levels of service is unclear
  - Agency does not provide ICS for fear of state or federal medicaid audits
  - Purpose is to allow for flexibility in service provision (providing easier access to families)
- Some contradicting definitions of AC/ICS
  - AC is sometimes perceived as ***"just a warm body"*** but also as ***"helping client's refocus"***
- AC workers motivate and keep kids on task
- AC work with kids on Academics, Social Skills, and Interactions with the Family
- The AC is different than a CM in that an AC spends more time
- Purpose is to keep children and youth in school
- Provided in homes and at school
- Blended role, all AC workers function as psycho-social aides

2) Demographics of providers of the AC/ICS services

- Female, ages early to late 20's
- 2 ½ FTE for the agency for children's services
- 2 levels of provider
  - Level 1, more experienced, higher hourly pay rate, receives some benefits
  - Level 2, base hourly pay, no benefits
- Work in the time frame of 9 AM to 6 PM with some hours on weekends

3) Demographics of the recipients of the AC/ICS services

- Middle school age, currently all boys, 2 referrals to serve girls
- Youth who do not qualify for special education but need some support at school
- Small number of youth receive the service (3) and been in services almost 2 years

4) Administration of the AC and ICS services

Activation of AC/ICS

- Family request, therapist/case manager referral, children's services director (CSD) identified the need
- Families relay that they started AC because they didn't ***"qualify for respite"***

- AC is a hard service to get according to families, persistence pays off
- AC workers are introduced to the youth they work with in psycho-social group
- Service is implemented in school when youth is at risk for dropping out and when their behavior or inattention was getting in the way

Administrative Challenges

- Amount and need is discussed with treatment team
    - Administrators are mindful of overdependence
    - Persistent requests for service from families activates service
- Agency has more expectations for professionalism which may hurt recruiting

Ending of AC/ICS Service

- Usually continued contact occurs in psycho-social group once AC is ended
- AC will end when medications have been stabilized according to a family

Matching

- CSD makes the matches and schedules the services
- Personalities and interests of the youth and worker make better matches
- No specific matching based on characteristics due to limited availability of staff

Supervision

- Structure
    - CSD handles administrative supervision (see training and matching)
    - Psycho-social coordinator (PSC) handles clinical supervision in course of psycho-social group
    - PSC observation contact with AC 4 times a week in group
- Peer interaction workers have informally at school is helpful

Integration of Service within the Agency, Families, and Community

- Families
    - Youth and parents said they felt very supported by workers but not as much by the agency
- Community
    - School personnel are assisting with treatment planning (initiating a change of AC worker from one youth who is doing well to another)
    - School and agency administrators are exploring a position to be part-time para and part-time AC worker
    - CSD is part of Student Improvement Team
- Agency
    - Executive Director meets all employees hired by the agency
        - Intuitive assessment of the employee
        - Board expectation
        - Sets expectations for employee conduct ***"Don't sleep with clients, steal from clients or say you did something you didn't do."***
        - Start of a relationship in a small community
    - Worker expressed a sense of feeling isolated from other service providers in the agency
    - An administrator said the clinical staff in the agency ***"don't see this service as accessible."***

    - Administrators are taking steps to hire new staff while educating staff within the agency about how AC may be utilized.

Monitoring Professional Boundaries-Strategies

- PSC functions as an AC mentor for staff who need extra support negotiating professional relationship issues
    - If youth is saying AC is ***"best buddy in the whole world",*** the pair may be too attached according to a seasoned staff member
    - Critical to teach the AC their role with the youth and suggestions for how to work toward a goal in the community
- Additional challenge in a rural community when previous connections exist
- Boundaries are monitored when a ***"concern is raised"***
- Boundary issues are addressed within a discretionary range (malicious intent vs didn't know better)
- It is inherent in the way services are set up that boundary issues are going to surface. ***"We set people up to cross boundaries, we have the least trained, least educated people spending the most time with a vulnerable population in their homes."***
- Contradictory relationship for the youth "Trust me really, just know that one day I won't be around."

Recruiting and Retention

- Adding more staff at time of interviews to meet increased need
- Strategies
    - Advertisement in local newspaper
    - Recruit at the community college
- Why leave? Pay is poor
- Why Stay? Satisfaction in helping children and youth

Training

- All staff are required to do the online training
- Some informal with case managers
- Feedback about online training
    - So far no staff have been able to pass it without help and consultation
    - ***"Would time spent on the test be better spent on learning about ethics and boundaries?"***
    - Practical and easy to access
    - Staff said content was good, but learn better in a classroom setting
- Staff did not feel prepared to provide AC from training
- Staff did not feel like there was a way to give feedback about lack of training
- Staff said shadowing would be helpful
- Ongoing training would be helpful, specifically, how to motivate youth

Liability

- Agency noted that a number of years ago they had an AC with serious boundary violations despite every effort to do appropriate background and reference checks

5) Effectiveness of the AC/ICS service (rating on a 5 point scale 1, least effective to 5 most effective)

- Scores ranged were 4.5-5 from administrators, 4-5 families, 3-5 workers
- Service is effective in schools according to administrators, less so in homes (4.5)
- Not effective when youth don't listen or are not engaged according to workers
- Families said it's "a refreshing look from outside the family"

6) Barriers to providing the AC/ICS service

- Having a pool of available providers
- Turnover
- Supervision is difficult, direct observation and feedback is absent
- Families say if they want the service they must wait for a good provider
- Vague state guidelines for ICS which makes medical necessity hard to justify

7) Systems feedback.

Agency

- Administrators would like to see AC more integrated within the agency
- AC staff would like more contact with treatment teams and clinical staff
- AC staff would like more training (see training section above)

State

- Thanks for the better reimbursement rates
- Training needs some work (practical applications of boundaries and face to face)
- State definition is unclear regarding expectations of different levels of service
- Not cost effective for agency to pay AC staff to attend meetings and complete all necessary paperwork

8) Pre-service Training Program

- Would be hard to recruit people to a training program that would result in a $7 an hour job

CONCLUSION

Strengths

This rural agency has a professional, ethical orientation to service provision in the Community Based Services in which Attendant Care is provided. The small AC staff are committed to the work they do and families perceive this commitment with appreciation. The AC that has been provided is effective according to all stakeholders interviewed.

Needs

Shadowing of more experienced staff in the community as well as ongoing training are needs identified by AC workers. AC for children needs better integration and teamwork within the agency's service structure. Workers appear to be more aligned with families than the agency which may contribute to increased relationship boundary concerns. The structure of supervision is not clear for workers which poses more concern when professional boundary issues and other supervisory considerations do arise.

Agency 7

Agency #7 was chosen as a site for data collection due to urban location and high utilization of both AC and ICS. Respondents were 15 recipients of service, 3 administrators, and 5 AC/ICS workers. Between interviews and the final report, this agency reported rapid program changes, including a complete new administrative structure (one program director, two coordinators, and 1 administrative staff).

1) Definition of Attendant Care and Individual Community Support

- Goal directed one on one care
- Provided in the community settings and schools
- Mentor
- Connecting and building relationships
- Teaching new skills
- Attend to the needs of the child and in doing so attend to the needs of the family unit
- Differences between AC and ICS
    - AC is social support for the family monitoring
    - ICS is teaching and training
    - ICS workers have more training and/or education
    - Need for ICS is determined by more severe symptoms

2) Demographics of providers of the AC/ICS services

- Ages: early 20s (minimum of 21) to their late 60s
- 90% are female.
- Duration of employment: 15 months to 4 years
- Minimum of high school education
- Half are college graduates, but is not necessary
- 25-30 full-time workers, total of 70
- First job in the field
- Ethnicity: Mostly Caucasian, African-American, few Hispanics, fewer Asians

3) Demographics of the recipients of the AC/ICS services

- Typical youth served is pre-teen to early teens (mostly male).
- Transient, in service 3-6 months
- Two thirds of the referrals come from the agency's internal referrals and one third from the affiliate agency
- Ages range from 3 to 24.
- Trend of referrals with dual diagnosis MR/SED in their early teens
- Trend of younger children, preschool age and toddlers being referred
- Severe behaviors are the reason for referrals

4) Administration of the AC and ICS services

Activation of AC/ICS

- Determined by the plans of care
- When youth are at risk of out of home placement
- An extended need for support beyond what case management can provide
- When funding is available
- Mental health providers with knowledge of the service refer families

Administrative Challenges

- Requests for extraordinary hours of service in some cases
- Stepping back services when goal attainment is achieved

- Treatment plans that constrain flexibility in providing both levels of service
- Team Leaders must balance providing supervision and direct service

Ending of AC/ICS Service

- When the goal on the plan of care is reached
- Families unanimously said funding dictates the end of service rather than goal attainment

Matching

- Time Consuming
- Responsibility for matches is split between 4 Team Leaders
- Factors considered are physical size, severity of youth/child, experience of provider, and availability
- Duration of the wait (currently 38 hours) is longer the more specific the match

Supervision

- Structure
    - Meetings 2 times a month
        - Monthly all AC staff.
        - Team Leaders meet monthly with their groups of AC (15-20 to each)
    - Paperwork is turned in one day a week.
    - Individual access to supervision is gained 24/7 through cell phone that is rotated among the 4 Team Leaders.
    - Program tracks appointments that AC/ICS workers have with clients
- Staff Feedback about Supervision Process
    - Supervision is accessible
    - Straightforward supervisors are desireable
    - More structured supervision has improved the program

Integration of Service within the Agency, Families, and Community

- Families
    - Wish information about AC was more available
    - Unanimously express it's effectiveness
- Community
    - AC and ICS provided in schools and is accepted in some and others not
- Agency
    - Workers express feeling supported by the agency
    - Subcontractor relationship presents challenges at the administrative and clinical levels for the affiliate agency
    - Bi-monthly team meetings with case managers and therapists to discuss issues regarding service provision help with relationship challenges

Monitoring Professional Boundaries-Strategies

- Scenarios are presented in the initial personnel interview
- The number of hours of AC/ICS provided to families is assessed closely to prevent overdependence
- Teamwork helps monitor boundary issues
- Pagers are used as safeguards against calling workers at home
- AC workers have 24/7 access to supervision to trouble shoot boundary questions
- Boundaries are not rigid: families feel supported

Recruiting and Retention

- Strategies
  - Adds in the local paper
  - Referrals from employees: incentive bonus for 3 month hires ($50)
  - School contacts
  - Infrequently, through family recommendation
  - Conduct an analysis of characteristics of long-time workers
  - Families said
    - Make the service an internship in a degree program
    - Recruit social work, psychology and sociology students
- Why leave? Pursue professional development, relocate, more money
- Why Stay? because they like "helping kids."

Training

- The basic training is a week long. Topics include:
  - Children's Department manual
  - CPI (Crisis Prevention and Intervention)
  - CPR
  - Mental illness overview
  - Medications for children
  - Cultural diversity
  - Safety in the community
  - Online AC training
- Shadowing up to 10 hours in different settings (school, home, summer camp)
- Trainees provide written and informal feedback about training
- Workers said school shadowing was least effective
- Most workers didn't feel prepared from training, administrators want more comprehensive training using a model of intervention
- Need a better training budget
- Online training feedback
  - Does not give practical real world applications for staff
  - Not cost effective for this agency considering numbers of staff and time it takes to complete the training
  - Face to face group training would be better to address cost and practical aspects of training needed
- Families suggested a film addressing some of the severe behaviors

Role Definition

- Case managers and Attendant Care workers perform similar tasks
- Attendant Care is a supplement to case management

Liability

- Providers record providing service when they didn't which results in fraudulent billing posing a risk to the agency
- Safety issues when dealing with suicidal/homicidal youth

5) Effectiveness of the AC/ICS service (rating on a 5 point scale 1, least effective to 5 most effective)

- Administrators gave ratings ranging from 2 to 3.5
  - Factors affecting outcomes; training, team effort, turnover
- Workers gave slightly higher ratings ranging from mostly 4 to 5.

  - Factors affecting outcome; youth/family involvement, negative home environments that do not change
- Families mostly said 5, a sibling spoke to ineffectiveness
  - ***"Graduated"…***from the program
  - ***"They don't try to kill themselves…"***
  - ***"I couldn't live without attendant care…"***
  - ***"A chance to do one on one"*** with another child in a family of 5 children.
  - Sibling feels AC is a reward for negative behaviors

6) Medical Neccessity

- Determined by a plan of care and signed off on by a QMHP
- Documentation is critical to show medical necessity
- Need better review of cases who have been receiving a lot of AC/ICS for long time and appear to be stable

7) Barriers to providing the AC/ICS service

- Funding
- Rapid turnover
- Cancellations

8) Systems feedback.

Agency

- Better training budget
- More face to face supervision

State

- Secure more funding
- Refine the definition of AC to include younger ages and dual diagnosis
- Broad definition results in AC/ICS becoming the "***catch all***" in the system of care. Is this an appropriate use of the service?

9) Pre-service Training Program

- Spend training resources on program specific requirements
- Incentive for workers who plan to be full-time AC providers
- Training gives workers ***"authority and more credibility with families."***
- Internship as an AC provider in some social service degree program
- Lack of motivation to participate in training for an entry level position

CONCLUSION

Strengths

This urban CMHC has creative ideas about how to utilize skill level of seasoned providers within the program to create a team oriented AC/ICS program. The program is committed to youth and families. Families view themselves as a valuable part of the treatment. Monitoring techniques and access to supervision is effective in addressing the worker/client professional relationships. The style and structure of supervision is effective by worker report.

Needs

All stakeholder groups expressed improvements that could be made to training. Consistent communication with affiliate agency is needed to address clinical and administrative challenges. The reason for end of service needs to be made clear to families. Families and the agency gave contradictory messages regarding when the AC/ICS service is ended (goal attainment versus funding running out).

Appendix B

Questions Asked of Stakeholder Groups

APPENDIX B-QUESTIONS ASKED OF STAKEHOLDER GROUPS

QUESTIONS FOR ADMINISTRATORS

Definition of AC service (Administrators perspective)
If you were to give a definition of AC (outside of State definition or federal definitions) what would it be?
What are the differences between AC and ICS? Added 3/04
Who is receiving AC services?
- How is it determined/ what determines when a kid needs AC services?
- How is it determined how much AC will be provided?
- How is it determined/ what determines the end AC service?

Who is providing AC services?
- Number of AC workers
- Demographics: Age, Gender, race, education
- Full-time,
- Part-time workers
- Blended (meaning workers who provided AC or ICS and another services such as Case Management)?added 3/04

Matching
Are AC workers and kids matched? If so, how?
Integration
- How are AC services organized?
- Does the organization have a coordinator? If so what are the responsibilities?
- Are the AC workers part of the wraparound team? Do they know the other service providers and have an opportunity to converse?

Boundary Considerations
- Where is AC provided?
- Is attendant care used in schools and communities?
- How do you monitor the AC services when considering "how close is too close and how close is just right"
    - Can you think of an example of when the too close attendance isolated the client from other professionals such as teachers?

Supervision
- Who provides supervision to AC workers
- How often, how long, where?
- How is SV structured (groups, one-on-one, other)
- Do attendants have to adhere to the same professional standards as therapists?
    - Can they meet with a kid at their own home?
    - What boundaries are to be kept?
- What works well in current SV, and how could supervision be improved?

Recruiting
- What are current recruiting practices?

- What are the basic requirements for an AC worker (meaning qualifications PRIOR to training)?
- Are friends, family members, or peers considered desirable or appropriate as attendants? If yes, when and how? If no, why not?
- What works well in current recruiting, and how could recruitment be improved?
- What **personal qualities** do you look for?

Retention

- How long to AC workers stay on the job?
- Why do they leave or think about leaving?
- What makes AC workers stay?
    - Are there incentives for AC workers to stay?
      If so, which are they?
      If not, should there be incentives? If yes, which ones?
- Are there opportunities for career advancement? (added 5/04)

Training

- What are the current training requirements for ACs?
    - Is it sufficient? (Critiques of Web-based Training provided by WSU)
    - Is there an opportunity for feedback to training providers?
    - What feedback would you have?
        - What is good about the training?
        - How could it be improved?
- What ***experiential*** training is provided to AC workers (before service)?
    - Is it sufficient?
    - Is there an opportunity for feedback to training providers?
    - What feedback would you have?
        - What is good about the training?
        - How could it be improved?
- What kind of ***ongoing*** training is provided for ACs?
    - What, if any, ongoing training is required?
    - Is it sufficient?
    - Is there an opportunity for feedback to training providers?
    - What feedback would you have?
        - What is good about the training?
        - How could it be improved?

Defining and re-defining Concrete Roles

- The lit review relayed that AC tasks will vary with changing need of clients, how is this conveyed to the workers?

Pre-service Training

- Would there be any benefits to pre-service training *such as the old mental health technician programs,* that educate at the community college level for full time jobs in human services?

Evaluation of AC effectiveness by administrators of AC service

- What do you like most about providing AC?
- What do you like least about providing AC?
- On a scale from 1-5 (1 being the least effective , 3 being neutral and 5 being most effective) how would you rate the effectiveness of AC? Why would you give AC this rating?

Medical necessity

- How do you interpret medical neccesity?
- Can you give an example of when AC is medically necessary and when it is not?
- Is medical necessity a barrier to providing AC? If yes, why?

Barriers to Service Provision

- Would you like to be providing more AC?
- If so what do you see as the barriers for expanding this service

Systems feedback regarding AC service

- What feedback would you give to the agency regarding AC?
- What feedback would you give the state regarding AC?

Anything else you like to add regarding the AC service?

QUESTIONS FOR ATTENDANT CARE WORKERS

How long have you been providing the attendant care service?

Recruiting

- How did you find out about Attendant Care?
- What steps did you take to learn about AC?
- What are your ideas about how to recruit other AC workers?

Supervision

- What works well in your supervision?
- What does not work well?
- What suggestions do you have that you feel would improve supervision?

Training

- Is the required training sufficient?
    - Was it sufficient?
    - Was there an opportunity for feedback to training providers? (ask if you don't already know)
    - What feedback would you have?
        - What is good about the training?
        - How could it be improved?
- Is the ***experiential*** training provided to you (before service) sufficient?
    - What feedback would you have?
        - What is good about the training?
        - How could it be improved?
- Is ***ongoing*** training sufficient?
    - Is there an opportunity for feedback to training providers?
    - What feedback would you have?
        - What is good about the training?
        - How could it be improved?

Retention

- You have been on the job ____? If you have thought about leaving or would ever leave what would be the reason?
- What makes you want to stay (if not already answered)?
- What incentives do you have to continue providing AC? If not, should there be incentives? What incentives would you suggest?

Definition of AC service (ACP perspective)

- If you were to give a definition of AC what would it be?
- How is AC diff from ICS?

Evaluation of AC effectiveness by providers of AC service

- On a scale from 1-5 (1 being the least effective , 3 being neutral and 5 being most effective) how would you rate the effectiveness of AC?
- What do you like most about providing AC?
- What do you like least about providing AC?

Medical necessity

- How do you interpret medical necessity?
- Can you give an example of when AC is medically necessary and when it is not?
- Is medical necessity a barrier to providing AC? If yes, why?

Systems feedback regarding AC service

- What feedback would you give to the agency regarding the AC?
- What feedback would you give the state regarding the AC?

QUESTIONS FOR YOUTH AND PARENTS

Definition of AC service (consumer perspective)

If you were to give a definition of AC what would it be?

What has your experience of AC been? What is it that you do with your AC worker?

Beginning of Service Provision

- How did you find out about Attendant Care?
- How was the service explained to you? Was it clear what you would be doing with the AC worker?
- How is AC different from CM or similar to other home based services you have received?(added 3/04)
- How was it determined about how much service you receive?
- How was the AC worker chosen? Did you have say in this?

Duration of Services

- How long have you been receiving AC?
- How many AC have you had? Anything you would like to say about this?
- Have you thought about stopping the service? If yes/no, why?
- What makes you want to keep receiving the service? What makes you want to stop?

Evaluation of AC effectiveness by parents and youth

- What do you like most about AC?
- What do you like least about AC?

- On a scale from 1-5 (1 being the least effective , 3 being neutral and 5 being most effective) how would you rate the effectiveness of AC?

Systems feedback regarding AC service

- What feedback would you give to the agency regarding the AC service?
- What feedback would you give the state regarding the AC service?

Barriers

- **Recruitment**
  Sometimes it has been difficult for agencies to find AC workers, what are your ideas about how to the agency could recruit other AC workers?
- **What personal qualities do you think AC workers have or need to have?**
- **Training**
  Do you feel like the AC worker you have (or had) knew what they were doing and helped you?
  What do you think would be helpful for them to know before they started working with you?
  What would be helpful ongoing training?

Is there anything else that is important for me to know about the AC service?

Appendix C

Definition of AC/ICS

APPENDIX C-DEFINITION OF AC/ICS

SOURCE: Kansas Medical Assistance Program Provider Community Mental Health Center Provider Manual (2003), [online]: https://www.kmap-state ks.us/Documents/Content/Provider%20Manuals/Community%20Mental%20Health%205-04.pdf.

<table>
<tr><th>Attendant Care</th><th>Individual Community Support</th></tr>
<tr><th colspan="2">Definition</th></tr>
<tr><td>One on one support or supervision with the goal of maintaining an individual with severe and persistent mental illness or child with SED in natural community locations, such as where the person lives, works or socializes. All supports provided must relate to the specific goals set forth in the consumer's treatment plan and must be provided under the supervision of a qualified mental health professional. Service may include:
• providing direct support and supervision in accomplishing activities of daily living and
• supporting the consumer and or the family in maintaining daily routines critical to a stable lifestyle.</td><td>Face to face interventions in a community setting. This includes activities which assist persons to function more independently in natural community settings of their choice. The need and level of this service is determined by the treatment team in collaboration with the consumer and family. Services include the following:
• Personal support, which shall have it's objective assistance with daily activities necessary to maintain personal stability in a community setting.
• Support provided to an individual adult or child, which shall include education and in-home consultation and shall have as its objective the delivery of specific training in daily living to an individual, which will be needed to provide natural supports, maintain the family support system, improve self-help skills, interpret policies, procedures and regulations that impact the individual living in the community, and monitor progress with treatment plan goals and objectives.
• Under supervision, personal support provided to individuals in crisis situations. (Community Mental Health Center Provider Manual 2003).</td></tr>
</table>

Each person working as an AC /ICS worker shall, at a minimum:

- Be 18 years or older; if consumer is under the age of 18, the ICS worker must be at least three years older than the consumer. (For adult consumers, this requirement does not apply; however provider agencies are expected to use good judgement when making work assignments;
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and the ability to react effectively in a wide variety of human service situations
- Pass KBI, SRS childe abuse check, adult abuse registry and motor vehicle screens.

Training and Experience

• Have completed a basic training program developed by the provider agency within 30 days of employment, according to curriculums approved by the Division of Health Care Policy	• One year of college course work in the field of human services or one year of experience in the field of human services; or a combination of education and work experience in the field of human services • Have other experience in the provision of services to persons with mental illness or sever emotional disturbance which may be substituted for one year of education or family members or others about persons with mental illness or SED and includes persons who are themselves recovering from such an illness • Have certification of completion of a basic training program developed by the provider agency within 30 days of employment, and additional training within 6 months of employment according to curriculums approved by the Division of Health Care Policy; and

Supervision

The AC and ICS worker is supervised by a staff person meeting the qualifications for targeted case management and/or community psychiatric supportive treatment or other "approved center staff" which may include a MSW (Master's Level Social Worker), LMLP (Licensed Master's Level Psychologist), licensed psychologist or master's degree psychiatric nurse within the agency delivering attendant care services, and is available at all time to provide backup support and/or consultation.

Appendix D

Useful Resources

APPENDIX D-USEFUL RESOURCES

SOURCE: Unknown, retrieved from Agency #3 Attendant Care Coordinator

Appendix D-1 Sticky Situation Scenarios

1. You are out in the community with a client and the client runs away from you. You cannot find them and start to panic. What is the first thing you should do?

    a. Start screaming
    b. Call the CM
    c. Call your supervisor
    d. Call the police
    e. Call the parents

2. A client becomes angry while with you. It appears to you that the client may try and harm themselves or someone else. What should you do?

    a. Run away from them
    b. Implement MAB techniques
    c. Tell them to "calm down"
    d. Call your supervisor or CM

3. Your client thinks your car is really cool. He asks you if you would let him drive it "just around a parking lot." What should you do?

    a. Let him drive your car, even though he is underage.
    b. Let him drive your car because he has a license and is of age.
    c. Not allow him to drive your car at all.

4. Which of these are reasons you should never allow a client to drive your car?

    a. It is a boundary violation
    b. The client could cause an accident and injure themselves or you.
    c. It is against the law.
    d. It is against agency policy.
    e. All of the above.

5. Your client begins talks to you about personal troubles he or she is having. Although the client has a therapist, he/she tells you that they would rather talk to you about it and get your advice on how to deal with the problem. How should you respond to this?

    a. Tell the client what he/she should do to handle the situation.
    b. Tell the client that you don't want to talk about it and they should talk to their therapist.

c. Listen to the client and acknowledge the client's feelings. Tell them that they should talk with their therapist to get the best advice.

6. Your client's mother invites you to stay for dinner after you drop your client off at home. What should you do?

a. Since you are really hungry, you agree to stay and have a nice dinner with your client and their family.
b. Tell the mother that you are not supposed to do this and she shouldn't ask you again.
c. Thank her for the invitation and how nice that is of her. However, tell her that you are unable to stay.
d. Tell her no, but tell her that you will another time.

7. Your client's parents attempt to give you a present for a special occasion or holiday. What should you do?

a. Tell them thank you and take the gift.
b. Tell them you cannot accept the gift and give it back.
c. Tell them that you will accept the gift on the agency's behalf and will place it in the agency's front office for all employees to enjoy.

8. It is your client's birthday and you want to buy him/her a gift. What should you do?

a. Buy them the gift.
b. Tell the CM that you are going to buy the client a gift.
c. Ask the CM or your supervisor if it is appropriate to buy the gift beforehand.
d. Do not buy the client a gift.

9. Your client tells you that her mother hit her last night while they were fighting. What should you do?
a. Confront the mother about this report.
b. Contact SRS to make an abuse report.
c. Contact the CM or your supervisor immediately to report what the client told you.
d. Contact the police.

10. Your client tells you that he really wants a toy but does not have the money to buy it. He asks you to loan him a couple of dollars to buy it. You know that it would make him very happy if he could have it. What should you do?
a. Loan him the money.
b. Tell him no and that he has to find the money himself.
c. Offer to help him think of ways to earn the money himself

Appendix D-2 Referral Form

ATTENDANT CARE / RESPITE CARE REFERRAL FORM

Case Manager: Complete Sections A – D, attach a copy of the Plan of Care & forward to the Program Coordinator

A. QUALIFYING CRITERIA

_____ Child is at risk of a more restrictive residential, educational, program placement.

_____ Parent / School Program is / are willing to accept services. ____SED _____ Current FSGC Client

Case Manager / Contact Person________________________________ CM / Contact Phone # ________________

B. REFERRAL DATA **Referral Date**________________

_____Attendant Care Referral (Attendant Care is provided as a short term, stabilization service.)

_____Respite Care Referral (Respite Care needs will be assessed every 90 days with the review of the Plan of Care.)

Referral Source ____________________________ Reason for Request ______________________________

List Other Resources Considered or available to the family.

____

C. CLIENT INFORMATION __Non Contract ___ Adoption ___FC – KCSL ___ FC – The Farm __ Waiver __HW

Client Name ______ Age ______ DOB ______ Gender ______ Home Phone # ______

Parent's Name ______ Address ______ Work Phone # ______

Child's Primary Axis I Diagnosis ______________________________ ____MR/DD ____Behavioral ____Autism

____Medical ____Neurological ____ Other Physical Other: ______________________________

(Complete Rest of this Box for Respite Care Only)

Siblings Included in Care **DOB** **Special Needs?**

1. ____

2. ____

Presenting Problem: (Describe the child's problem / needs, sibling / peer interactions, need for respite care)

____

____

Strengths: (Enjoyable activities – May attach the POC)______________________________

____

____

Describe a Potential Crisis: (Required)______________________________

____

Strategies for Parent Interactions:

____

____

Describe any special qualifications / skills required of the Respite Care Provider: ____________________

D. REQUESTED SERVICES

Services are requested from ____/____/_____ to ____/_____/_____ on the following days of the week:
Date Date

Day of the Week	Hours of Service	Daily Hours
Monday	From __________ to __________	
Tuesday	From __________ to __________	
Wednesday	From __________ to __________	
Thursday	From __________ to __________	
Friday	From __________ to __________	
Saturday	From __________ to __________	
Sunday	From __________ to __________	
	Weekly Totals	

Services will be provided in the following settings:
_____HOME _____SCHOOL _____COMMUNITY OTHER:______________________________

E. DISPOSITION (Completed by the Program Coordinator)

Request Assessed By ______________________________ Date:______________

_____Case Accepted Assigned Attendant Care / Respite Care Provider______________________

_____Case Denied Reason ______________________________

F. SERVICE BLOCK (Completed by the Program Coordinator, CM, & AC / RC. Forward to UM Clerk)

SCC _______ Effective Date________________ Requested By________________

Goal 1. (as identified on the CISP) ______________________________

Objective ______________________________

____

Goal 2. (as identified on the CISP) ______________________________

Objective ______________________________

____

______________________________ ______________________________

Professional Signature **Physician Signature**

F. CONTRACT FOR SERVICES

~ --- agrees to provide ______________________ with the above stated services.

F accepts responsibility for the supervision and conduct of the Attendant Care / Respite Care provider.

______________________________ ______________________________

Program Coordinator Date Primary Therapist Date

______________________________ ______________________________

Case Manager Date Attendant Care / Respite Care Provider Date

______________________________ ______________________________

Child or Youth Date Parent / Guardian / Collaborative Agency Date

Children's Psychosocial Treatment Group
Behavior Management System
Research and Practice

has utilized two psychologists as consultants for shaping the delivery of services to children, adolescents and their families seeking assistance with behavioral and/or emotional difficulties. Cheryl McNeil, Ph.D., co-developer of Parent-Child Interaction Therapy (PCIT), and researcher specializing in the field of children with disruptive behavioral and emotional issues, provided specialized training to staff in May 1999. This training established a behavior management system based on the principles of PCIT and Dr. McNeil's research for teachers in managing disruptive behaviors in the classroom. The behavior management techniques utilized are outlined in the proceeding pages.

Dennis Embry, Ph.D. has provided consultative services to Inc. staff on several occasions. Dr. Embry specializes in translating research into practical interventions. His knowledge has assisted the program regarding the importance of individualizing rewards, and the neurological benefits of positive praise and touch, among many other importance aspects of helping children overcome emotional and behavioral challenges. A few of his articles are contained in this manual for review.

The following pages provide an outline of Dr. Embry's research and literature review regarding best practice guidelines for children. The corresponding column represents specific interventions developed by Dr. McNeil and utilized as intervention strategies in the program. Although, Dr. Embry and Dr. McNeil have not designed intervention strategies as a direct result of each others professional work, their models for understanding "what" treatment characteristics need to be present and "how" to deliver specific interventions has provided staff a researched based behavior management system. Children that enter our psycho-social treatment groups have the benefit of their body of knowledge and are guided toward success with interventions that are delivered in a manner that is nurturing to a child's self-image.

In her training sessions, Dr. McNeil emphasizes, per classroom research, the number of times per day that a "typical" ADHD child requires behavioral redirection. Dr. McNeil's research findings indicate that on average the "typical ADHD child" receives 100 times per school day verbal re-direction from teachers, about their poor interaction with others, their inability to sit quietly and attend to their schoolwork, and in general the negative impact their presence can have on others. It is because of the need to provide a frequent ratio of feedback and guidance to children who are at risk of developing, or who exhibit emotional and behavioral challenges, easily develop a poor image of self and a general feeling of incompetence to being able to "do the right thing".

Research provided by both Dr. Embry and Dr. McNeil underscore the importance of teaching children, at a very young age, how to illicit positive responses from adults and develop a sense of competence and control over themselves and their environment. [illegible] Program has developed a system of "shaping" behaviors that will enhance positive social interactions.

Appendix D-3 Parent-Child Interactional Therapy & Dr. Embry's Best Practice Guidelines

"What treatment characteristics are needed" Research based characteristics critical to success for prevention and intervention services per Dr. Embry research and literature review:	"How to deliver interventions" Interventions utilized by J er Dr. McNeil**:
1. Encourage "high levels of praise by...staff for attention to task and academic productivity, especially for high-risk children".	1. Labeled Praise** delivered per frequency of need of iindividual child; Utilize "SMILIES"** as feedback for productive and pro-social behavior.
2. Engaging in "differential attention from adults to othe students and other behavior or using differential einforcement of other behavior, when a child has a minor misbehavior".	2. Utilize Strategic Ignoring** of minor misbehavior and provide positive praise** and at same time deliver "SMILIES"** to children modeling pro-social behavior; Us "TWO CHOICES"** visual cue.
3. Use group activity as rewards for "teams" on a daily basis and basing rewards on individual points.	3. Target Game** as reward to kids that have earned more smilies than frownies. This allows for treat or fun activity delivered 1-2 times per group session. Group Curriculum that includes Adventure Based Games and scheduled activities.
4. Provide "daily self-monitoring and post" academic and behavioral successes.	4. Daily self-evaluation at end of each session; PROPS Points.
5. Provide frequent stimulus that "channel" positive behavior and "reduce down time during transitions".	5. Quick paced group curriculum providing structured activities managed b staff with increased labeled praise during times of transition**.
6. Use common "symbolic models to illustrate" mastering pro-social behaviors.	6. Staff and peers model, role-play and rehearse social skills and steps as outlined by Boys Town with high frequency of labeled praise and recognition for mastering steps to each skill**.
7. Use cognitive-behavorial questioning and techniques to encourage control of "emotionally charged events".	7. Staff utilize "two-choices"** visual cue and encourage use of "chill zone"** for reduction of emotionality and increase likelihood for self-correction. Use of adventure based games to increase self-awareness and process individual responses.

Appendix D-3 Parent-Child Interactional Therapy & Dr. Embry's Best Practice Guidelines

"WHAT treatment characteristics are needed" Dr. Embry research and literature review, continued from previous page	"HOW to deliver interventons" Dr. McNeil intervention strategies, as denoted by**, continued from previous page.
8. Provide "daily positive home notes to student's families for positive behavior and achievement, linked to rewards at home.	8. ~ :nd notes home to parents/guardians on weekly basis regarding social skill of focus for the week, as well as behaviors observed.
9. Develop positions of responsibility for children.	9. Group members are assigned daily chores and advanced group members act as leaders and "mentors" to new group participants.
10. Deliver consequences quickly, i.e. response-cost, cognitive mediation and overcorrection procedures for negative behavior.	10. At first sign of negative behavior staff provide feedback using "two choices" visual cue**; If child does not self-correct staff briefly respond that child has earned "a frownie"**, further disruptive behavior or several "frownies" in one session result in loss of one or more PROPS points, Time-out is utilized within the group room first for continued misbehavior and then out of the room if further escalation of behavior occurs**. Physical restraint is used only as a last resort to protect the child from harm to self or others.