CORE ELEMENT:
PREPARING TO EXIT

Preparing to Exit from IHT begins with the family vision for a preferred future and flows through all stages of the intervention. With regular checks on progress, the IHT team and family move together toward the family vision. Specific actions, as the family approaches the planned discharge date, include validating youth and family progress, planning for setbacks and sustainability, and learning about family member experience of the service. Unplanned exits, or a severe increase in youth needs, require efforts to ease difficult transitions, re-engage family members, and learn what we can in order to prevent abrupt discharges in the future.

CONTRIBUTION TO THE OUTCOME: Planning for exit from the point of intake emphasizes the hope that changes will endure over time with less professional intervention. Planning attends proactively to safety, community connections, changes in life circumstances, and other variables that may affect the end of treatment and after-care planning. Careful collaboration is essential to guide when and how to complete an episode of care. Ending treatment may be cause for celebration of a family's strength in improving their situation. Unplanned exits are an opportunity to learn about how practitioners, collaborating partners, and the system of care can better support positive outcomes.

REMINDER: Review all Elements. See especially: Assessment and Clinical Understanding, Collaborative Intervention Planning, Intensive Therapeutic Intervention, and Care Coordination and Collaboration. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Preparing from the start		
• Reviews with family members the family vision for healthier functioning in the future and how IHT intervention can help. • Builds consensus among family members on how they will measure progress. • Explains to family and all collaterals that continuation of service depends on family choice and medical necessity criteria (not on a pre-determined time limit). • Plans for exit throughout, from the first meeting.	• Plans for termination without linking to family vision. • Discusses termination without actual transition planning or ongoing processing. • Establishes goals for ending but without plan to track progress. • Shows confusion about "readiness" — for example, goals achieved but no exploration of family confidence to function without IHT. • Does not explain to the managed care entity (MCE) why child meets the medical necessity criteria (MNC). • Assumes other stakeholders understand MNC.	• Dictates vision or goals. • Avoids discussion with youth and family of ending until end is close. • Tells family or other stakeholders that IHT is "**short-term**" or other arbitrary length. • Allows other stakeholders to dictate length of treatment, overriding family voice. • Does not explain MNC.
Monitoring progress and setbacks		
• Continually monitors perceptions of progress and setbacks from perspectives of all family members and formal/informal supports. • Reviews progress on strengths and needs in CANS and other clinical tools. • Keeps data on the selected measures (days of school missed, number of tantrums) to support impressions. • Addresses different perceptions to reach consensus on readiness to end intervention. • Uses setbacks and moments of crisis as opportunities to learn and plan for a future with less intensive supports.	• Includes only a subset of family or provider perceptions. • Has measurable objectives but does not track relevant data. • Attends to achievements without acknowledging setbacks or continued concerns. • Ignores learning opportunities in setbacks and crises. • Uses limited set of data indicators (CANS only). • Checks in but without resolving conflicting perceptions among family and other Team members.	• No discussion of progress. • Uses only IHT perceptions of progress. • No progress measures. • Allows one voice to dominate all other input. • No evidence of checking with team. • Decides unilaterally that family is ready for discharge.
Supports after IHT		
• Identifies as early as appropriate the community resources and less intensive clinical services (outpatient) likely to sustain healthy functioning during and after IHT. • Facilitates appropriate connections to both formal and community resources.	• Makes referrals without follow-up. • Dominates referral process without engaging family in making self-referrals. • Considers only formal services for after-care. • Uses cookie cutter plan without individualizing to family.	• No identification of resources to continue after IHT. • Pressures family to use a certain resource. • Makes referrals without knowledge and consent of family.

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Transition to adulthood		
• Attends to unique challenges of transition-age youth, especially those leaving foster care or group care, who will be living independently after discharge.	• Plans for mental health needs without attending to young adult aspirational goals. • Makes referrals without follow up. • Considers young adult needs without consulting or considering parenting adults. • Addresses some but not all challenges of independent living.	• No planning for young adult moving to independence. • Assumes young adult wants to leave Department of Children & Families, parents, other supports. • Ignores parents as resource. • Ignores or fails to assess youth's practical skills for independence.
Exiting IHT to more intensive services		
• Considers new challenges that may require more intensive services (with or without continuing IHT). • Develops clear assessment of adjustment needs. • Holds face-to-face meetings with full Team of family and stakeholders to address new needs and unresolved conflicting perceptions about ending intervention. • When unable to reach consensus, makes interim plan with Team to monitor each disagreement with specific measures of acceptable and unacceptable occurrences of the event that is causing disagreement and to revisit within a specified time frame.	• Adds more services without assessment of need, rather than adapting IHT intervention. • Monitors challenges inconsistently. • Has no clear plan for addressing any identified setbacks. • Communicates individually with team but never holds face-to-face meeting. • Aligns with a particular team member to the exclusion of other points of view. • Holds meeting without preparing family. • Concludes Team meeting with unresolved next steps.	• No acknowledgement of setbacks. • No flexibility in adapting IHT and adjusting service mix. • Discusses setbacks only with collaterals, not family. • Advocates for a service that is not accessible to family. • Ignores differing opinions and makes decision on own. • No family input. • Purposely leaves out "difficult" Team members.
Planning for exit to less intensive services		
• Anticipates challenges after discharge and develops with family a post-transition crisis plan to address potential risks, coping skills for reducing risk, behaviors that precede crisis, and specific steps for family members to respond effectively to risks (avert crisis, manage crisis).	• Praises successes without discussing likelihood of setbacks as normal part of growth. • Plan addresses some but not all risks. • Plan relies on access to formal supports rather than family resources.	• No plan for setbacks after discharge from IHT. • Plan gives emergency contacts only.
• Prepares for planned discharge by gradually meeting less frequently, reviewing internalized skills, and ensuring that family members can coordinate care. • Facilitates a "pre-meeting" with family to prepare for presenting what the family hopes to accomplish by ending IHT (or making other changes in services). • Processes loss of IHT support and changes in support network with family. • Establishes connections with any new services prior to ending IHT.	• Discusses discharge with only a subset of family. • Superficial review of accomplishments without full comprehension of the work. • Acknowledges only family loss, no reciprocity. • Insufficient attention to solidifying gains as part of clinical process. • Ends without stepping down frequency of visits. • Opens discussion with family only when there are positive outcomes, not other types of ending. • Referrals made, but not early enough to allow time for a transition meeting.	• No evidence of family voice in transition phase. • No effort to solidify gains. • Family left holding the bag — for example, has phone numbers but no support or guidance to self-refer. • No recognition of access barriers. • No communication with other providers and supports. • Talks about referrals without making them. • Badmouths other services or waitlists.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Assists in addressing access barriers. • Participates in face-to-face "warm hand-off" transition meeting with family members and new providers; shares clinical documents. • Addresses any family reluctance to ending service and develops response to anything that might prevent ending. • Plans with family a final "graduation" celebration to conclude intervention as planned and validate successes. • When transition meeting is not possible, shares clinical documents, discusses wait lists with family, advocates for priority access when appropriate, and coaches family on follow-up actions.	• Referrals made without follow-up or without problem-solving family barriers to using them. • Discharge summary shared with some but not all relevant collaterals. • No face-to-face meeting (but other kinds of communication). • Makes insufficient plan to bridge gaps in service (when new service not yet available). • Empathizes with family reluctance to end service but has no plan to address. • Plans celebration without taking family wishes into account.	• Does not consider family concerns about preparing to exit. • No final meeting. • Invites participants without consulting with family.
Closing summary		
• **Clinician*** develops and shares with family members a discharge summary that includes family vision, review of needs and strengths, goals, progress, current medications, challenges, next steps for sustaining gains or continuing treatment, and contact information for all formal and informal supports. • Uses language of hope and possibility in discharge summary. • Explicitly states signs of resiliency. • Elicits family input on their experience of IHT. **Clinician may refer to clinical team consisting of IHT clinician and others involved in deliberation; clinician is designated as individual responsible for final plan.*	• Covers only some but not all areas. • Minimal or superficial treatment of important topics or contacts. • Summary developed but not shared with family. • Does not seek input from family on their experience of the service. • Discharge summary completed after discharge. • Includes generic next steps, not unique to family.	• No discharge summary. • No family input. • Focuses on remaining problems rather than accomplishments.
Unplanned exits		
• When IHT ends in unplanned manner (insurance interruptions, child removal from home, "firing" of IHT team, family displacement), makes diligent efforts to contact family for resolution prior to closing services. • Communicates with other Team members, and works with hub-dependent providers to find a way forward. • Reviews with team whether there were warning signs or missed opportunities that could have prevented premature ending.	• Minimal follow-up (phone message or letter only). • Minimizes IHT role in unplanned discharge.	• Contacts Team members even if consent withdrawn. • No effort at follow-up. • No communication with hub-dependent providers. • Blames family for abrupt ending.