Advancing Intensive In-Home Treatment practice: Core competencies, practice standards, and implementation supports

Presenters:
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Eric Bruns, Ph.D., University of Washington School of Medicine
Defining and Establishing Quality Standards for In-Home Behavioral Health Treatment for Youth with Serious Emotional and Behavioral Needs and their Families

Eric Bruns, Ph.D., University of Washington
Background

- Intensive in-home behavioral health treatment (IBHT) services occupy a critical place in the children’s behavioral health continuum of care.
- Exist in some form in most states.
- The IBHT workforce consists mainly of entry level Master’s level clinicians who are asked to serve the most complex and highest risk youth and families.
Developmental progression

- Varying levels of operationalization and evidence of effectiveness depending on model, state requirements, etc.
- EBP’s such as MST generate significant adherence and outcome data.
- Significant state-level variation. “IBHT generally lacks the data generation, data collection, data analysis and data feedback capability that would allow for basic quality assurance and improvement” (Moffett et al., 2016, p. 3).
Overall Goal for the Project

• To review, compile, and synthesize existing literature and information in order to define evidence-based standards for IBHT at practitioner, organizational, and system levels.

• The ultimate goals:
  1. Produce materials to guide the field (e.g., informational briefs, quality frameworks, recommended standards and indicators)
  2. Inform future efforts (e.g., learning or quality collaboratives, workforce development models, national interest or trade groups)
Potential Users of Information and TA on IBHT

• **States, jurisdictions, and managed care entities** to inform RFPs/contracts, financing, investments in workforce development, and accountability;

• **Provider organizations** to inform training, coaching, supervision, and CQI (including fidelity); potentially credentialing

• **Practitioners** to inform their work with youth and families, enhance practice, and aid in matching protocols and practices appropriately to youth and families’ needs
Initial Steps in the Process

1. Compile literature and information from research and states (Completed)
   • EBPs used in IBHT
   • Empirically-based practice elements for in-home services / placement prevention
   • Proposed program elements / organizational standards
   • Overarching strategies adopted by states and payors for IBHT
Initial Steps in the Process, cont.

2. Get initial feedback from experts (now underway)
   - NASMHPD children’s leads
   - Other children’s state mental health authority (SMHA) representatives
   - Family and youth leaders
   - Researchers
   - EBP advocates
   - Model developers and other clinical experts
   - TA Network core partners
   - Managed care organization (MCO) representatives
Initial Steps in the Process, cont.

3. Get next steps feedback from TAN and NASMHPD (May)

4. Develop strategic action plan, e.g.,:
   - Dissemination of findings and recommendations
   - Delphi process with experts on best practice approaches or standards
   - Initial quality collaborative with early adopter states, MCOs, provider organizations
INTENSIVE HOME-BASED TREATMENT PRACTICE FRAMEWORK:
MATCHING STRATEGIES AND TECHNIQUES TO YOUTH AND
FAMILY NEEDS

RICK SHEPLER, PH.D., PCC-S
CENTER FOR INNOVATIVE PRACTICES
BEGIN CENTER FOR VIOLENCE PREVENTION
CASE WESTERN RESERVE UNIVERSITY
Introduction

- Intensive In-Home Treatment (IIHT) is designed to address the complex needs of youth with serious emotional disabilities (SED) who are at risk of out of home placement.
- IIHT is implemented in most states and is an integral part of comprehensive continua of care.
- The IIHT workforce consists mainly of entry level Master’s level clinicians who are asked to serve the most complex and highest risk youth and families.
- These novice clinicians need additional supports that include in depth training, intensive supervision, and practice frameworks that helps them prioritize interventions and strategies to best meet the presenting needs of youth and families.
Intensive Home-Based Treatment

• IHBT is an intensive, time-limited behavioral health treatment for children and adolescents with significant behavioral health challenges and related functional impairments in key life domains.

• IHBT incorporates a comprehensive set of behavioral health services which are delivered in the home, school and community, with the purpose of stabilizing behavioral health and safety concerns, for youth who are at-risk of placement due to his or her behavioral health challenges, being reunified from placement, or require a high intensity of behavioral health interventions to safely remain in the home.
<table>
<thead>
<tr>
<th>Intensive Home-Based Service Delivery Model</th>
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<tr>
<td><strong>Location of Service</strong></td>
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</table>
| **Intensity** | Frequency: 2 to 5 sessions per week  
Duration: 4 to 8 hours per week |
| **Crisis response & availability** | 24/7 |
| **Active safety planning & monitoring** | Ongoing |
| **Small caseloads** | 4 to 6 families per FTE; **no mixed caseloads** (e.g. Outpatient & IHBT) |
| **Flexible scheduling** | Convenient to family |
| **Treatment duration** | 3 to 6 months |
| **Systemic engagement and community teaming** | Child and family teaming; skillful advocacy; family partnering; culturally mindful engagement |
| **Active clinical supervision & oversight** | 24/7 availability; field support; weekly team meetings |
| **Provider credentials** | Licensed Behavioral Health Professional: MA level preferred. |
| **Comprehensive service array: integrated and seamless; single point of clinical responsibility** | Crisis stabilization, safety planning, skill building, trauma-focused, family therapy, resiliency & support-building, cognitive interventions |
IHBT Model Components

- Culturally Mindful Engagement and Family Partnerships
- Home-Based Service Delivery Modality
- Multidimensional Assessment
- Comprehensive Treatment Array Matched to Needs and Strengths
- Cross-System Collaboration and Service Coordination
- Resiliency-Oriented Developmental Perspective
Families with Complex Needs and Challenges

- Youth & Family Safety
- Family Stressors
- Trauma History
- Family & Neighborhood Risk Factors
- Basic Needs (financial, transportation, housing)

Family Unit

- Family Dynamics (Relationships, Boundaries, Hierarchy, Communication, Structure)
- SU Disorders
- MH Disorders
- Health, Sleep, Nutrition, Exercise, Medication Compliance
- Acculturation; Language Barriers

Family Supports & Resources
- Neighborhood, School, Community Connections
- Family Skills

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Multidimensional Assessment

I. **Diagnoses:** youth who meet the criteria for Mental Health Disorder and related symptom manifestation

II. **Developmental Functioning:** (cognitive, emotional, & behavioral maturity)

III. **Contextual Functioning:** Individual functioning in relevant life domains, including risk and protective factors, and risk and recovery environments

IV. **Safety and Risk Factors:** Self and other harm, personal, family, and community safety
Contextual Assessment and Treatment

School

Family

Peers

Informal Supports

Community

Youth

Work

Shepler and Baltrinic, 2006

+ = Protective Factors

- = Risk Factors
<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority Concerns/ Needs</th>
<th>Barriers</th>
<th>Strengths</th>
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<tbody>
<tr>
<td>Individual</td>
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<td>Home/Family</td>
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<td></td>
<td></td>
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<tr>
<td>School</td>
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<tr>
<td>Community</td>
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<tr>
<td>Risk &amp; Safety Issues</td>
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</tbody>
</table>
Contextual Functional Analysis

Contextual & Relational Dynamics: Family, Peers, School, Community

Dispositional Factors

De-stabilizing Event or Trigger

Trauma Filter

Youth

SU Disorder

MH Disorder

Salient Behavior/Symptom

Exacerbating Response

Risks Factors, Skills, Resources, and Supports

Escalation Cycle

Safety Issue

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Multiple Risks Require Multiple Interventions (Sameroff, Gutman, and Peck, 2003)

- Interventions need to be as complex as the multiplicity of risk factors and contexts
- Most interventions in single domains have not produced major reductions in problem behaviors
  - Most youth experience risks across multiple social contexts
  - Interventions need to address all the social contexts in which the risks occur
Risk and Resiliency Focus (Mannes; Shepler)

Resiliency

The more assets the better

The less risk the better

Increase Protective Factors in Multiple Environments

Reduce Risk Environments and Behaviors

Safety is Foundational
Safe environments for recovery and resiliency promotion
Establish Positive Connections & Functional Success through Relational Supports & Strategic Accommodations

Asset Building, Futures Orientation, and Meaningful Contribution

Build Competencies, Skills & Coping Across Settings

Resiliency & Recovery

Safety, Stabilization, & Risk Reduction

Basic Needs, Resources, & Validation

(Shepler, 2011)
Comprehensive service requires integrative treatment framework

• Services and supports are matched to each family’s presenting needs, strengths and circumstances
• A family need hierarchy is utilized to assist in assessing and prioritizing the youth’s and family needs
• Strategies and interventions are matched to the most salient need, progressing to more complex needs once the primary needs are met
• What key factors if not addressed will lead to relapse or increased behavioral health symptoms or decreased functioning in a key life domain?
Integrated and Comprehensive Treatment Matched to Need

Youth and Family Need Hierarchy (Shepler, 1991, 1999)
<table>
<thead>
<tr>
<th>Crisis &amp; Safety</th>
<th>Skill Building</th>
<th>Coping</th>
<th>Family</th>
<th>Eco-systemic</th>
<th>Resilience Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and Safety Assessment</td>
<td>Emotional Regulation</td>
<td>CBT</td>
<td>Solution-Focused; Structural; Strategic</td>
<td>Child and Family Teaming</td>
<td>Pro-social peers and activities</td>
</tr>
<tr>
<td>Safety Planning &amp; Means reduction</td>
<td>Problem Solving</td>
<td>DBT</td>
<td>Relationship &amp; Support Building</td>
<td>Cross-system coordination</td>
<td>Strengths identification; asset building and support</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>Communication &amp; interpersonal skills</td>
<td>Trauma-focused</td>
<td>Behavior Management</td>
<td>Functional success environments</td>
<td>Youth &amp; Family Supports</td>
</tr>
<tr>
<td>24/7 response</td>
<td>Conflict resolution</td>
<td>Motivational Interviewing</td>
<td>Family &amp; intergenerational dynamics</td>
<td>Strategic accommodations</td>
<td>Futures orientation</td>
</tr>
<tr>
<td>Active Monitoring</td>
<td>Coping skills</td>
<td>Mindfulness</td>
<td>Supervision Monitoring</td>
<td>Advocacy</td>
<td>Linkage to mentors</td>
</tr>
</tbody>
</table>
Workforce Development

• Comprehensive and ongoing training
• Weekly clinical consultation from model developer
• Intensive clinical supervision including field supervision
• Inform clinicians: collect and disseminate outcomes.
• Yearly fidelity monitoring
• Think of this as a post-graduate fellowship experience
IHBT Core Competency Areas

- Family systems
- Risk assessment and crisis stabilization
- Behavior management for children/adolescents with SED
- Cultural & linguistic competence
- Cross-system collaboration and coordination
- Trauma-informed care
- Resiliency-oriented, developmentally focused

- Skill building
- Educational and vocational functioning
- Youth and family engagement and partnering
- Strength-based assessment and treatment planning
- Co-Occurring Disorders
- Ethics in IHBT
- IHBT Supervision
For more Information on IHBT

Rick Shepler: richard.shepler@case.edu
Supervisory Strategies in In-Home Therapy

University of Maryland, Baltimore
Training Institutes
July 25-28, 2018
Background and context - IHT

- Intensive in-home therapeutic service
  - Average 14 – 16 hours per month of service per youth
- Delivered by a team of 2
  - MA level clinician
  - BA level therapeutic training & support staff
- Implemented in 2009 as part of federal class action lawsuit – Rosie D.
- MassHealth (Medicaid) funded
- Approx. 70 providers with 160 sites across the Commonwealth
Background and context - IHT

- Serves youth and families with complex behavioral health needs
- Workforce relatively young and new to the field
- High staff turn-over – 18-24 months
- Each provider responsible for onboarding and training of staff – no “state provided” training
- Results of qualitative reviews of care found:
  - Variation in quality of service delivery across the state
  - Variable understanding by practitioners of their role and responsibilities
What is a practice profile?

- Tool that breaks down large concepts such as “engagement” into discreet skills and activities that can be taught, learned, and observed.
- Operationalizes the “what” of a service
- Breaks down those elements at the level of “saying and doing”.
- Developed through a rigorous stakeholder engagement process and are further informed by the research literature.
Practice Profile Development Methodology

- Semi-Structured Interviews
- Systematic Scoping Review
- Document Review
- Vetting and Consensus
- Usability Testing
- Practice Profile
REMINDER: Review all Elements. See especially: Practicing Cultural Relevance, Engagement, Risk Assessment and Safety Planning, Engaging Natural Supports and Community Resources, and Collaborative Intervention Planning. 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.

<table>
<thead>
<tr>
<th>IDEAL PRACTICE</th>
<th>DEVELOPMENTAL PRACTICE</th>
<th>UNACCEPTABLE PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First meetings and initial assessment</strong></td>
<td><strong>Discusses with some but not all key family members.</strong></td>
<td><strong>No youth voice and no attempt to initiate contact or discussion.</strong></td>
</tr>
<tr>
<td>Full informs family of the assessment process and purpose.</td>
<td>Uses only clinical language without family-friendly language.</td>
<td>Ignores family’s concerns in favor of provider bias.</td>
</tr>
<tr>
<td>Elicits each individual family member’s impression of core concerns, including risk and safety, in their own words.</td>
<td>Late or incomplete initial assessment.</td>
<td>No initial assessment.</td>
</tr>
<tr>
<td>Uses family member language in subsequent descriptions of needs and strengths.</td>
<td>Leaves out family concerns, strengths, or expressed vision for future.</td>
<td>Relies solely on another provider’s assessment.</td>
</tr>
<tr>
<td>Attends to pace and timing of information-gathering when families feel overwhelmed.</td>
<td>Slanted toward provider view of what family “should” work on.</td>
<td>Ignores or weeds out important concerns due to lack of expertise of IHT team.</td>
</tr>
<tr>
<td>Within 24 hours, clinician completes a brief initial assessment with family input regarding needs and strengths, youth/family vision for their future, what helps, what gets in the way, and next steps to guide first stages of IHT intervention prior to comprehensive assessment.</td>
<td><strong>Exploring needs, vision, history of help, and strengths</strong></td>
<td><strong>Lacks curiosity about family.</strong></td>
</tr>
<tr>
<td><strong>In gathering further information for comprehensive assessment, explores family members’ perspectives on identified needs — what causes them, what keeps them going, what stressors make them worse.</strong></td>
<td><strong>Explores needs but not family perspective on context.</strong></td>
<td>Biased toward provider view of what causes problems; does not balance with family view.</td>
</tr>
<tr>
<td>Invites family members to describe times in the past when needs were less acute and what was different.</td>
<td><strong>Discusses with only a subset of family members or discusses only as a group.</strong></td>
<td>Exaggerates or minimizes challenges that family is experiencing.</td>
</tr>
<tr>
<td><strong>Invites discussion of why choose IHT at this time (why now?).</strong></td>
<td><strong>No follow-up to clarify how family thinks about needs; too superficial.</strong></td>
<td>Assumes knowledge of stressors.</td>
</tr>
<tr>
<td><strong>Invites family members to envision and describe a time in the future when their family is able to manage these challenges more effectively.</strong></td>
<td><strong>Too narrow a scope for what might cause problems or distress.</strong></td>
<td>Discusses stressors without acknowledging coping strategies.</td>
</tr>
<tr>
<td><strong>Discusses this future-oriented vision as a way to</strong></td>
<td><strong>Looks at only limited range of possible stressors.</strong></td>
<td><strong>No discussion of future or discharge.</strong></td>
</tr>
<tr>
<td><strong>Talks about discharge from IHT without linking to family vision.</strong></td>
<td><strong>Looks only at general or external stressors but not intergenerational issues.</strong></td>
<td>Expresses pessimism, hopelessness about change.</td>
</tr>
<tr>
<td><strong>Alters vision to make it more “realistic” or “achievable.”</strong></td>
<td><strong>No discussion of future or discharge.</strong></td>
<td>Generates vision without family endorsement.</td>
</tr>
</tbody>
</table>
Tip: You can’t just hand it out!
The secret weapon in implementation

The clinical supervisor!
Supervision strategies

- Self-assessment
- Behavioral rehearsal
- Field observation
Implementation Workgroup

BAMSI, Brockton
Family Continuity Program, Hyannis/ Plymouth
Gandara, Holyoke
High Point Tx Center, Brockton/Taunton
JRI/ Children's Friend, Lynn/ Salem
North Suffolk Mental Health, Boston/ Metro
Pyramid Builders, Boston
South Shore Mental Health, Southeast
Wayside, Metrowest

MassHealth
CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI)

#LEADINGCHANGE
Monthly Supervision Guided by Staff Self-Assessment

Definition
Supervision meetings that are guided by the IHT Practice Profile self-assessment are intended to be discussions about the quality and consistency of IHT staff's practice across cases, within and across Practice Profile elements. The supervisor and supervisee have a joint obligation to ensure that regular (we suggest monthly) times are dedicated to supervisee-focused discussions.

Purpose
A supervisory session that is focused on a clinician's or TTS's practice development allows supervisors to:

- Reflect with IHT staff about their practice.
- Mutually assess staff's knowledge, skills, and attitudes.
- Support staff in their practice development progression.

Tools
- Self-Assessment Tool
- Individual Skill Plan

<table>
<thead>
<tr>
<th>Learning Need #1 (What IHT practice element needs to be developed or improved?):</th>
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<tbody>
<tr>
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<tr>
<td>Learning Plan #1 (What activity will occur to help the practitioner develop or improve this skill?):</td>
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</tbody>
</table>
| Key Dates #1
Start date: ___/___/___ Expected completion date: ___/___/___ Actual completion date ___/___/___ |
|                                                                             |
|                                                                             |
| Learning Need #2 (What IHT practice element needs to be developed or improved?): |
|                                                                             |
|                                                                             |
| Learning Plan #2 (What activity will occur to help the practitioner develop or improve this skill?): |
|                                                                             |
|                                                                             |
| Key Dates #2
Start date: ___/___/___ Expected completion date: ___/___/___ Actual completion date ___/___/___ |
Self-Assessment

“This helped increase my awareness of my supervisees’ strengths and areas to target for development and served as a reflective tool for the TTS.”

“It made me think about my practice in a way I would not have otherwise. It allowed me room to grow.”
How likely is it that supervisors would recommend utilizing a self-assessment in the context of supervision to a colleague?

1 = I would not recommend this
5 = I'm unsure if I'd recommend this
10 = I would strongly recommend this
Behavioral Rehearsals

Definition
Behavioral rehearsals are opportunities to practice skills using realistic scenarios while in a safe and supportive environment. Using a real or constructed case scenario, IHT staff practice their skills with colleagues who act in the roles of a youth, family member(s), and/or stakeholder(s).

Purpose
Behavioral rehearsal allows supervisors to:
- Bring staff together in a group venue to share experiences and expertise.
- Build a collaborative work environment.
- Share best practices among staff.

Tools
- Behavioral Rehearsal Observation tool
- Guidance for debriefing and providing feedback
- Sample Scenarios
Behavioral Rehearsals

“A majority of staff was dreading this strategy, but that seemed to flip. After the rehearsal, most of staff stated they enjoyed this strategy. It was great to see staff engaging and playing different roles. Some staff also commented on how this helped them release stress.”

“This was not as anxiety-provoking as I thought it would be and was a great way to gain practical skills”
How likely is it that supervisors would recommend using Behavioral Rehearsals to a colleague?

<table>
<thead>
<tr>
<th>NUMBER OF SUPERVISORS</th>
<th>1 = I WOULD NOT RECOMMEND THIS</th>
<th>5 = I'M UNSURE IF I'D RECOMMEND THIS</th>
<th>10 = I WOULD STRONGLY RECOMMEND THIS</th>
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<tbody>
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</tbody>
</table>
Field Observation

Definition
A field observation is a direct observation by the Supervisor of IHT staff outside of the office in order to directly assess their practice skills. Direct observation ensures that supervisors are not relying solely on staff self-reports or case documentation to understand a staff’s practice skills and knowledge.

Purpose
Field observation allows supervisors to:
- Assess staff’s skills and attitudes in working with families.
- Assess the degree to which staff practice is consistent with case documentation and self-reports.
- Assess progress on skill development plans.
- Understand the nature and challenges of the work and the working environment.
- Join with supervisees around the experience (positive and negative aspects) of practicing in a home environment.

Tools
- Field Observation tool
- Guidance for debriefing and providing feedback
“I think it should be routine practice as it can help with burn out of teams so they don’t feel they are all alone with tough families and gives a way to reflect strengths and growth for team.”

“It is helpful to have an outside perspective, particularly in a case where I was feeling stuck regarding prioritizing needs and moving in a positive direction with treatment.”
How likely is it that you would recommend conducting Field Observations to a colleague?

Supervisors

1 = I WOULD NOT RECOMMEND THIS
5 = I'M UNSURE IF I'D RECOMMEND THIS
10 = I WOULD STRONGLY RECOMMEND THIS
Questions?
Intensive, In-home Child & Adolescent Psychiatric Service (IICAPS)

Structuring IHBT to Promote Quality Improvement
IICAPS Partnership

IICAPS Providers:
19 sites, statewide in CT

CT State agencies:
- DCF
- DSS

Families and Children

IICAPS Services:
- training
- credentialing
- quality assurance
- data evaluation

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Conflicts of Interest/Disclosures

• Woolston:
What’s IICAPS?

- Intensive In-home Child & Adolescent Psychiatric Service
- CT based, Medicaid funded IHBT
- 19 sites that cover CT
- Discharge about 2,100 cases/year
- Started 1996 without manual or specific tx structures
- 2005: manualized with training, outcome & process measures
IICAPS in brief

• Conceptualizations
• Network growth
• Outcomes 2009-2017
• The power of Quality Improvement: How new data changed IICAPS
What’s the clinical problem?

• Children, 4-18, who have serious, persistent, multi-domain, behavioral & emotional disturbances

• Who display behaviors that are dangerous to self & others causing high risk for requiring institutional based care

• Who have frequent & multiple “co-morbidities”: Axes I, II, III
Clinical problem (revised)

• But these children aren’t in isolation
• They live in families with multi-generational trauma/adversity and in broader microsystems with present and historic compromised functioning at multiple levels
• Consistent with Developmental Trauma Disorder (van der Kolk et al, 2005, 2009)
What’s the Problem?

- Parental stress
- Parental coping problems
- Ineffective Parenting: Compromised RF & attachment
- Problematic school environ.
- Problematic social environ
- Out of Control behavior
- Child emotional & behavioral problems
- Traumatization
- Institutional service use
- Mal-treatment

Main Problem: Problematic social environ.

Ohio Scales

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Families in IICAPS

• Burdened by multi-generational adversity
• Living with multi-dimensional stressors
• Struggling with trauma, loss, poor education, unemployment, poor health, etc
• Results in difficulty with engagement, focus and follow through
• Interventions with too much structure or too little structure will likely be unsuccessful

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Growth of the IICAPS Network

[Graph showing the growth of IICAPS teams, sites, and closed cases from 2007 to 2017.]
IICAPS Network: Outcomes

• Cases Closed between July 1, 2009-June 30, 2017 
  \( (FYs \ 09/10 \ – \ FY16/17) \)

• N=17,082

• Tx Completers (n=10,848; 67.5%)

• Non-completers (n=5,216; 32.5%)

• Evaluation Only (n=1,018)
Ohio Scales: Problem Severity & Functioning Domains

- Parental Stress
- Parenting & family management skills
- Child Emotional & Behavioral Problems
- Out of Control Behavior
- Environmental Stressors

Main Problem

Institutional Service Use

Service Utilization Questionnaire

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Ohio Problem Severity:
Paired T-test, IICAPS Intake and Discharge
(Treatment Completers; N= 10,848)

Proportional Decrease, Parent Report:  37.6%  (p<.0001)
Proportional Decrease, Youth Report:  34.7%  (p<.0001)
Proportional Decrease, Worker Report:  36.5%  (p<.0001)

Clinical cutoff = 20
Decreases in Ohio Scales Problem Severity Scores over Eight Fiscal Years for Treatment Completers

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Ohio Child Functioning:
Paired T-test, IICAPS Intake and Discharge
(Treatment Completers; N=10,848)

Proportional Increase, Parent Report: 23.7% (p<.0001)
Proportional Increase, Youth Report: 11.1% (p<.0001)
Proportional Increase, Worker Report: 26.9% (p<.0001)
Increases in Ohio Scales Functioning Scores over Eight Fiscal Years for Treatment Completers
Main Problem Ratings & Scores

Defining Main Problem: co-construction of description of behavior that puts child at risk for requiring institutional treatment

Rating Main Problem: 10 point scale with behavioral anchor points ranging from:

1 - Imminent risk of injury to self or others/gravely disturbed

to:

10 - No disturbance
Main Problem Rating:
Paired T-test Results
Measured at IICAPS Intake and Discharge

Mean Difference, Treatment Completers: 3.5 pts. (p<.0001)
Mean Difference, Non-completers: 1.2 pts. (p<.0001)
Service Utilization Data

• Service Utilization Questionnaire (SUQ): created by the IICAPS developers

• Parent report; excellent validity when compared to claims payment data

• Administered at Intake to collect data on service utilization during the 6 months prior to IICAPS Intake

• Administered at Discharge to collect data on service utilization during the period of the IICAPS Intervention (time variable)
Service Utilization Data: Number of Patients with a Treatment Event

Treatment Completers

Proportional Decrease, Pts w/Psych Inpatient Admission: 54.6%
Proportional Decrease, Pts w/ED Visit: 40.3%
Service Utilization Data: Total Days of Psychiatric Inpatient Stay
Treatment Completers

Proportional Decrease, Days of Psychiatric Inpatient Stay: 65.6%
Decrease in Psychiatric Inpatient Admissions and Days over Eight Fiscal Years for Treatment Completers

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New Tool; New Data; New Understanding

• Important Childhood Events (ICE) 2014
• Semi-structured activity with parent involving 20 questions about caregiver’s experience during childhood:
  • 10 questions of adversity (ACE)
  • 10 questions resilience (RCE)
• n= 5,213 (4,241 birth parents)
• 80% completion across sites
ACEs by Study - IICAPS Birth Parents Only

- Kaiser/CDC (San Diego, CA)
- Urban ACEs (Philadelphia, PA)
- Homeless Mothers of 4-6 y/o children
- IICAPS - Birth Parents

Endorsed (Percentage)
IICAPS Summary:
8 years of experience

• Stat. & clin. significant **improvements** in:
  • Ohio Symptom Severity
  • Ohio Functioning
  • Main Problem rating

• Stat. & clin. significant **decreases** in:
  • Psychiatric hospitalization admissions and days
  • ED visits for psychiatric reasons

• **Parental** childhood adversity is extremely prevalent
What we’ve learned from literature review

• 5 RCTs and 2 quasi-experimental design studies of IHBT show only trends indicating efficacy

What we’ve learned from quality improvement data review

• Chronic school absenteeism is a significant problem in IICAPS population and may respond well to IICAPS

• Conway, C. A., et al., School functioning as an outcome in child psychiatry: The effect of intensive home-based family therapy on school absenteeism in a high-risk clinical population. Submitted for publication
Next steps

- **Family Cycle**: a semi-structured, family activity to enhance family acknowledgement and communication of impact of trauma & adversity

**Status**: manuscript describing Family Cycle submitted for publication; Family Cycle Tool currently being rolled out at Yale site; network roll out, 2019
Next steps

• IICAPS Short Parent Observation Tool (I-SPOT): clinician observation tool to monitor impact of Family Cycle. Status: In development; anticipated roll out to Yale site: 10/2018

• Family Structure Clinician Questionnaire; Family Functioning Assessment Clinician Questionnaire. Data collection tools to enhance understanding of families. Status: Roll out to Yale site: 10/2018
Next steps

• Dissemination of IICAPS structures and concepts into IHBT, an intensive in-home treatment for SED children & families in Ohio. Collaboration amongst IICAPS Services, Center for Innovative Practices (Case Western Reserve U), Lorain County Mental Health Board. **Status**: Initial training completed; implementation underway at 3 Lorain County child serving mental health agencies
Next Steps

• Latent Class Analysis of Treatment completers v. non-Completers
• Exploratory Analysis of relationship of Goal Attainment and Ohio scores
Publications


• Conway, C. A., et al., School functioning as an outcome in child psychiatry: The effect of intensive home-based family therapy on school absenteeism in a high-risk clinical population. Submitted for publication

• Stob, V. et al., The Family Cycle: A Conceptual Tool for Clinicians and Families. Submitted for publication
Thank you

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