Session 55:

Advancing Intensive In-Home Treatment Practice: Clinical innovations, practice frameworks and supports

Presenters: Joseph Woolston, MD., Yale University; Richard Shepler, Ph.D., PCC-S, David Hussey, Ph.D. & Bobbi Beale, Psy.D. 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 continuums 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 PRACTICE FRAMEWORK: MATCHING STRATEGIES AND TECHNIQUES TO YOUTH AND FAMILY NEEDS

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CENTER FOR INNOVATIVE PRACTICES
BEGIN CENTER FOR VIOLENCE PREVENTION
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><strong>Location of Service</strong></th>
<th>Home and Community</th>
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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 |
Youth and Families with Complex Needs and Challenges

- System Involvement Stressors (Lack of Support & Connection, Demands, Pressures, Burden)
- Trauma
- Family and Neighborhood Violence; Neg. Peers
- Resource Poor (financial, transportation, housing, supports)
- Safety Needs
- Disparities; Service Access Language Barriers
- Developmental Factors (Risk & Protective Factors)
- Family Stressors, Conflicts, & Challenges

Youth
- SU Disorders
- MH Disorders
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
Conceptualization Tools
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
# Behavioral Health Timeline

<table>
<thead>
<tr>
<th>Age</th>
<th>Developmental Assets, Milestones, and Successes</th>
<th>Significant Life Events (Trauma, Family, Legal, School, Peers, Physical)</th>
<th>Mental Health Symptoms</th>
<th>Substance Use</th>
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Contextual Assessment and Treatment

Shepler and Baltrinic, 2006

+ = Protective Factors

- = Risk Factors
Intervention and Conceptualization Strategies
<table>
<thead>
<tr>
<th>Resiliency promotion</th>
<th>Crisis and Safety</th>
<th>Skill Building</th>
<th>Cognitive</th>
<th>Family</th>
<th>Ecological</th>
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<tbody>
<tr>
<td>Strategic accommodations</td>
<td>Safety Planning</td>
<td>Emotional &amp; physical regulation</td>
<td>CBT</td>
<td>Structural</td>
<td>Child and family teaming</td>
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<tr>
<td>Pro-social peers &amp; activities</td>
<td>Risk assessment</td>
<td>Problem solving</td>
<td>Trauma-focused</td>
<td>Solution focused</td>
<td>Cross-system collaboration</td>
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<td>Strengths identification</td>
<td>Active monitoring</td>
<td>Communication</td>
<td>MI</td>
<td>Behavior management</td>
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<td>Youth and family supports</td>
<td>24/7 response</td>
<td>Conflict resolution</td>
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<td>Relationship building</td>
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<td>Linkage to mentors</td>
<td>Crisis stabilization</td>
<td>Supervision and Monitoring</td>
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<td>Trauma-focused</td>
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<td>Asset building</td>
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<td>Futures orientation</td>
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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

Wellness & Resiliency

Eco-systemic Functioning

Basic Skills and Coping

Basic Needs, Safety, and Stabilization

Youth and Family Need Hierarchy (Shepler, 1991, 1999)
Risk and Resiliency Focus (Mannes; Shepler)

- 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

Establish Positive Connections & Functional Success through Relational Supports & Strategic Accommodations

Safety, Stabilization, & Risk Reduction

Basic Needs, Resources, & Validation

(Shepler, 2011)
Contextual Functional Analysis

Youth

SU Disorder

MH Disorder

Dispositional Factors

De-stabilizing Event or Trigger

Trauma Filter

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

Risks Factors, Skills, Resources, and Supports

Safety Issue

Exacerbating Response

Salient Behavior/Symptom

Escalation Cycle

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Adaptive Systemic Response

Youth

- SU Disorder
- MH Disorder

Coping skills and strategies
- Emotional regulation skills
- Stress reduction

Remove triggers

Remove trauma triggers; Safe environments

Coping response

Adaptive, supportive response

Contextual & relational supports
- Behavioral redirection
- Change the environment
- Pro-social activities

Health & Wellness: Mindfulness, etc.

De-escalation Cycle

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<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority Concerns/ Needs</th>
<th>Barriers</th>
<th>Strengths</th>
<th>Plan</th>
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<tbody>
<tr>
<td>Individual</td>
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<td>Home/Family</td>
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<td>School</td>
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<tr>
<td>Community/Peers</td>
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<tr>
<td>Risk &amp; Safety Issues</td>
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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

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Intensive, In-home Child & Adolescent Psychiatric Service (IICAPS)

Structuring IHBT to Promote Quality Improvement
Conflicts of Interest/Disclosures

• Woolston:
IICAPS Partnership

IICAPS Providers:
19 sites, statewide in CT

Families and Children

CT State agencies:
- DCF
- DSS

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

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What’s the clinical problem?
Version I: 10/1/2010

• 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

• And who live in…
A Microsystem Characterized by SED: “(MP)$^3$ Syndrome”

- M-1: “Multi-problem” children with serious & persistent, out-of-control behavior that is dangerous to self and/or others
- M-2: Living in “multi-problem” multi-generational families
- M-3: Attending “multi-problem” schools and living in “multi-problem” neighborhoods

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Parental stress
Out of control behavior
Child emotional & behavioral problems
Institutional service use
Problems in school, neighborhood, access to resources

Compromised Parenting & Family Management Practices

Parental disability
Compromised Parenting & Family Management Practices

Biological, other vulnerabilities (e.g., PDD NOS)

Child emotional & behavioral problems
Out of control behavior

Problem Solving Training Theory; Goal Setting, Goal Striving

Parental stress

Ecological Systems Theory
Institutional service use

Social Learning Theory

Vicious cycle of (MP)³

Family Domain

School/Environment Domains

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IICAPS

• Intensive, in-home, relationship based tx, ecologically & family focused
• 2 person clinical team treats 8 families
• 3-4 teams in weekly Rounds co-led by CAP & senior mental health clinician
• Weekly team supervision: 15 min/case
• Manualized: Tools, Domains, Phases
• Funding: Medicaid, fee-for-service

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IICAPS Service Provision

- Team provides each family approximately 5 hours/week of direct and indirect services
- Average max. LOS= ~6 months
- Services are provided wherever indicated to maximize engagement & improvement in microsystem functioning
- Documentation structures are Medicaid compliant
IICAPS Theoretical Constructs

- **Social Learning Theory** (Bandura) and its clinical application, **Parent Management Training** (Patterson; Kazdin)

- **Ecological Systems Theory** (Bronfenbrenner)

- **Problem Solving Training** (D'zurilla)

- **Goal Setting/Goal Striving** (Oettingen; Gollwitzer)
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)
IICAPS Outcomes Measures

Ohio Scales: Problem Severity & Functioning Domains

Environmental Stressors

Main Problem Rating

Service Utilization Questionnaire (SUQ)

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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)
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

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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%

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Decrease in Psychiatric Inpatient Admissions and Days over Eight Fiscal Years for Treatment Completers
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
ACE Items Endorsed

- HH Member Incarcerated: 23.1%
- HH Mental Illness: 40.8%
- HH Substance Abuse: 46.1%
- Domestic Violence: 28.2%
- Divorce/Separation: 54%
- Physical Neglect: 17.8%
- Emotional Neglect: 38.8%
- Sexual Abuse: 29.6%
- Physical Abuse: 37.2%
- Emotional Abuse: 42.4%

Percent of Families with Endorsed Item
ACE Items Endorsed - Birth vs Other Parents

- HH Member Incarcerated
  - Non-birth parents: 16.6%
  - Birth parents: 24.6%

- HH Mental Illness
  - Non-birth parents: 27.8%
  - Birth parents: 43.7%

- HH Substance Abuse
  - Non-birth parents: 38.1%
  - Birth parents: 47.9%

- Domestic Violence
  - Non-birth parents: 20.7%
  - Birth parents: 29.9%

- Divorce/Separation
  - Non-birth parents: 43.9%
  - Birth parents: 56.4%

- Physical Neglect
  - Non-birth parents: 12.7%
  - Birth parents: 19%

- Emotional Neglect
  - Non-birth parents: 28.2%
  - Birth parents: 42.3%

- Sexual Abuse
  - Non-birth parents: 21.5%
  - Birth parents: 31.5%

- Physical Abuse
  - Non-birth parents: 29.5%
  - Birth parents: 38.9%

- Emotional Abuse
  - Non-birth parents: 32.5%
  - Birth parents: 44.7%

Percent of Families with Endorsed Item
ACEs by Study - IICAPS Birth Parents Only

- Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Physical Neglect
- Emotional Neglect
- Divorce/Sep
- HH Substance
- HH Mental
- Domestic Violence
- HH Member Incarcerated

Legend:
- Kaiser/CDC (San Diego, CA)
- Urban ACEs (Philadelphia, PA)
- Homeless Mothers of 4-6 y/o children
- IICAPS - Birth Parents
IICAPS: 2016 version 2.0

- Intensive, in-home, relationship based tx, ecologically & family focused, attachment informed
- 2 person clinical team treats 8 families
- 3-4 teams in weekly Rounds co-led by CAP & senior mental health clinician
- Weekly team supervision: 15 min/case
- Manualized: Tools, Domains, Phases
- Funding: Medicaid, fee-for-service

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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)
Parental stress

Out of Control behavior

Child emotional & behavioral problems

Ineffective Parenting: Compromised RF & attachment

Problematic school environ.

Problematic social environ

Traumatization

Mal-treatment

Institutional service use

Ohio Scales

Parental coping problems

Parental Hx Child Maltx

Main Problem

ICE

SUQ

Ohio Scales
IICAPS Theoretical Constructs

- **Attachment Theory** (Bowlby; Ainsworth; Main); and its clinical application, **Mentalizing** (Fonagy; Steele; Steele; Target)

- **Social Learning Theory** (Bandura)
- **Ecological Systems Theory** (Bronfenbrenner)
- **Goal Setting/Goal Striving** (Oettingen; Gollwitzer)
- **Problem Solving Training** (D'zurilla)
IICAPS Interventions

Psychiatric Evaluation & Psychotherapy informed by Developmental Trauma

Intensive Care Management

Problem Solving Training

Environmental Stressors

Mobile Crisis Intervention

Child Emotional & Behavioral Problems

Out of Control Behavior

Institutional Service Use

Parental Stress

Parenting skills & practices

Problem Solving Training

Parenting Skill Building; Enhancing Reflective Functioning

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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 our research

- 5 RCTs and 2 quasi-experimental design studies of IHBT show trends indicating efficacy
- Chronic school absenteeism is a significant problem in IICAPS population and may respond well to IICAPS
Next Steps

• Development & implementation:
  – Family Cycle: a semi-structured, family activity to enhance family acknowledgement of impact of trauma & adversity;
  – Clinician Observation Scale of Parental RF

• 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. In preparation
Thank you

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