

Intermediate Levels of Care for Children with Behavioral Health Needs

A Review of Best Practices, Current Implementation, and Recommendations for Strengthening Services in Connecticut

FEBRUARY 2024



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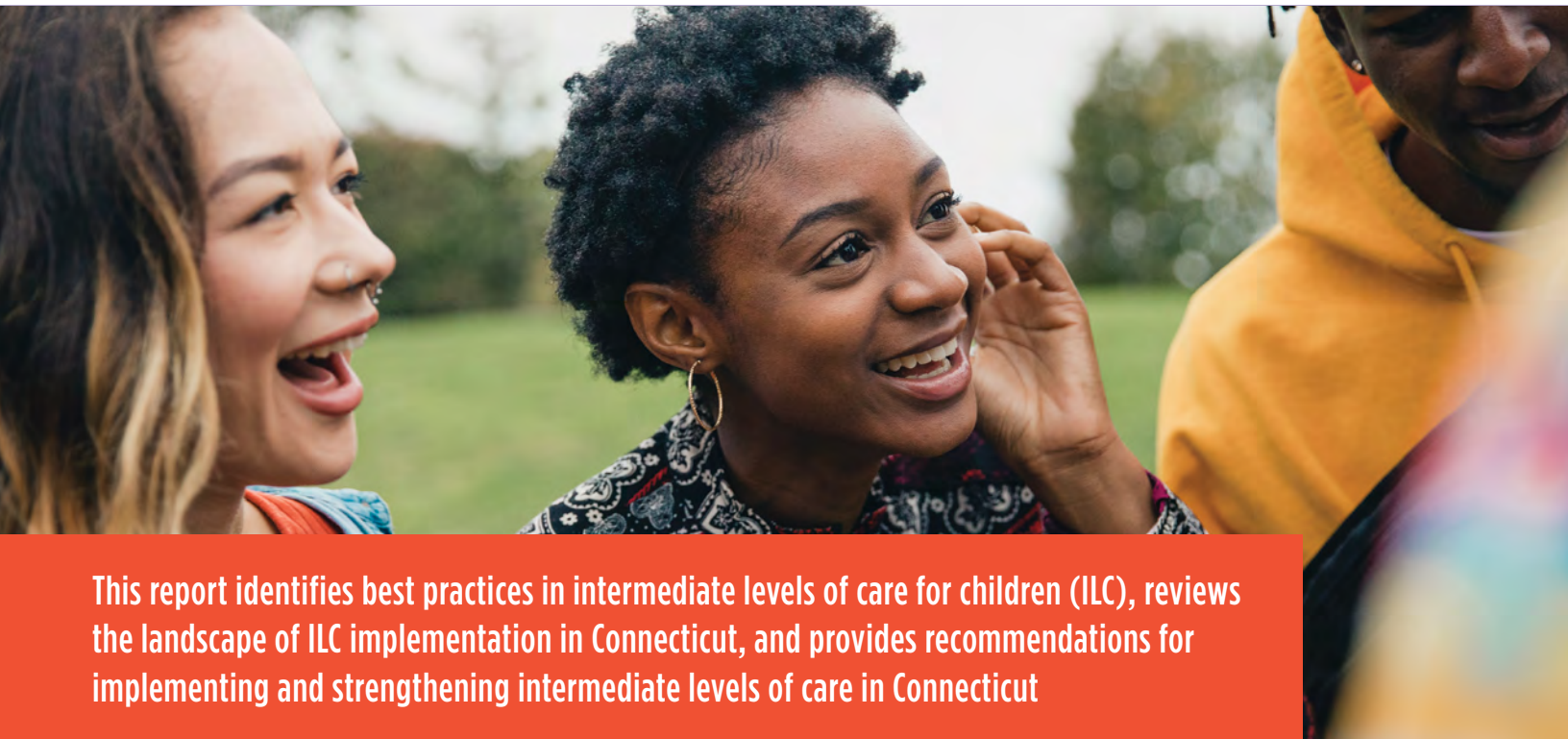
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EXECUTIVE SUMMARY



This report identifies best practices in intermediate levels of care for children (ILC), reviews the landscape of ILC implementation in Connecticut, and provides recommendations for implementing and strengthening intermediate levels of care in Connecticut

Connecticut’s behavioral health system for children includes multiple levels of care intended to meet the needs of children with a wide range of presenting concerns, diagnoses, and acuity. This continuum of care ranges from outpatient care for children with mild or moderate acuity to inpatient hospitalization for children with very high acuity or risk for harm to themselves or others. Intermediate levels of care (ILC) serve youth who do not require inpatient hospitalization but who need more intensive and frequent support than outpatient treatment provides. The term ILC has been defined and used in different ways, sometimes including a broader range of in-home and center-based programs. This report focuses on center-based ILC treatment programs.

ILC services offer a “step-up” for children whose symptoms are more acute than can be treated effectively by outpatient care and a “step-down” for children ready to be discharged from inpatient hospitalization or residential placements. ILC services, therefore, play a crucial role in system throughput. If there are waitlists for ILC programs, there can be delays in care at both the lower and higher levels of care while children await appropriate placement. For families needing help with their child’s behavioral health, accessing the right level of care and giving providers the flexibility to move a child “up” or “down” a level as conditions worsen or improve is important to achieving positive outcomes.

ACKNOWLEDGMENTS

This report was developed by the Child Health and Development Institute for and with funding from the Connecticut Department of Children and Families (DCF). The authors are grateful to staff from DCF and Caredon Behavioral Health, who provided data and helped distribute surveys to program staff, as well as to the staff working in intermediate levels of care who responded to surveys or participated in the focus group; their input greatly informed the content of this report. The authors also thank the following individuals whose contributions strengthened the content and design of the report: Elisabeth Cannata, PhD (Wheeler), Alyssa Korell, PhD (CHDI), Julie Tacinelli (CHDI), and Jeffrey Vanderploeg, PhD (CHDI).

Intermediate Levels of Care for Children with Behavioral Health Needs

Connecticut’s system of care for children has many strengths on which to build, including a comparatively robust continuum of services, a specific focus on the child and youth population, a dedicated network of providers, and good access to evidence-based practices. However, children and families needing intermediate levels of care are not always able to access these services. Expanding the state’s capacity to meet the growing need for effective ILC services will further strengthen Connecticut’s system of care for children, youth, and families.

In recognition of the critical role ILC offers in the broader behavioral health continuum of care for children and families and recent workgroup recommendations about strengthening ILC from the Children’s Behavioral Health Plan Implementation Advisory Board (CBHPIAB), the Connecticut Department of Children and Families (DCF) contracted with the Child Health and Development Institute (CHDI) to develop recommendations for strengthening implementation of these services. **DCF requested that CHDI identify ILC implementation best practices, current practices of ILC programs within Connecticut, and make recommendations as to how the state can strengthen this level of care for children.**

Abbreviations at a Glance
ILC = Intermediate Levels of Care
IOP = Intensive Outpatient Program
PHP = Partial Hospitalization Program
EDT = Extended Day Treatment
PRTF = Psychiatric Residential Treatment Facility

ILC services play a crucial role in the children’s behavioral health continuum of care. For the purposes of this report, only center-based ILC programs are included; specifically intensive outpatient programs (IOP), partial hospitalization programs (PHP), extended day treatment (EDT), and psychiatric residential treatment facilities (PRTF).

METHODOLOGY

In preparing this report, CHDI conducted a comprehensive review of ILC literature and Connecticut-based programs inclusive of the following methods:

- A literature review of ILC best practices for children and youth
- A survey of ILC programs in Connecticut regarding implementation practices
- A survey of program staff working in ILC programs in Connecticut regarding their experience implementing services in these levels of care, their job satisfaction, and training needs
- A review of EDT data collected in DCF’s Provide Information Exchange database
- A focus group with ILC staff



Report Findings Demonstrate Many Strengths as Well as Opportunities to Expand and Improve Implementation

The report findings were drawn from an assessment of the following ILC practices: program structure, populations served, use of evidence-based treatments (EBTs) and milieu models, and workforce development. Limited information was available from the PRTF programs, and therefore, most findings reflect IOP, PHP, and/or EDT programs.



Findings include:

Demand for ILC services is increasing. Nationally, the use of ILC services by children with behavioral health needs is increasing. Within Connecticut, ILC programs are in high demand and maintain waitlists of children in need of their services. There is consensus about the need to expand the availability of ILC programs for children in the state.

State ILC programs align with care guidelines.

The state's ILC programs appear to generally provide services that align with the program structures found in the broader literature regarding intervention types, dosage, and length of stay.

Data on racial and ethnic disparities related to ILC services is mixed. There is little information in the literature regarding equity in access or outcomes across race and ethnicity, gender, or sexual orientation. Based on data from Connecticut programs, it appears that Medicaid-covered children of color may be receiving care in PHPs, IOPs, and PRTFs at disproportionately lower rates than their White peers. Based upon DCF data, however, EDT services appear to serve higher rates of Black and Hispanic children than in the general statewide child population.

EBTs and measurement-based care are not consistently used across Connecticut ILC programs. There was some promising research on the successful use of EBTs in these settings; however, not enough to indicate that one particular EBT would be most effective across settings, and there was almost no research on the use of milieu models. Within Connecticut, EBTs seem to be more commonly used within EDTs than in other ILC service types but did not appear to be consistently implemented across providers and children. Measurement-based care was not consistently used to inform or improve treatment for any of the service types.

ILC programs are experiencing staffing shortages.

The program and staff survey responses identified multiple training priorities for ILC programs and demonstrated interest among staff to increase their knowledge and skills. Similar to the rest of the behavioral health field, most programs are experiencing staffing shortages, with an average of one in three positions being vacant.

Recommendations to Strengthen ILC Services for Children in Connecticut

Growing and strengthening intermediate levels of care requires a coordinated effort and sustained commitment from policymakers, payers, behavioral health system administrators, and providers. Connecticut is resourceful and can apply the following system and program solutions to increase families' access to ILC services and improve the quality of ILC programs in Connecticut. The result is a stronger and healthier future for our state.

System Recommendations:

- 1 Address the Workforce Shortage
- 2 Increase Capacity and Availability of Intermediate Levels of Care for Children
- 3 Improve Data Collection, Reporting, and Continuous Quality Improvement

Program Recommendations:

- 4 Expand Training on Evidence-Based Treatments and Milieu Models and Implement as Standard Programming
- 5 Implement Measurement-Based Care
- 6 Pilot Implementation of a Standardized Model
- 7 Expand Other Training Opportunities
- 8 Intentionally Diversify Program Leadership, Staff, and Children Served
- 9 Continue Review of Psychiatric Residential Treatment Facility Program Implementation

EDT-Specific Recommendations:

- 10 Ensure Access to Full Diagnostic Evaluations
- 11 Continue and Expand Equity-Focused Quality Improvement Efforts
- 12 Address Staff Wellness and Job Satisfaction

INTRODUCTION



Compared to many states, Connecticut has a robust behavioral health system of care for children. The continuum of services includes multiple levels of care intended to meet the needs of children with a wide range of presenting concerns, diagnoses, and acuity. For example, this continuum ranges from outpatient care, which typically involves weekly or bi-weekly sessions and is appropriate for children with mild or moderate acuity, to inpatient hospitalization, which is secure 24-hour care appropriate for children with very high acuity and/or at very high risk for harm to self or others. **Intermediate levels of care (ILC) offer a critical service for youth who do not require inpatient hospitalization but who need more intensive and frequent support than outpatient treatment provides.**

Definitions of ILC vary and may include in-home services (e.g., Intensive In-Home Child and Adolescent Psychiatric Services, Multidimensional Family Therapy) and/or center- or site-based services (e.g., intensive outpatient, extended day treatment).

These options offer both a “step-down” service for children discharged from inpatient hospitalization to help them return to the community and a “step-up” service when outpatient care or in-home providers have identified that a child needs more intensive services.

These multiple roles of ILC within the broader system result in high demand for ILC programs by providers and families, especially in the context of children’s increasing behavioral health needs over the past several years.^{1,2} Interest in improving access to and quality of these programs in Connecticut has been voiced in multiple settings, including workgroups convened by the Department of Children and Families (DCF) in 2021 and 2022 to strengthen implementation of the state’s Behavioral Health Plan for Children required by Public Act 13-178. While the primary focus of these workgroups was on developing urgent crisis centers and emergency department diversion, both groups’ final recommendations included improving access to ILC as a strategy to alleviate delays in other components of the system and better meet the needs of children.^{3,4}

The workgroups emphasized the critical role ILC offers within the broader system; children cannot be discharged without an appropriate service in place, and for many youth, outpatient care is too big of a step-down from inpatient hospitalization. While awaiting openings in ILC programs, inpatient programs delay discharges of youth, creating shortages in inpatient beds. Similarly, outpatient care providers report that they are receiving more referrals for children with acuity and needs that would be more appropriately treated within an ILC program.

Following these recommendations from the Children’s Behavioral Health Plan Implementation Workgroups, DCF contracted with the Child Health and Development Institute (CHDI) to develop a report on best practices and recommendations to strengthen ILC programs serving children in Connecticut. CHDI partnered with Dr. Amber Childs (Yale University School of Medicine, Department of Psychiatry) to assist with this report.

For the purposes of this project, only the following center-based ILC programs have been included in the review: partial hospitalization programs (PHP), intensive outpatient programs (IOP), extended day treatment (EDT), and psychiatric residential treatment facilities (PRTF). Note that while PRTF is often not included as an *intermediate level* of care (it is 24-hour care), it has been included in this review because children who are referred to PRTF typically have lower acuity symptoms than those needing inpatient hospitalization or residential treatment, and PRTF is sometimes used as a step-down from these more intensive levels of care.

DCF requested that the report address the following questions:

1

What does the research indicate are best practices in implementing ILC services for children? Are there evidence-based practices and/or milieu models that have been successful in these settings?

2

What are the current practices among ILC programs serving children in Connecticut, and how do they compare to best practices?

3

What recommendations can be made to strengthen practice across ILC program types for children in Connecticut? Are there additional recommendations specific to EDT that can be addressed through DCF’s contractual relationship with these programs?



The report includes findings related to the questions above and specifically assesses the following ILC practices: program structure, use of evidence-based treatments (EBTs) and milieu models, populations served, and workforce development. Equity and disparities are considered across research questions. The report concludes with recommendations for strengthening the state’s ILC services. As requested, given the contractual relationship DCF has with many EDT programs (see section on ILC in Connecticut) and the availability of data through DCF’s Provider Information Exchange (PIE) database, specific findings and recommendations related to EDT are emphasized, and Appendix A provides an analysis of EDT service data.

Note that this report is being developed within the context of changes in behavioral health needs and services following the COVID-19 pandemic. These include increasing behavioral health needs among youth, as well as changes in the workforce. It cannot be understated that this review has been conducted during a national behavioral health workforce shortage, which has had an extensive impact on all levels of care, including ILC, even causing temporary closures of some programs. These challenges have likely influenced some of the findings. Recommendations provided within this report will be most impactful by simultaneously addressing the overall children’s behavioral health staffing shortage.

METHODOLOGY

The findings and recommendations presented in this report have been developed using the following methods: **(1)** a comprehensive literature review of ILC implementation; **(2)** a survey of program leadership and staff at ILC programs serving children in Connecticut; **(3)** a focus group with members of the ILC workforce; and **(4)** analysis of EDT data provided by DCF.



Literature Review. In 2022, Dr. Childs completed a report on best practices based upon a comprehensive review of ILC empirical research and grey literature.⁵ The review identified information related to program models and treatment components, use of evidence-based treatments and milieu models, child outcomes, diagnoses and psychiatric presentations treated, equity in outcomes, staffing competencies and training needs, and cost savings. Following an initial screening of the literature, 61 articles were found to meet the criteria for inclusion in the review. The review was critical in developing the recommendations in this report, including the finding that many gaps remain in our collective understanding of ILC best practices. These gaps included a lack of research regarding outcomes for children of color, children from low-income families, sexual and gender minority youth, children with developmental and/or intellectual disabilities, and children with substance use disorder, as well as findings related to virtual settings, dosage of treatment components, cost-effectiveness, and long-term outcomes for children. Overall, there was substantially more literature devoted to PHPs and IOPs, limited PRTF research, and only a very small number of articles focused on EDTs.

Surveys. Two surveys were developed and distributed to ILC programs serving children across the state between February and April 2023. Staff from DCF and Carelon Behavioral Health, the administrative services organization (ASO) for the state's Behavioral Health Partnership, identified primary contacts for 42 ILC programs and encouraged responses to the surveys. During the initial outreach, two programs reported being closed due to staffing challenges.

The first survey was a program-level survey intended to be completed by program directors or supervisors. It solicited information regarding overall program

staffing, treatment components, populations served, care settings, standardized use of EBTs and measurement-based care, training, and general strengths and challenges experienced by the programs. The survey had a 50% response rate overall (21 of the 43 programs included in the survey distribution submitted a completed response). Response rates varied by program type [EDT (47%); IOP (65%); PHP (33%); PRTF (25%)].

The second survey was of ILC program staff, inclusive of all licensed and non-licensed staff with a direct role in the care of children. Program staff emails were provided to CHDI by program supervisors (99 staff were identified through this process). Programs and staff were given two months for completion of the surveys, which included multiple reminders and gift card incentives for two randomly selected respondents from each survey.

The staff survey had a 33% response rate. It is likely that the relatively lower response rate was reflective of the staffing challenges and high caseloads reported. Most staff respondents were from EDT and IOP programs (21 and 12 responses, respectively). PHP and PRTF had limited representation (three and two responses, respectively). Note that five staff worked in more than one program type. The staff survey included questions regarding the respondents' own demographics, professional background, experience being trained and implementing EBTs, other training completed and preferences for future training opportunities, reasons for staying in their position or seeking new employment, and their thoughts on the general strengths and challenges of the programs. The survey included portions of the *Current Assessment Practice Evaluation – Revised (CAPER)*, which asks questions regarding their use of standardized measures. It also included questions from the *Turnover Intention Scale (TIS 6)* regarding their job satisfaction and interest in staying in or leaving their current position. *Given the response rates, staff responses should be interpreted cautiously and not as representative of all ILC staff in Connecticut.*

EDT Data. DCF-funded behavioral health programs are required to enter child-level data into DCF's Provider Information Exchange (PIE) database. CHDI analyzed PIE data from EDT services provided between July 1, 2018, and June 30, 2023. An analysis of this data was conducted using SPSS v.29. EDT services provided during this timeframe consisted of 2,568 episodes of care for 2,364 unique children served by 11 programs across 18 sites. The data were analyzed to assess populations served, service characteristics, and outcomes. Across the analysis, equity and disparities by race and ethnicity were assessed and included within the report as available. While relevant information from the analysis is included throughout the report, detail from the full analysis is provided within Appendix A.

Focus Group. A focus group of ILC staff was conducted in September 2023 with six staff from five different agencies. The participants included one administrator, four clinicians, and one in a direct care (non-licensed) role. Five of the participants worked in EDT programs, and one in an IOP program; one of the EDT staff had also previously worked in an IOP program. The topics discussed in the focus group included strengths and challenges experienced within the programs and explored the relevance of draft report findings and recommendations with the participants' own professional experiences.



Intermediate Levels of Care in Connecticut

There are 66 ILC programs serving children in Connecticut** (25 IOP, 13 PHP, 23 EDT, and 5 PRTF).

Both hospitals and community-based providers offer ILC services, and many agencies and sites offer more than one program type. Appendix B includes a map of all programs throughout the state identified as accepting Medicaid reimbursement during a scan in the summer of 2023. DCF funds grants to 11 EDT provider agencies (18 sites) and provides training, monitoring, and reporting on contract deliverables. DCF also facilitates opportunities for peer-to-peer learning and support across agencies. DCF directly operates two of the five PRTF sites in the state: Solnit North (for male youth) and Solnit South, which maintains both co-ed and female-only units.

Carelon Behavioral Health is the state's ASO for the three state agencies that make up Connecticut's Behavioral Health Partnership (BHP): DCF, Department of Social Services (DSS), and Department of Mental Health and Addiction Services (DMHAS). In its role as ASO, Carelon works to develop an integrated behavioral health system for Medicaid (locally known as HUSKY) and DCF's Limited Benefits members. Relevant to this report, Carelon establishes care guidelines as program requirements for Medicaid reimbursement. They also provide quality improvement support to programs. A summary of Carelon's care guidelines is provided in Table 1 and is largely reflective of the broader literature on ILC program requirements.⁵

	Treatment Model	Target Length of Stay	Acuity
EDT	<p>≥3 hrs/day; 2-5 days/wk ≥2.5 hrs therapeutic services</p> <p>Recreational therapeutic services are primary focus; client may require medical observation, monitoring, or adjustment</p>	Up to 6 months	Moderate symptoms; symptoms are persistent in nature; may have been unsuccessful in shorter-term or other community-based programs
IOP	<p>≥3 hrs/day; 2-5 days/wk ≥2.5 hrs clinical services</p> <p>Recreational therapeutic services can be incorporated; client may require medical observation, monitoring, or adjustment</p>	2-6 weeks	Moderate symptoms; does not require diagnostic work; may require medication management; may have been unsuccessful in outpatient care or is stepping down from inpatient/PHP
PHP	<p>≥4 hrs/day; 5 days/wk ≥3.5 hrs clinical services</p> <p>Recreational therapeutic services may be incorporated; client may require intensive nursing or medical intervention</p>	2-4 weeks	More severe symptoms compared to IOP guidelines; may require continued diagnostic work or medical evaluation; may have been unsuccessful in IOP or outpatient services or recently released from inpatient hospitalization
PRTF	<p>24-hour care</p> <p>Individual, family, and group therapy, parent guidance, must include schooling</p>	15-30 days for diversion from inpatient; 30-120 days for step-down from inpatient	Comparatively severe symptoms; less restrictive than inpatient hospitalization, but more intensive than residential, community, or home-based treatment

*Throughout the document, "community-based" is used to refer to programs that are provided in a clinic or other site that is not a hospital setting.

**Program count at time of analysis in preparation for this report.



Nationally, ILC use is increasing among youth.

Per the 2020 National Mental Health Services Survey (N-MHSS), **26.7% of youth using outpatient services received them in an ILC setting**⁷ (PRTF not included in this ILC criteria), which is an increase from 23.2% reported in the 2018 survey.⁸ **In Connecticut, ILC programs have served more youth over the past two years, but have not yet returned to pre-pandemic levels** (see Figures 1 and 2).⁹ EDT services, in particular have not rebounded. In clarifying discussions during an EDT provider group meeting, providers reported this decline was due primarily to **staffing shortages with both clinicians and drivers who transport children to EDT sites**. Because EDT is primarily an after-school program, drivers are necessary for getting children from their school to EDT sites. Providers also reported that the history of long EDT waitlists has deterred some referral sources from continuing to contact EDT providers, and multiple agencies stated that they would like to receive more (and more appropriate) referrals directly from DCF regional offices.

Figure 1: CT Medicaid-Enrolled Youth Discharged from ILC Programs

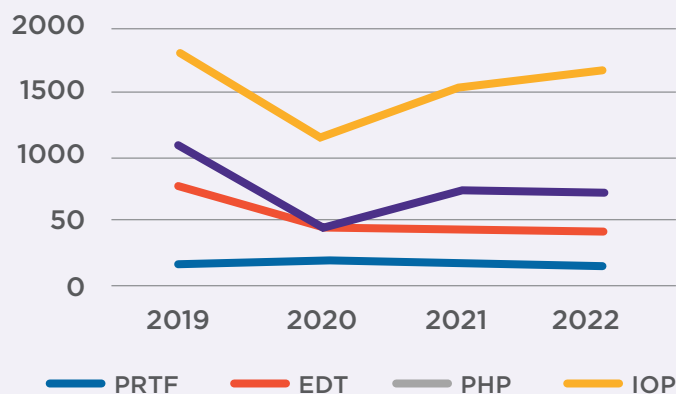
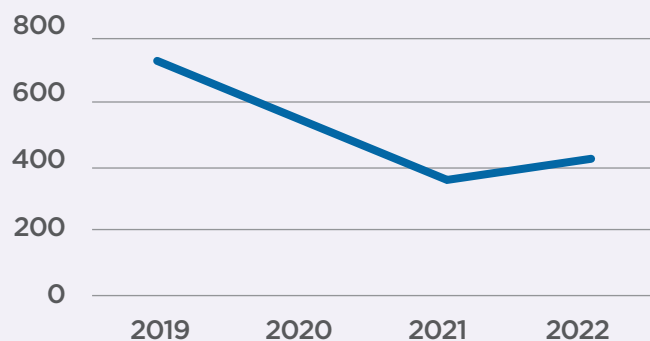


Figure 2: Youth Discharged from DCF Funded EDTs (All Insurance Types)





Overall, for ILC programs, demand appears to outpace capacity; a BHP report in 2021 found that inpatient care providers had challenges finding step-down care availability at PRTF, PHP, and IOP programs,¹⁰ with staffing challenges causing reductions in available care, waitlists, and delays in discharge from inpatient care settings.⁹ Multiple respondents to a survey regarding the state’s children’s behavioral health workforce conducted by CHDI in the spring of 2023 provided unsolicited comments regarding the need for ILC services to reduce challenges with throughput in the system and improve appropriate placement based on acuity.

As part of a separate project, CHDI recently surveyed Mobile Crisis staff regarding barriers they’ve encountered to referrals at discharge. The majority of respondents (n=73) reported challenges with referrals to each of the ILC services, with the most commonly cited barrier

to services being waitlists. IOPs had the highest rate of respondents reporting waitlists as a barrier (85%), followed by EDT (71%), PHP (64%), and PRTF (58%). The next most common barriers associated with these types of services were barriers encountered by the family following a referral (e.g., transportation, insurance denials, scheduling conflicts), followed by ineligibility due to age, and finally, the service not being available within the given region (i.e., distance from the family’s residence). In an analysis by region, all regions report barriers related to waitlists (with the lowest rates reported in the western region); however, staff from the eastern region were more likely to report that the services were not available within the region.

More systematic collection of staff vacancies, referral, and waitlist data is needed to clarify whether the delays in care are related to staffing shortages, eligibility criteria, or an actual need for additional ILC capacity.

Table 2: Statewide Barriers to Referrals Upon Discharge from Mobile Crisis

	Type of Barrier Experienced by Mobile Crisis Staff							No Barriers Experienced
	Waitlist	Distance	Referral Not Accepted	Barrier to Family	Ineligibility Due To:			
					Age	ID/DD/ASD	SUD	
PHP	64%	23%	23%	38%	38%	12%	3%	12%
IOP	85%	19%	19%	40%	48%	10%	4%	4%
EDT	71%	15%	12%	38%	25%	7%	3%	7%
PRTF	58%	16%	18%	15%	18%	8%	0%	11%

Findings Demonstrate Strengths and Opportunities

The following section reflects responses to the Connecticut ILC program and staff surveys, as well as EDT data analysis and focus group findings. Recommendations and best practices from the broader ILC review are included as available. Note that while the majority of survey responses were from IOP and EDT programs and staff, the literature review found more research had been conducted on PHP and IOP programs than EDT and PRTF. Literature regarding IOPs and PHPs, given their similar program structures, tended to have similar findings. Cross-cutting findings across ILC types are included, but differences by program type are noted when relevant.

Program Structure

PHP and IOP have similar treatment models (see Table 1) with differences pertaining to dosage, length of stay, and acuity. Both may be used as step-down care from psychiatric inpatient care or can receive referrals directly from outpatient services or other community-based programs. Based upon both the Caredon Level of Care Guidelines and the program survey responses, Connecticut IOPs and PHPs appeared to align with the broader literature on these programs' structures and treatment components. These programs focus more on clinical interventions (individual, group, and family therapy) with less art or recreation therapy included. Medication management, care coordination, and skill building/psychoeducation for children and caregivers are common program components as well.

Most programs within Connecticut reported providing services on-site and in-person. There was very little variation in setting and, at the time of the survey, limited use of telehealth. On average, when fully staffed, IOP and PHP programs can serve 31 children at any given time, with an average of 12–15 hours per week of treatment provided per youth. The average length of stay is 6–12 weeks. Based on the staff survey, caseloads ranged from 12–16 youth per clinician.

Implementation of EDT programs varies more than that of IOP and PHP, including the number of hours of intervention as well as the setting (i.e., on-site, client's home, etc.).¹¹ The limited literature on EDT demonstrates a greater focus on recreational therapy than clinical treatment, and addresses children's skill building and integration into community, school, and home. Focus

group participants from EDT programs identified additional (and varying) components of their program models that included both direct provision of basic needs (e.g., meals for families) and extended recreational activities such as field trips. They also noted the use of private donations and grants for funding these services. Note that data collected through PIE are not detailed in regard to services provided (e.g., hours of therapy, etc.), so it is not possible to assess this aspect of EDT services with existing data.

Per responses to the survey, youth in most EDT programs in Connecticut spend most of their time in group and recreational therapy (e.g., physical activities, art, games, etc.). All programs have at least one hour per week of family therapy, and most provide at least one hour per week of individual therapy. They also offer medication management and extensive coordination with other providers, schools, families, and relevant systems. The majority offered most services in-person at the provider's location. Despite the additional flexibility in the program model in general relative to PHP and IOP, EDT programs reported very little variation in setting and limited use of telehealth. EDT programs have a similar average capacity as IOP and PHP (an average of 30 children when fully staffed). The average number of hours of treatment was higher for EDT than IOP and PHP (an average of 15–17 hours per week of treatment, which is primarily group and recreational therapy), a much longer average length of stay (six months per survey responses; and a median 170 days per FY 2023 PIE EDT data), and a lower caseload (maximum of four children per direct care staff and maximum of eight children per clinician).

Nationally, PRTFs are commonly used for children involved in the child welfare system.¹² While PRTF settings provide 24-hour care, they are intended for youth with lower acuity than those appropriate for inpatient hospitalization. The shift over the last two decades toward more community-based interventions and the use of wraparound services to prevent out-of-home placement has called the need for PRTF beds into question in some states.¹³ Consistent with Connecticut's care guidelines, PRTFs typically have longer lengths of stay and more engagement with families and other community partners than inpatient hospitalization.¹² The PRTF program response reflected a capacity similar to that of the other ILC program types and a length of

stay consistent with the broader literature (over four months).

One aspect of program implementation that was not clear from the survey but was raised in the focus group was access to thorough diagnostic evaluations upon intake. All participants raised this as either a need or a strength of their program. Some programs had access to a psychiatrist to complete a full diagnostic and medication evaluation. Other programs did not have sufficient availability of staff who were trained to complete a full diagnostic evaluation, experienced significant wait times prior to the diagnostic evaluation, and/or had challenges gaining trust in a psychiatric evaluation among families who did not want medications.



Populations Served

Demographics. White youth were over-represented in the available literature and are also over-represented among Medicaid member youth in ILC programs in Connecticut (see Figure 3).^{14,9} Unfortunately, the proportion of children of color served by these programs is not well documented in the literature nor is ILC's effectiveness across racial and ethnic groups. Data on the race and ethnicity of Medicaid-enrolled youth is collected, analyzed, and discussed as an area for quality improvement by the BHP in their role working with providers and similarly by DCF's program staff when working with EDT providers. While multiple racial and ethnic categories are included within BHP data generally, publicly available data focused on the proportion of White youth receiving services versus the overall Medicaid population and the over-representation of White youth within programs. It should be noted that the race and ethnicity of more than 50% of Medicaid-enrolled youth are unknown, creating challenges with assessing equity in access and utilization of services. Therefore, the data presented below should be an indicator that there appear to be disparities in youth

served by ILC programs in the state; however, the gap in available data presents challenges in fully identifying and addressing disparities across these services.

EDT programs in Connecticut, in contrast, tend to serve a greater proportion of Black non-Hispanic and Hispanic youth than the general state population (see Figure 4; PIE data). Note that a significant percentage (14% in 2022)[†] of youth do not have race or ethnicity reported. In examining available data on referral sources to EDTs, the most common referral sources are other programs within the same agency and other community-based agencies. Black children, however, tend to have higher rates of referrals from schools and DCF as well as self-referrals by families than do White or Hispanic children (in FY 2023, schools made up 18% of referral sources overall but over 40% of Black children's referrals; this pattern is consistent in prior years, however the disparity less stark). Hispanic children have a greater likelihood of a referral coming from other programs within the agency.

Figure 3: Proportion of Medicaid Enrolled Youth Served Who Are White (2022)

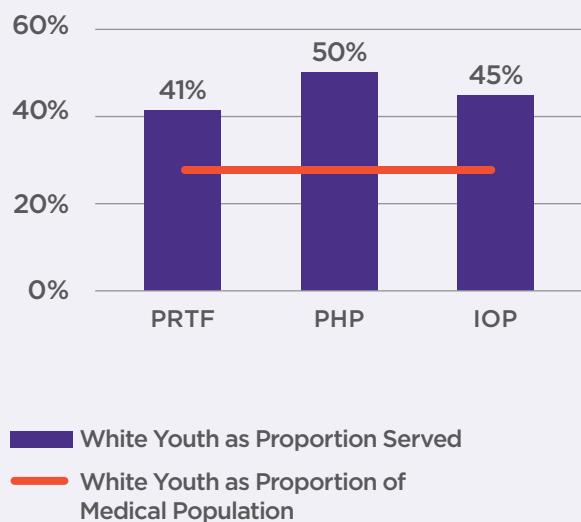
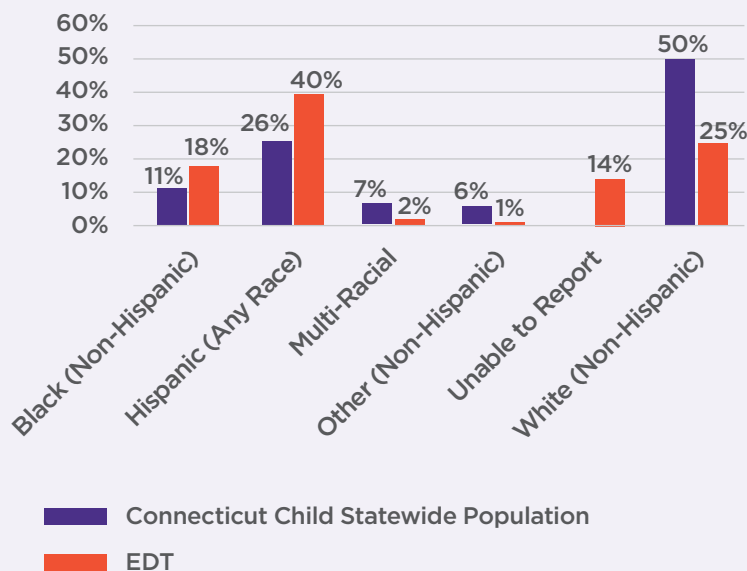


Figure 4: Race and Ethnicity of Children Served in EDT (All Insurance Types; 2022)



[†]Note that in most use of EDT data in this report, data is reported by the fiscal year. In order to be consistent with the demographic report of other ILC program types in Connecticut, however, the data in Figure 4 is reported by the calendar year (January 1, 2022 – December 31, 2022).

EDTs tend to serve children demonstrating persistent behavior problems that cannot be easily addressed through shorter-term programs, such as IOPs or PHPs.¹¹ The broader behavioral health literature demonstrates racial disparities in diagnoses by clinicians and similarly by school staff, with both identifying more externalizing behaviors among children of color (e.g., White children tend to be diagnosed more with depression or anxiety and Black children are more likely to be diagnosed with behavioral or conduct problems).^{15,16} While it is a positive finding that statewide EDT programs are serving a racially and ethnically diverse population of children, in light of broader literature on diagnosis bias and the disparities across EDT referral sources, it is possible that structural racism and/or personal bias may be having an effect on referrals and/or diagnoses of Black children in EDT.

Within the literature, PHP and IOP programs tended to serve children among their similar-aged peers. Most studies were of programs serving children over the age of 13, with some serving 6–13-year-olds.⁵ Based upon survey responses, IOPs and PHPs in Connecticut are also mostly serving 13–18-year-olds, with at least half of all children served being within this age group for 82% of programs. There were very few children of other age groups served by IOP/PHPs (this was a barrier noted by Mobile Crisis providers, see Table 2). PRTF tends to be used nationally for older children,¹⁴ but must serve children under the age of 21 to be Medicaid-eligible.¹⁷

EDT programs are serving younger children to some extent. EDTs reported that 6–12-year-olds made up at least 50% of children served; 0–5-year-olds, while eligible, were rarely served. Finally, 16–18-year-olds were ineligible for most programs and rarely served in the others. Per EDT data, the median age of children served was consistently 10-year-olds between 2019 and 2023 (without much variation by race or ethnicity). Across providers, however, there is variation, with median ages ranging from 8–13 years in calendar year 2022.

The limited literature regarding ILC services for LGBTQ+, nonbinary, and transgender youth found mixed results in regard to clinical outcomes.^{18,19,20} Strengthening services for these youth has also been identified by the BHP as a focus within Connecticut programs,¹⁰ and generally is an area for growth in behavioral health care.²¹ For PRTF, in particular, given that Solnit campuses were traditionally separated by sex, there was a lack of clarity on how

non-binary and transgender youth could be placed at Solnit. A process is now in place that allows Solnit to identify on a case-by-case basis where the child will be most comfortably served.¹⁰

DCF's PIE database does allow for the collection of gender in addition to the sex of children; however, only about 30% of children had gender identified in the last fiscal year's EDT dataset. Among those, two children identified as transgender. Given the higher rates of behavioral health needs reported by LGBTQ+ youth, including those within Connecticut,²² services would benefit from additional research and consistent data collection regarding services for LGBTQ+ youth.

Presenting Concerns/Diagnosis. Most of the available PHP and IOP literature was related to programs serving transdiagnostic populations, particularly adolescents. They tended to be effective in addressing internalizing symptoms, specifically in reducing symptoms associated with anxiety, depression, general emotional problems, and overall distress. There is also some evidence that PHP is effective in treating youth with high levels of exposure to adverse childhood experiences.⁵ For programs designed to serve children with specific diagnoses, literature on effective PHPs included those with a focus on eating disorders (and with co-occurring disorders),²³ mood disorders,²⁴ as well as one demonstrating promising results serving children with co-occurring medical complexities and behavioral health diagnoses.^{25,26,27} In IOPs there has been some indication of effectiveness for disruptive behavior disorders,^{28,29,30} but with possible diminishing outcomes over time.²⁸ There are programs that commonly admit for obsessive-compulsive disorder (OCD) and are effective, as well as OCD-focused programs that were found to be effective.^{31,32,33} Positive outcomes have also been found for IOPs serving children with eating disorders.³⁴

Based upon survey responses, generalized anxiety and depression are the most common diagnoses of children treated in most Connecticut IOP and PHP programs (reported as a diagnosis for the majority of children in 91% of programs). The next most commonly treated diagnoses were mood disorders (the majority of children in 62% of programs) and post-traumatic stress disorder (PTSD) (77% of programs reported half or more of children served were diagnosed with PTSD). While four programs stated they do not accept children with SUD or co-occurring disorders, about half the programs (46%)

served children with SUD. Children with ODD were served by 62% of programs. ASD and OCD were each only treated within one program, and the programs each reported very few children with these as primary diagnoses.

In the limited literature on EDTs, they often serve children who have longer histories of behavioral health needs or have diagnoses that require longer lengths of stay.¹¹ On a survey of EDT programs, the most common primary diagnoses reported were attention deficit hyperactivity disorder (ADHD), PTSD, depression, and mood disorders. SUD often makes children ineligible for treatment (reported by 62% of programs) and was seldom or never treated by the others. No programs reported ASD or OCD as primary diagnoses. DCF's EDT data had similar findings, with ADHD accounting for 34% of primary diagnoses in FY 2023, followed by disruptive mood disorder (13%) and major depressive disorder (9%). Unlike reports on the survey, PTSD accounted for only 5% of primary diagnoses per FY 2023 data (rates in prior years were similar). In reviewing data on primary presenting problems, disruptive behavior was the most common (36%), followed by ADHD (14%). This is consistent with the broader literature regarding the use of EDTs for externalizing behaviors. The data also demonstrated disproportionate rates of disruptive behavior being identified as the primary presenting problem among Black children served in the programs (48%), compared to 37% for Hispanic children and 39% for White. As discussed earlier, this is consistent with the literature on bias in identification of externalizing behaviors.¹⁶

One study of children served in PRTFs who had Medicaid coverage found the most common diagnosis to be major depression and affective psychosis, followed by conduct disorder.¹⁷ Per the only PRTF survey response, ADHD, depression, generalized anxiety, mood disorder, oppositional defiant disorder (ODD), and PTSD were all reported as commonly treated. Substance use disorder (SUD) was treated for very few children, and autism spectrum disorder (ASD) and (OCD) were not reported as treated.

ASD, other developmental disabilities (DD) and intellectual disabilities (ID), as well as high risk for suicide, are common exclusionary criteria in the literature and generally were not served within programs in Connecticut. One article noted that suicidal thoughts and PTSD were associated with the highest rates of PHP readmission.³⁵ Another study, however, found that an



IOP with a focus on youth with a high risk for suicide was found to have promising outcomes,³⁶ as was one designed specifically for children with ASD or ID.³⁷ The lack of behavioral health services for children with ASD, DD, and ID and associated workforce competencies for supporting children with these diagnoses is raised regularly as a concern within the state. It would be beneficial to explore how to effectively serve these populations of children within Connecticut's ILC programs.

Evidence-Based Treatments and Measurement-Based Care

Evidence-Based Treatments. The literature review found only scattered information on the use and effectiveness of evidence-based treatments (EBTs) within ILC settings. The following provides a summary of the findings that have appeared in the literature to date. Research has found effectiveness associated with the use of dialectical behavioral therapy (DBT), acceptance and commitment therapy (ACT), and cognitive behavioral therapy (CBT) in PHPs.⁵ DBT was found to be more effective in symptom reduction than treatment as usual in one PHP study.³⁸ DBT, ACT, and CBT were also found to be effective for use in IOPs.⁵ Exposure and response prevention therapy (ERP) was found to be effective in the treatment of anxiety, and the use of CBT and ERP were found to be effective in OCD-focused IOPs.^{39,31,32,33} Evidence associated with the use of milieu models was a gap in the literature.

Per the survey results, 90% of ILC programs reported using at least one EBT. DBT was the most commonly used EBT (by over 40% of programs), Attachment, Regulation, and Competency (ARC) was used by 26%, and CBT was used by 15%. Of note is that while PTSD was a common primary diagnosis, limited use of EBTs designed specifically for treating PTSD were used [e.g., Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)]. A milieu model was used in 27% of IOPs and PHPs. Each was using a different model, including Risking Connection, Collaborative Problem Solving, and Restorative Approach. Most programs reported making some modifications to the EBTs used. The most cited barriers to using EBTs included a lack of resources for training staff, consultation, and/or materials. The majority of respondents to the staff survey reported having no EBT training.

All EDT programs report using at least one EBT. The most commonly used EBT was CBT (data from 2022 reflected use with nearly 50% of children), followed by DBT (nearly 30%). While it was not mentioned in the survey, per the EDT PIE data, approximately 14% of children received solution-focused brief therapy, and a very small number of children received TF-CBT. The milieu models Playmakers and Risking Connection were regularly reported as being used in the programs (training on these models is directly funded by DCF). Most staff report making modifications to any EBTs used in the program at least some of the time. About 50% of EDT staff reported being trained on an EBT; this is

greater than IOP/PHP staff. The longer length of stay for EDT programs, as well as state grant funding, may offer a more supportive climate for EBT implementation in EDT programs than in other ILC program types. EDT data from PIE also demonstrates that most children receive an EBT. The most commonly used EBT programs reported in PIE in FY 2023 were CBT (48%), followed by DBT and motivational interviewing (MI).

A systematic review of PRTFs in 2020 found limited research on the use of EBTs in this level of care but did find studies with positive results associated with the use of CBT-based treatments, including TF-CBT.¹² The only program-level response from a PRTF program reported the use of CBT and DBT. Two of the three PRTF responses to the staff survey included that they did not have training on EBTs. All staff responses reflected an interest in receiving EBT training and a preference for asynchronous training opportunities.

Measurement-Based Care. Measurement-based care (MBC) is the routine use of patient-reported outcome measures to engage service recipients in collaborative decision-making and treatment planning and has demonstrated positive outcomes when used in behavioral health services.⁴⁰ Staff reported some use of measures at intake for individuals. More staff at IOP programs reported using measures at intake than did staff at EDT programs (60% vs. 43%). Regular use of standardized measures to track progress with clients was much less common than use at intake. Only 52% of staff responded that they administered a standardized measure during treatment to any clients, and only 27% of staff reported any regular adjustments to treatment plans based on assessment data. Among the staff either using standardized measures during treatment or adjusting treatment plans, it was typically only for some (less than 40%) of clients.

Generally, among PHP and IOP programs in the state, outcome data used at a program level include data on successful discharge, and many also use symptom improvement outcomes and attainment of treatment goals. For EDTs, aggregate data on symptom improvement is used, and about half of programs use treatment goals and include measures of family engagement. Some EDT programs also use data on successful discharge. The limited research on PRTFs

indicates that it is not common for clinical measures to be systematically used in tracking progress or adjusting treatment. The staff survey responses indicated that measurement-based care was not used in practice but did report that they had been trained in it. The literature referenced a need to continue this research and strengthen the evidence base for PRTF (and other

residential program) implementation to demonstrate reasons for not keeping children in community-based services.⁴¹ Systematic use of measures by clinicians in clinical practice (e.g., MBC) as well as programs (e.g., aggregate data for program evaluation and quality improvement) is an area to strengthen across ILC programs.



Caregiver and Community Engagement

Psychoeducation and skill building for parents and caregivers, as well as family therapy, are common components of ILC services within Connecticut and beyond; however, implementation is not consistent. Literature on the use of parent or caregiver training, while not extensive, did indicate associated positive outcomes (e.g., parent training within PHPs was associated with reduced rehospitalization).⁴² No programs reported using an EBT for family therapy or caregiver training. Challenges with engaging caregivers in services have been identified both within the literature⁴³ as well as in Connecticut.¹⁰ In speaking with the parent of a child who had received services in PHPs and IOPs in Connecticut, the parent felt that family therapy during services and post-discharge was an area to strengthen and that family therapy was critical to success. The availability of family therapy for this parent had varied by provider and was never available as part of a discharge plan. The parent sought an outside provider for family therapy to support the child's step-down to outpatient services.

Generally, caregiver engagement is used by EDT programs as an outcome measure (50% reporting tracking it), but is only used by 10% of the other ILC programs. Participants in the focus group from EDT programs reported family engagement as one of the key strengths of their services, although the types of activities varied across participants. Some programs reported using private donations to support supplemental services for families, such as meals, recreational activities, etc.



Workforce Development

Staffing. Per the literature review, ILC programs generally use a multi-disciplinary staffing model, with a psychiatrist as director of the program, licensed supervisors and clinicians, an advanced practice registered nurse (APRN) or psychiatrist (staff or consultant) for medication management, and a variety of direct program staff, such as care coordinators, peer supports, community health workers, discharge planners, and/or other direct care staff positions. Connecticut staffing models are similar, with peer support but not community health workers nor care coordinators reported as part of staffing.⁴⁴

Consistent with other levels of care in the state, most programs reported being short-staffed, particularly among clinical and program/direct care staff. On average, EDTs reported being short 36% of their staff, IOPs short 23%, and PHPs down 37%. Across programs, almost no change to programming was reported (e.g., hours of group therapy, etc.) due to staffing challenges. Supervisory and APRN or psychiatrist positions were less likely to be vacant. Staffing shortages, as referenced earlier in this report, impact access to care. Per the survey, programs reported a 2-6 week wait for children to start services. EDT data similarly showed a median of 26 days between referral and start date for children who received services in FY 2023, with longer waits for Black and Hispanic children. When participants in the focus group were asked what programs could do to improve support to them in their roles, increasing staffing and reducing caseloads were the most common responses.

Per survey responses, ILC programs appear to have more diversity among their staff than among licensed behavioral health providers generally in the state.⁴⁵ Hispanic/Latinx staff are underrepresented compared to the overall state population, and staff of color are underrepresented among the program leadership responding to program surveys. Women comprised 88% of all respondents to the staff survey. Staff respondents were 52% White non-Hispanic, 21% Black non-Hispanic, and 15% Hispanic/Latinx. Less than one-fifth reported being bilingual, with 18% speaking a language in addition to English. Most (68%) of respondents to the program-level survey (reflecting program managers or directors) were non-Hispanic White women. As with other levels of care, diversifying the ILC staff, supervisors, and leadership remains an area of improvement in the state.

Most staff report having work environments that are supportive, fair, and flexible in accepting new ideas. They report that their agency takes quality seriously

and that the program provides high-quality services. Staff-reported opportunities for improvement included agencies needing to become nimbler and more responsive in making changes and better organizational planning. It appears that the majority of staff surveyed are receiving regular supervision (reporting an average of four hours/month).

Most respondents report at least some level of satisfaction and fulfillment and look forward to working at least some of the time, and most would be unlikely to leave their job for another opportunity with the same level of pay. There were noted differences in response to this question between EDT and IOP (67% and 100% unlikely to leave, respectively). Despite having some levels of satisfaction and fulfillment, and positive aspects of the work environment, many respondents reported considering leaving their job at least sometimes, with 24% considering it always or almost always. This was again more predominant among EDT staff than IOP staff (43% some of the time and 33% almost always or always vs. 25% some of the time and 8% almost always or always, respectively). More than half of the staff report frustration with being able to reach personal work-related goals. Across the scale, indicators of turnover intention were rated higher by EDT staff than IOP staff. Across all staff, 31% report that vicarious trauma has increased since the pandemic.

Training. Programs reported that staffing shortages had an impact on their ability to send staff to training. Per the staff survey, the average number of hours of training received varied between EDT and IOP. EDT staff averaged more in-person or live and more asynchronous hours of training than IOP staff. Overall, staff regularly reported getting trained in crisis safety planning, suicide assessment, crisis stabilization, and treatment planning. EDT staff had also been trained on cultural humility, administering measures, and self-care, and IOP staff were more likely to have had training on trauma screening. Responses to the staff survey indicated that staff are open to and interested in receiving more training. Desired training includes EBTs and training on single-session/brief interventions (over 80% of staff identified these as priorities). Training on first-episode psychosis was also desired across programs, while IOP staff identified foundational therapeutic skills, vicarious/secondary trauma, and cultural humility as of interest. EDT staff identified training on working with children with DD and/or ID, as well as training on MBC as a priority. EDT staff were split regarding preferring live online or in-person vs. asynchronous training. IOP staff had a slight preference for asynchronous training.



Strengths

This review found many strengths across Connecticut's ILC programs and their staff.

Strengths included:

1. Program implementation largely aligns with the broader (but limited) literature and the state's level of care guidelines in regard to treatment components, dosage, and length of stay.
2. There is some use of EBTs in ILC programs (and regularly within EDT programs) despite this not being common within the broader literature.
3. EDT programs are serving a population of children that is racially and ethnically more diverse than the state population, and DCF data demonstrate positive outcomes for symptom improvement, with even greater improvement among children of color (see Appendix A).
4. Staff reported dedication to and collaboration with families (particularly among EDT programs).
5. Staff report having supportive work environments, and an interest in attending more training.

Challenges

Many of the challenges identified are system level (common across levels of care in the state) and/or mirror broader literature on ILC services.

Challenges include:

1. Programs are in high demand but are operating with significant staffing shortages and in turn, experiencing waitlists and staff burnout.
2. There is limited racial, ethnic, and linguistic diversity among staff and program leadership as well as among children (with the exception of EDTs).
3. There is limited access to services for youth with ID, DD, or ASD diagnoses.
4. While there is some implementation of EBTs within Connecticut ILC programs, there is no standardized use of EBTs for individual therapy, family therapy, or milieu models.
5. There is very limited use of MBC.
6. Staff report limited opportunities for training (among IOPs and PHPs particularly).
7. While there is some quality improvement support from DCF and Carelon, there is an opportunity for a coordinated, continuous quality improvement structure to support more standardized training and data reporting to evaluate and improve outcomes for children.

EDT-specific challenges included:

1. Inconsistent access to comprehensive diagnostic evaluations.
2. Variation in family engagement strategies.
3. EBTs were implemented at lower rates for children of color than for White children in the program.
4. There were lower rates of job satisfaction reported among EDT staff than staff from other ILC program types.

Recommendations to Strengthen Intermediate Levels of Care in Connecticut

SYSTEM IMPROVEMENTS

1. Address the Workforce Shortage

There is a statewide (and national) shortage in the behavioral health workforce that is impacting services for children. Based upon the survey results, one-third of positions on average are vacant at ILC programs. Without long-term investments in the broader workforce needs, including issues related to the workforce pipeline, recruitment, retention, and diversity, improvements to ILC programs will be challenging to implement, if not impossible. Strengthening the quality of care, training staff, expanding capacity, etc., are dependent on fully staffed programs. Other efforts are in progress to identify recommendations related to workforce development ([see recent related report](#)). It will be critical to address this systemic issue in order to strengthen ILC services.

2. Increase Capacity and Availability of Intermediate Levels of Care for Children

There appears to be more demand for ILC services than availability, with programs reporting a two to six-week wait for services and historically similar or longer waitlists; these waitlists delay care for children entering ILC programs but also create problems with throughput across services in the system overall. For example, a wait for ILC availability for children being discharged from inpatient hospitalization to ILC can delay their discharge or result in them instead being placed in an inappropriate level of care for their needs, such as outpatient care. Similarly, children whose needs require them to step-up from outpatient care but must wait weeks for an ILC opening may end up in the emergency department instead. The state should invest further in additional ILC services in the eastern and western parts of the state where there is less availability of ILC programs currently.

While not specifically addressed within this report, there are also home-based ILC program models. Criteria that further clarifies eligibility as well as most appropriate program model and setting for children based upon their diagnosis, presenting problem, family dynamics, and other factors would benefit programs and families. Overall, additional information will need to be collected to determine what specific type(s) of additional ILC programs are needed in the state. To fully identify and address concerns regarding the availability and accessibility of services, the subsequent two recommendations must be addressed.



3. Improve Data Collection, Reporting, and Continuous Quality Improvement

Systematic data on referrals, services received and declined, waitlists, and staffing vacancies need to be collected and analyzed statewide to determine what additional capacity is needed across ILC programs. While it is clear that ILC services are in demand and that there are waitlists and delays in timely care, it is unclear to what extent delays are to be attributed to staff shortages, exclusionary criteria, and/or a general need for additional programs. There is also not currently consistent information about waitlists or service availability across ILC programs that is available for the public, referrers, or system leaders to monitor capacity and needs.

Both DCF and Carelon provide quality improvement services to ILC programs in the state. There appears to be opportunity, however, to improve data collection, analysis, and reporting across programs and to develop a mechanism for a coordinated and systematic statewide continuous quality improvement mechanism across ILC services. Individual providers should be involved in the review of program and site-level data, establish goals, and engage in feedback sessions regarding their progress. This should be inclusive of outcome data (changes from intake to discharge as well as long-term outcomes post-discharge) to inform program improvement, improve the service system, and contribute to the understanding of these levels of care in the broader field. Standardized data reporting could also be considered for public use and to inform state-level improvement efforts.



PROGRAM IMPROVEMENTS

4. Expand Training on Evidence-Based Treatments and Milieu Models and Implement as Standard Programming

It is a strength of the system that EBTs are being used in some Connecticut ILC programs and that staff report an interest in more EBT training. There is a need to increase staff training on EBTs (most staff are not trained) and to make EBT implementation more consistent across programs.

4a. Implement MATCH-ADTC. Given that IOPs and PHPs are most commonly treating depression, anxiety, and PTSD, and that EDT is commonly treating ADHD as well as depression, anxiety, and conduct disorder, the state should support the implementation of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH-ADTC), which treats the most common disorders and symptoms, including depression, anxiety, trauma and disruptive conduct (including conduct behaviors associated with ADHD) for children ages 6-15. There is an existing infrastructure to support training on and implementation of MATCH-ADTC in Connecticut and strong evidence of symptom improvement and satisfaction among children and caregivers, as well as evidence of reduction of treatment outcome disparities for children of color.

4b. Single-Session/Briefer EBTs. There is evidence that brief and even single-session interventions can be effective for children with a wide range of behavioral health concerns. This was one of the most requested training topics reported in the staff survey. Implementation of single-session interventions could be especially beneficial to IOPs and PHPs, which have shorter lengths of stay.

4c. Milieu Model. EDT programs reported regular use of a milieu model, while other ILC program

types did not. Risking Connection training is provided to EDT programs through DCF funding. As a trauma-informed, evidence-based milieu model, it could benefit other ILC program types. It is recommended that Risking Connection (or a similar milieu model) be expanded and piloted with other ILC programs.

4d. Family-Based Treatment. While programs reported engagement with families as a strength, no programs reported using evidence-based family therapy. There was demonstrated success from family therapy in ILC programs; however, no particular family-based treatment stood out from the literature review. It's recommended that Connecticut strengthen family engagement through training on and implementation of an evidence-based model.

An evidence-based model of family therapy, such as Brief Strategic Family Therapy, Multidimensional Family Therapy, or Functional Family Therapy, that provides treatment to the family system and has research demonstrating its benefits in improving symptoms among the populations most commonly served by ILC programs should be identified for implementation. It would also be beneficial to consider how to continue family therapy post-discharge, providing continuity of care as families are transitioning their child to lower levels of care and more time at home.

Combined, the recommended model components have the potential to provide the missing structure for ILC programs and produce strong outcomes for children and families. This is a significant shift for most programs. A slow rollout combined with both financial and programmatic support for staff training, caseload adjustments, materials, and consultation will be needed to properly support EBT implementation. See below regarding the recommendation for a pilot approach.

5. Implement Measurement-Based Care

The use of measurement-based care in ILC is minimal to none currently. MBC is an EBT that can be used regardless of the setting or population served and is associated with improved patient outcomes. MBC use may also have additional benefits in terms of more standardized data collection for program evaluation and quality improvement. Implementation of MBC should be provided across ILC programs, and efficiencies of scale can be used to minimize implementation and sustainment costs if training and quality improvement are provided across programs by a central entity.

6. Pilot Implementation of a Standardized Model

Pilot the implementation of a standardized model, reflective of recommendations 4 and 5, within at least one EDT program (and consider additional pilots in a different ILC service type). Preferably select programs that have fewer staffing challenges, are already successfully implementing Risking Connection, and have existing staff to support comprehensive diagnostics at intake and medication management since these are also important program components that require strengthening for many programs. Engage provider management and staff early in the process to inform decision-making throughout the development, implementation, and evaluation of the pilot.

Include the following program components as well as continuous quality improvement and evaluation plans. Consider a phased rollout, especially in light of staffing shortages.

- a. Implementation of MATCH for treatment of children as appropriate;
- b. Implementation of an evidence-based family therapy model; and
- c. Phased in implementation of measurement-based care.

7. Expand Other Training Opportunities

In addition to EBTs, training opportunities needed for (and of interest to) ILC staff include supporting children with developmental and intellectual disabilities, first-episode psychosis, social determinants of health, and culturally responsive training. Additionally, given the few children being treated for SUD or co-occurring disorders in these settings, juxtaposed with the rates of drug and alcohol use in the state, staff should be trained in screening and interventions for SUD, as well as treatment for co-occurring disorders.

It will be necessary for programs to receive funding for training, but also for the cost associated with covering the loss of staff time. Connecticut benefits from having many training opportunities, both live and asynchronous. An inventory of training can be considered for use by ILC staff, and any gaps identified. Flexibility in modality (e.g., live in-person, live online, and/or online asynchronous) should be offered when possible.

8. Intentionally Diversify Program Leadership, Staff, and Children Served

While there are systemic issues that need to be addressed to strengthen the diversity of the workforce, programs should implement policies and practices that expand the diversity of candidates, hires, and promotions. Programs should also work within the communities they serve to expand access and utilization and can increase staff capacity in working with diverse populations (e.g., skills related to cultural responsiveness, working with LGBTQ+ and gender-expansive youth, understanding of systemic racism and social determinants of health, etc.).

PROGRAM IMPROVEMENTS

9. Continue Review of Psychiatric Residential Treatment Facility Program Implementation

There are few PRTF programs within Connecticut and limited literature findings more broadly which have constrained this review in identifying findings specific to PRTF implementation. It would be beneficial to engage directly with Connecticut PRTF stakeholders, including program supervisors, staff, families, and youth, as well as those who regularly make referrals to PRTF (e.g., other behavioral health providers, DCF staff, and family advocates). Through a short-term workgroup, these stakeholders should solicit perspectives from out-of-state providers regarding best practices (some states have high utilization of PRTF services) and identify strengths and opportunities for improvement within Connecticut PRTFs. This process should result in a final set of recommendations specific to PRTF implementation.

11. Continue and Expand Equity-Focused Quality Improvement Efforts

DCF staff work closely with EDT providers to engage in discussions on quality improvement broadly, as well as regarding strategies for improving health equity through outreach and service delivery. This work can further incorporate PIE service and outcome data that is disaggregated to track both strengths and opportunities for improvement in reducing disparities.

12. Improve Staff Wellness and Job Satisfaction

EDT staff reported the highest levels of dissatisfaction with their positions. It is not clear what specific aspects of their role are driving these responses; however, it provides an opportunity for further engagement with programs on this issue. Through quality improvement work, DCF staff can encourage providers to strengthen staff wellness. Additionally, across the behavioral health field, there is a high report of staff burnout related to high caseloads and low salaries. As there are opportunities to improve staff shortages and increase staff salaries, EDT staff satisfaction may improve.

EDT-Specific Recommendations

In addition to the recommendations identified above that apply across ILC services, it is recommended that DCF explore opportunities through its contractual relationship with EDT providers to address the following recommendations. It is possible that supplemental grant funding would be necessary to meet additional implementation requirements.

10. Ensure Access to Staff who can Provide Full Diagnostic Evaluations

Staff in focus groups reported that not all programs had staff available to provide full diagnostic evaluations at intake. Programs should ensure that licensed masters-level clinicians on staff are sufficiently trained to provide diagnostic evaluations for all youth, and that access to comprehensive psychological evaluation is available when needed. Staffing plans across programs are inclusive of psychiatrists or APRNs for psychiatric evaluation, prescribing, and medication management. Access to psychiatrists or APRNs is particularly important given the high proportion of children with ADHD and the significant role that medication can offer in treating this diagnosis.

Connecticut's ILC programs for children have many strengths on which to build, including program alignment with care guidelines and broader literature on treatment models, program and staff dedication to delivering high-quality services, and some implementation of EBTs and engagement with families.

Expanding the state's capacity to meet the growing need for effective ILC services, meeting the ILC workforce needs, increasing use of evidence-based treatments, milieu models, and family engagement, and improving data collection, reporting, and quality improvement will further strengthen Connecticut's system of care for children, youth, and families.



Growing and strengthening intermediate levels of care requires a coordinated effort and sustained commitment from policymakers, payers, behavioral health administrators, and providers.

The result is a stronger and healthier future for our state.

APPENDIX A: EDT DATA ANALYSIS

EDT data collected within PIE for episodes of care that were open during the fiscal year 2023 (July 1, 2022 – June 30, 2023) is presented in the charts below. The analysis includes information on the population served, services provided (as available within PIE), and outcomes. Longitudinal data inclusive of FY 2019 – FY 2023 is included for a small number of indicators. As much as possible, disaggregation of data by race and ethnicity has been included in the analysis.[‡] Note that children identifying as multiracial and those identifying as a race or ethnicity other than Black, Hispanic, or White have been included within the analysis; however, given the smaller numbers of these children served within programs, readers should use caution drawing conclusions from this data.

Population Served

EDT services have declined since the pandemic, with only 358 new episodes of care (serving 356 unique children) in FY 2023 compared to 811 episodes in FY 2019. The majority of children served were male and between the ages of 10-13. The median age of children served in FY 2023 was 10 years, and there was little variation in median age by race or ethnicity. Approximately 10% of children had a primary language other than English, and a small number of children served are non-verbal. EDT services are provided to a higher proportion of Black and Hispanic children than in the general Connecticut child population. Additional analysis is needed to identify the breakdown by provider and geographic region to more fully assess the racial and ethnic representation of children served by programs.

Most children served in FY 2023 were referred to EDT programs by other program staff within the same agency or other programs within other community-based providers. The next most frequently cited referral source was schools, followed by families. Approximately 7% of episodes were the result of a direct DCF referral, and 5% of children were referred directly from inpatient services. While most children's families were not DCF-involved, 23% did have some level of DCF involvement, with 18% having in- or out-of-home child protective services involvement.

A significant portion of children have a history of utilizing higher levels of care for psychiatric treatment (24% with an inpatient hospitalization history and 10% with a history of out-of-home placement for psychiatric needs). Almost half of children (40%) are entering EDT services with a history of trauma exposure, with higher rates reported by Hispanic and Multiracial children. The most common primary presenting problem for all children in FY 2023 was disruptive behavior; however, the rate of identification of this presenting problem was disproportionately high for Black children. Hyperactivity was the next most common presenting problem for children served in EDT in FY 2023.



[‡]Terms related to racial and ethnic identity reflect the language used within the dataset.

Services Provided

Limited data is available within PIE regarding services delivered (e.g., dosage of individual therapy, family therapy, etc., is not reflected within the data). However, data related to timeliness of service delivery, length of stay, and use of evidence-based treatments is available, and relevant analyses are included in the charts below. In FY 2023, on average, there were 26 days between a child's referral date and episode start date, with longer wait times for Black and Hispanic children than White children. The median length of stay was 170 days, with longer stays for Black and Hispanic than White children. At discharge, most children were referred to outpatient services or an IOP.

Data collected on the use of EBTs reflected implementation for a relatively high proportion of episodes of care (56% overall). White children were more likely to receive EBTs than Black or Hispanic children during FY 2023. Cognitive behavioral therapy (CBT) was the most frequently used EBT, followed by dialectical behavior therapy (DBT) and motivational interviewing (MI). There was nearly no use of trauma-focused EBTs (only one child received TF-CBT) despite 7% of children having trauma symptoms as their primary presenting problem and 40% having entered the program with trauma exposure.

Outcomes

Based upon the outcome data within PIE, there is an indication that EDT services are resulting in improvements for children, especially for children of color. Children are completing treatment at a rate of 60%, and 66% are meeting treatment goals. More than half are making improvements in functioning (61%) and problem severity (59%) as measured by the Ohio Scales. Across rates of treatment completed, treatment goal met, and improvement in symptoms, Black and Hispanic children have slightly higher rates of positive outcomes. Parents reported less improvement in problem severity than workers did on the Ohio Scales and also reported less satisfaction with their children's outcomes on the Youth Services Survey for Families (YSS-F).



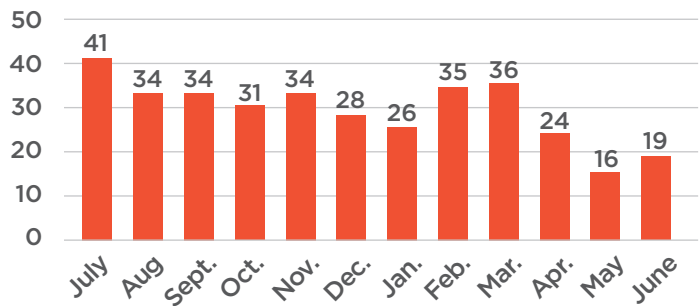
Summary

EDT services declined during the pandemic and have not returned yet to pre-pandemic levels. Few children have repeat episodes of care within EDT. Children served within EDT reflect higher proportions of Black and Hispanic children than proportions in the statewide child population. The majority of children are male and between 6-13 years old (median age is 10-years old). Children served have high rates of prior intensive services, including inpatient hospitalization. There are disparities in service delivery; Black and Hispanic children are experiencing longer wait times prior to a start date, but longer lengths of stay on average. Black and Hispanic children are also less likely to receive EBTs. Outcomes, however, are strong overall, with 60% of children completing treatment, meeting treatment goals, and improving in symptoms. Children of color appear to be experiencing slightly better outcomes than White children in spite of apparent disparities in aspects of service delivery.

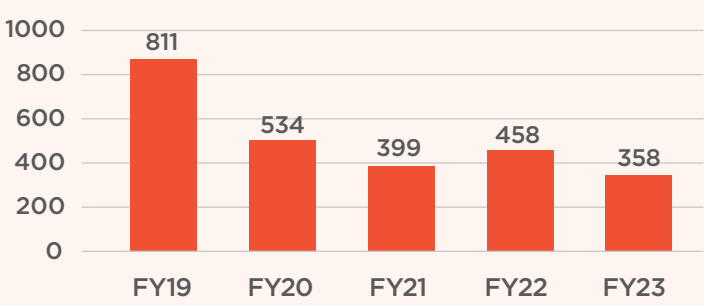
Families do not appear to be having the same perception of child outcomes as EDT clinicians do, based on data from the parent Ohio Scales and YSS-F results. It is possible that the recommendations related to both measurement-based care and family therapy could strengthen families' experience and perceptions of their child's outcomes.

POPULATION SERVED[§]

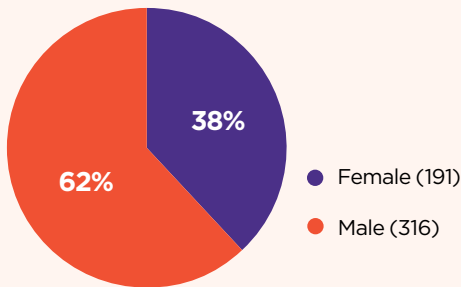
1. FY23 New Episodes by Month
358 Total Episodes



2. New Episodes FY19-FY23
2560 Total Episodes

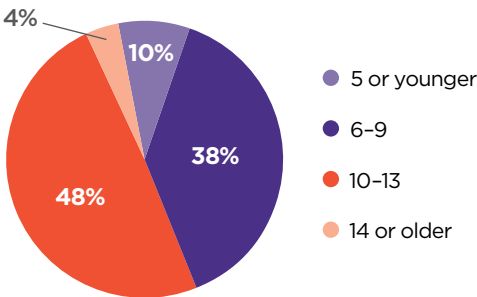


3. FY23 Sex of Children Served



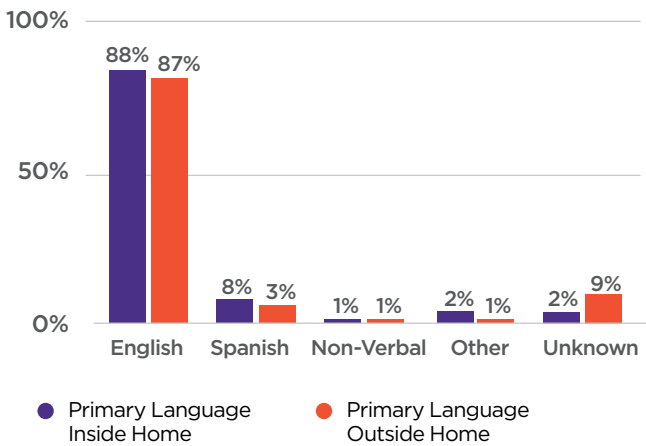
While gender is collected within PIE in addition to sex, the response rate is only 30% and so analysis of gender is not included in this report.

4. FY23 Age Groups Served

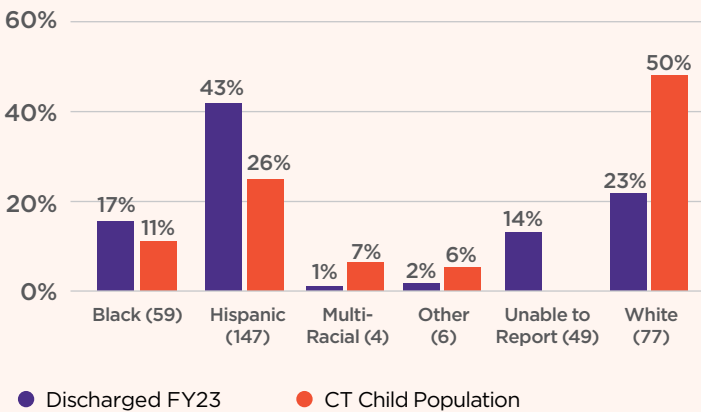


Median age was 10-years old with little variation by race and ethnicity.

5. FY23 Primary Language of Child



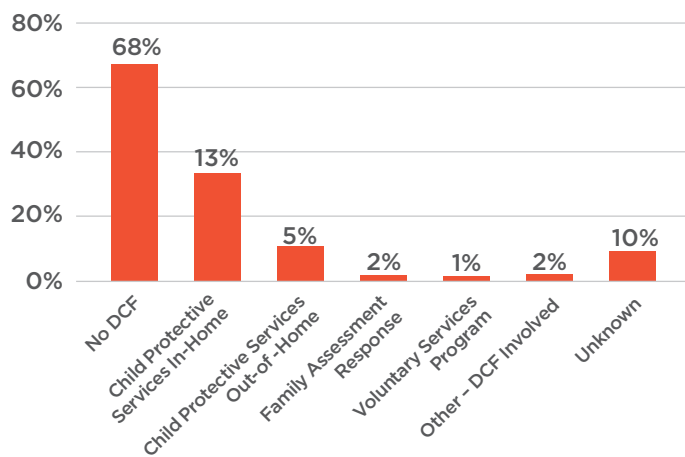
6. FY23 Discharges by Race and Ethnicity Compared to CT Statewide Child Population



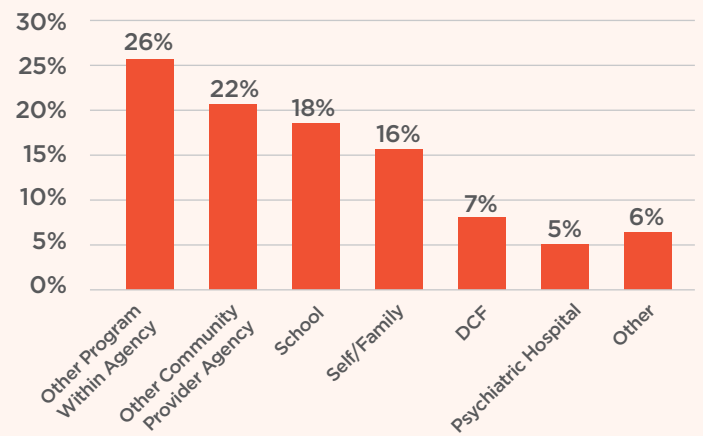
[§]All charts refer to FY23 data (July 1, 2022 – June 30, 2023) unless otherwise noted.



7. FY23 DCF Involvement at Intake

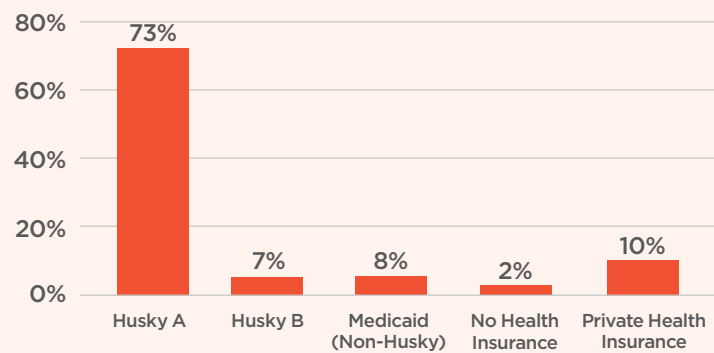


8. FY23 Referral Sources

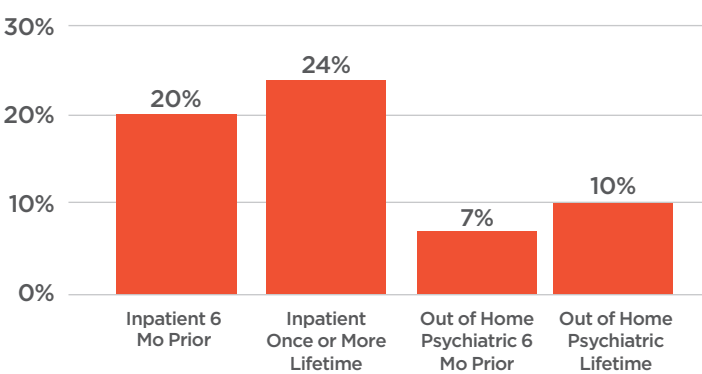


POPULATION SERVED^s (CONTINUED)

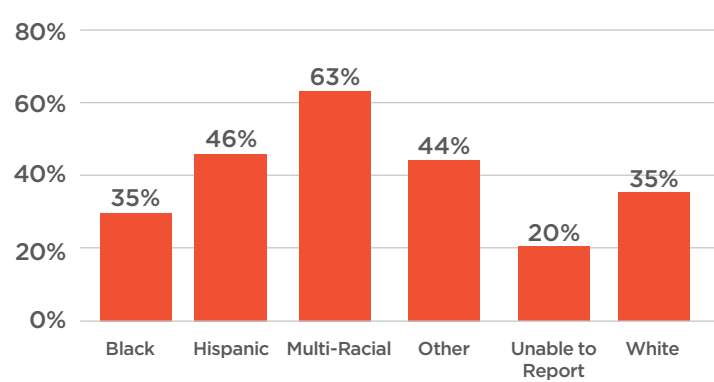
9. FY23 Insurance Status



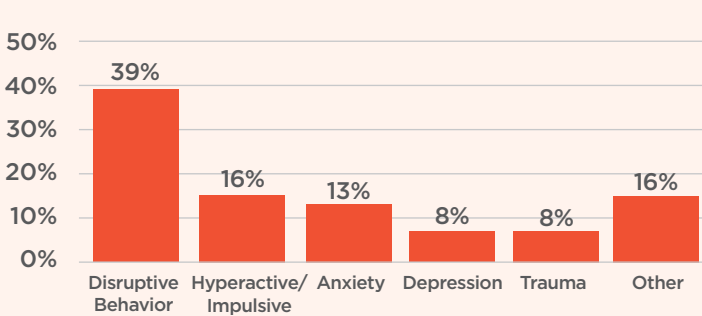
10. FY23 Inpatient History



11. FY23 History of Trauma Exposure

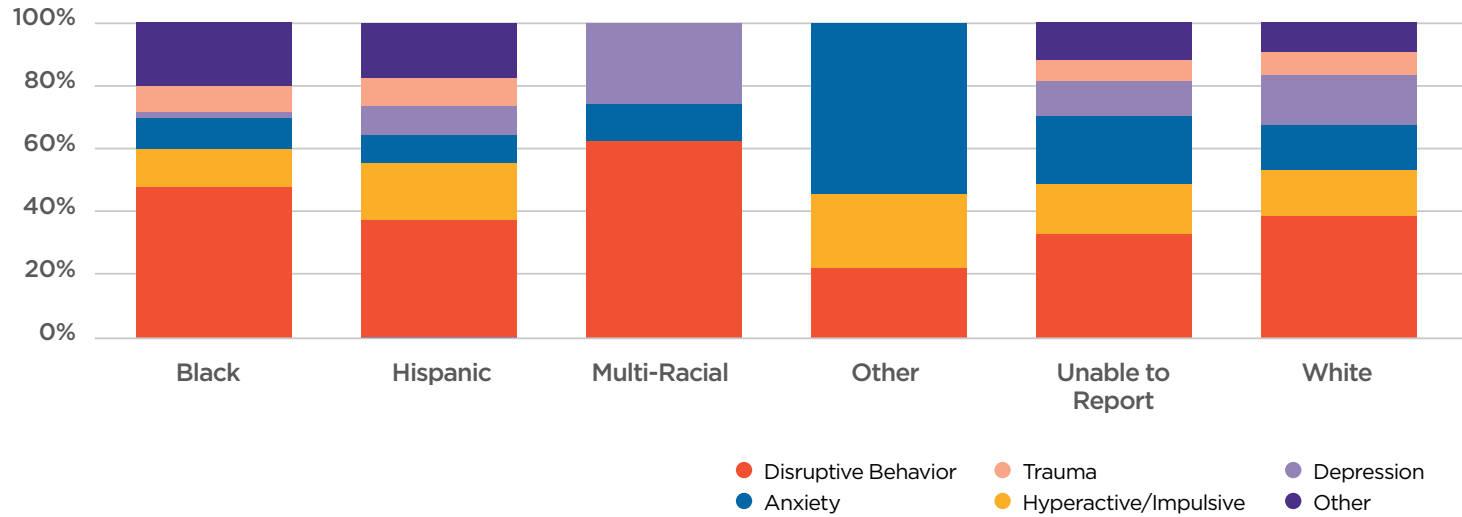


12. FY23 Primary Presenting Problem*



*10% had missing presenting problem data

13. FY23 Primary Presenting Problem by Race & Ethnicity

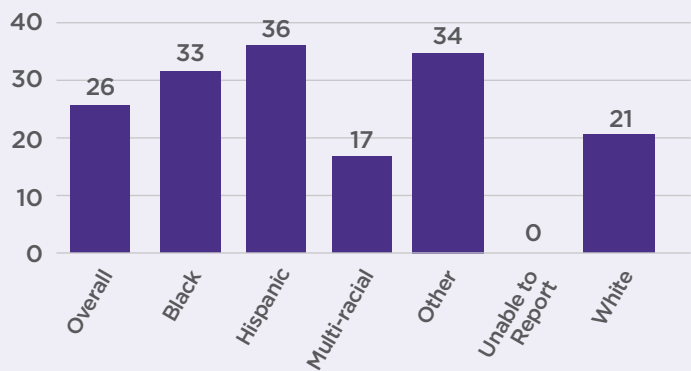




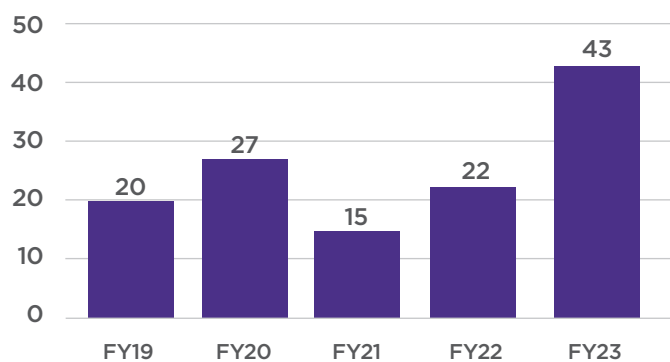
SERVICES PROVIDED



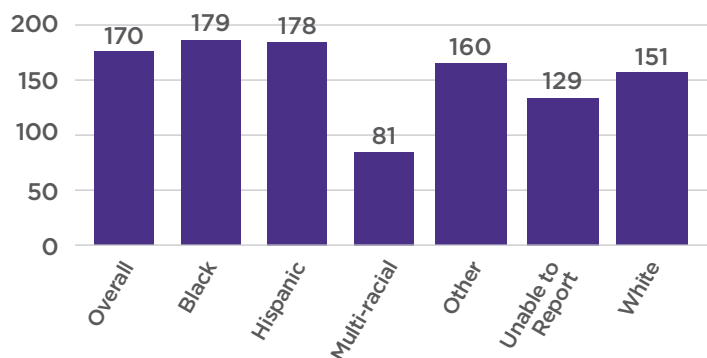
14. FY23 Median Days from Referral to Start Date



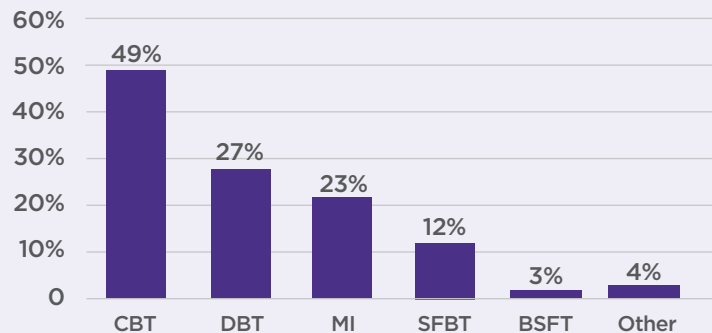
15. FY19-FY23 Median Days from Referral to Start Date



16. FY23 Median Length of Stay (Days)

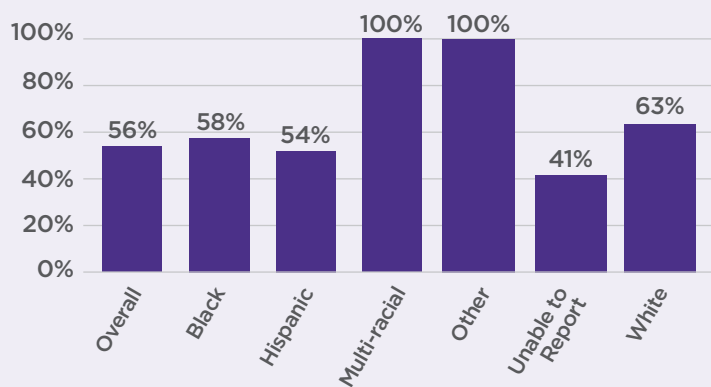


17. FY23 Percent of Episodes Using EBTs*

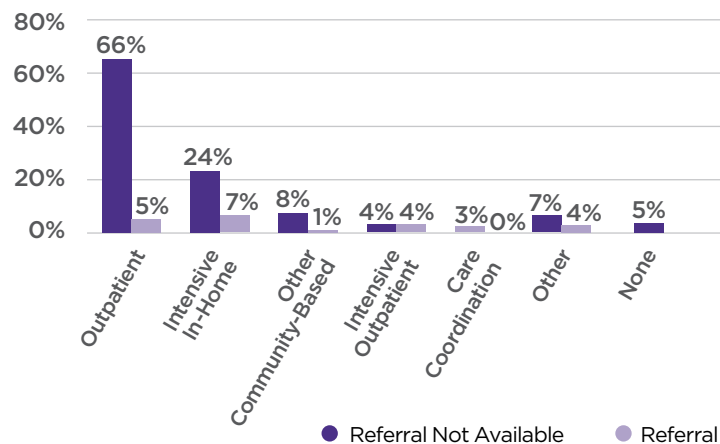


*More than one EBT may be used in an episode of care.

18. FY23 Percent of Episodes with Child Receiving At Least One EBT by Race

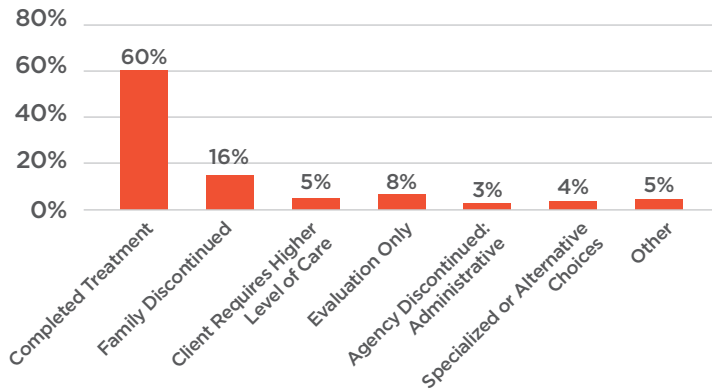


19. FY23 Care Referral Upon Discharge

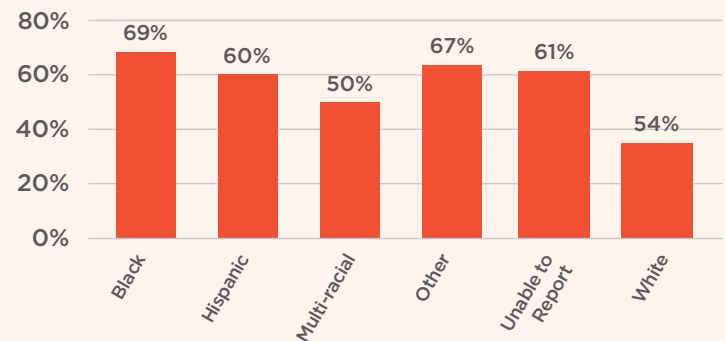


OUTCOMES

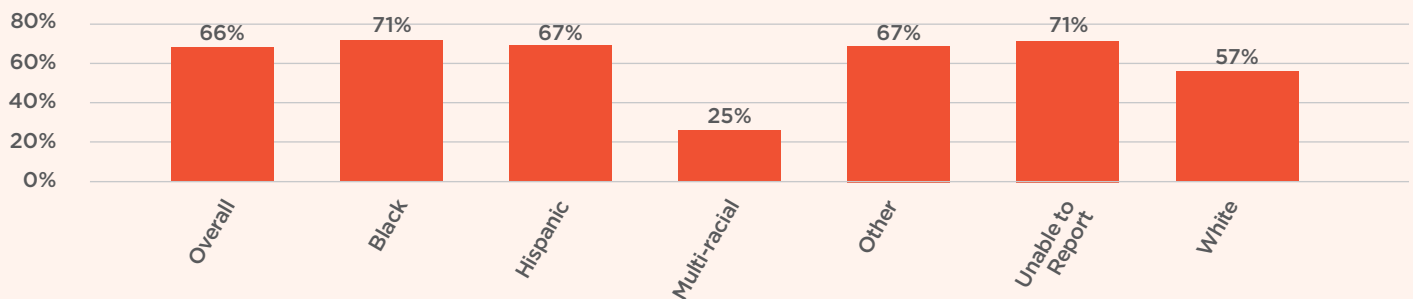
20. FY23 Treatment Completion Rates



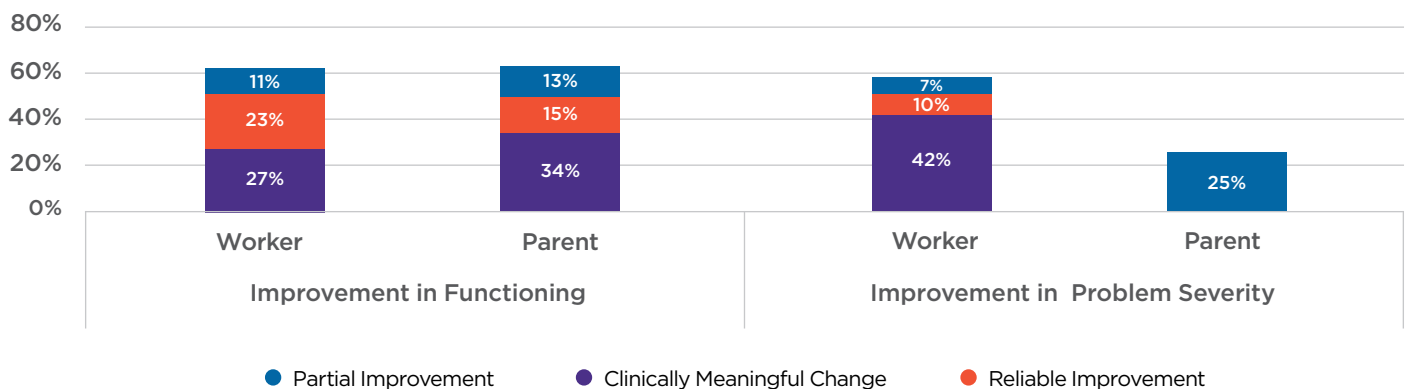
21. FY23 Proportion Completing Treatment by Race and Ethnicity



22. FY23 Proportion of Episodes with Treatment Goal Met

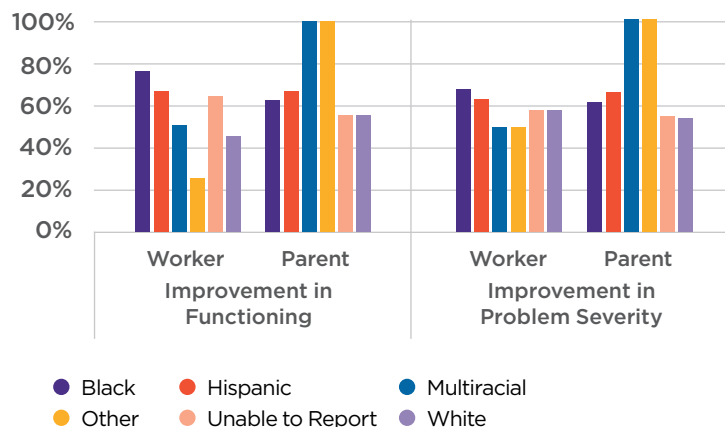


23. FY23 Improvement in Functioning and Problem Severity as Measured by the Ohio Scales^



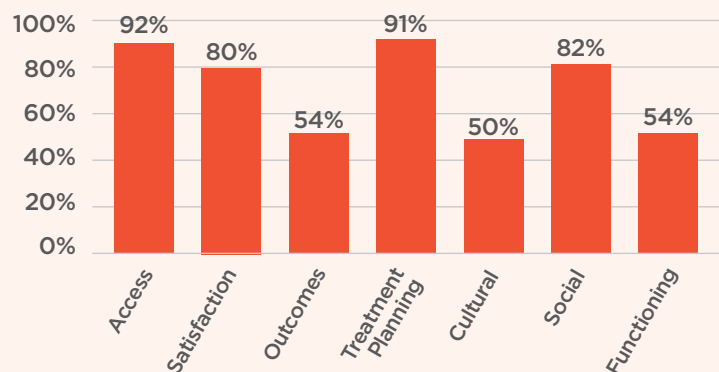
^Note Regarding Ohio Scale Charts: *Clinically meaningful change* requires a magnitude of improvement from intake to discharge that exceeds variation due to chance as well as a movement out of the "critical impairment" threshold. *Reliable improvement* reflects a magnitude of improvement of the same value but without a change in "critical impairment." *Partial improvement* reflects a magnitude of improvement that is at least half but less than the full magnitude of change associated with RCI or clinically meaningful change.

24. FY23 Improvement on Ohio Scales by Race and Ethnicity*



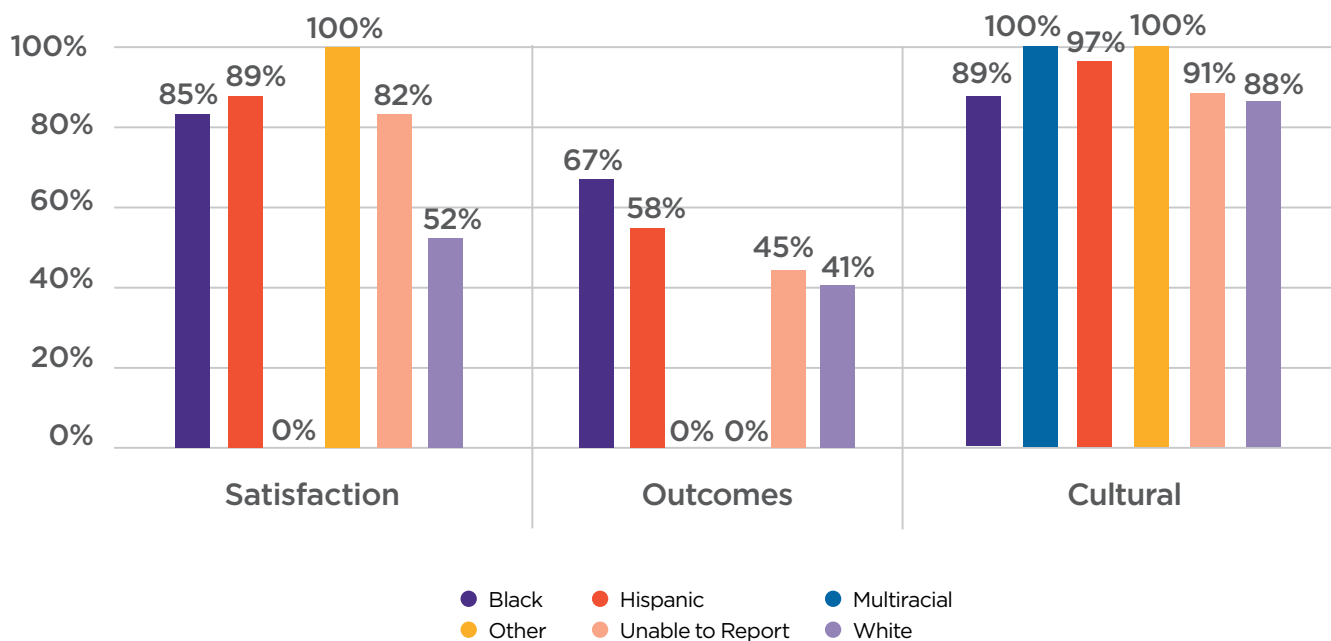
*Demonstrating at least partial improvement.

25. Proportion of Families Reporting Positive Experience with the Service in Each of the Following Domains*

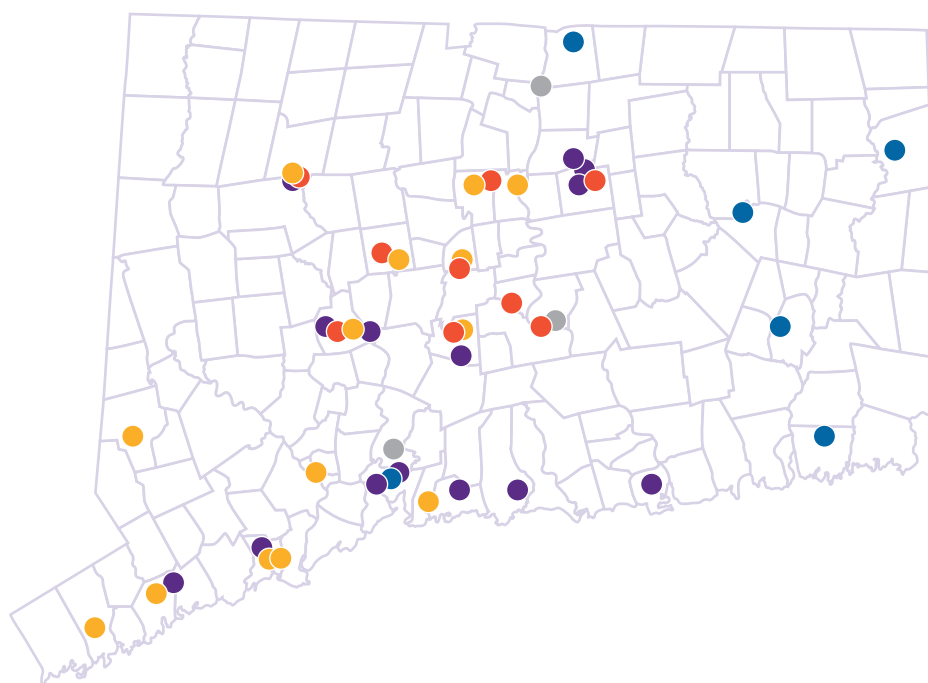


*Based upon responses to the Youth Services Survey for Families (YSS-F). Positive experience reflects agreeing or strongly agreeing with relevant statements on the assessment.

26. FY23 Positive Experience Reported on the Youth Services Survey for Families by Race and Ethnicity



APPENDIX B: ILC SITES FOR CHILDREN IN CONNECTICUT



Legend

- PRTF
- IOP
- EDT
- PRTF, IOP or PHP, IOP or IOP, EDT
- PHP, IOP, EDT

APPENDIX C: GLOSSARY OF ACRONYMS

ACT Acceptance and Commitment Therapy	DCF Department of Children and Families	MBC Measurement-Based Care
ADHD Attention Deficit Hyperactivity Disorder	DD Developmental Disability	MI Motivational Interviewing
ARC Attachment, Regulation and Competency	EBT Evidence-Based Treatment	OCD Obsessive-Compulsive Disorder
ASD Autism Spectrum Disorder	EDT Extended Day Treatment	ODD Oppositional Defiant Disorder
ASO Administrative Services Organization	ERP Exposure and Response Prevention	PHP Partial Hospitalization Program
BHP Behavioral Health Partnership	ID Intellectual Disability	PIE Provider Information Exchange
CBHPIAB Children's Behavioral Health Plan Implementation Advisory Board	ILC Intermediate Level of Care	PRTF Psychiatric Residential Treatment Facility
CBT Cognitive Behavioral Therapy	IOP Intensive Outpatient Treatment	PTSD Post-Traumatic Stress Disorder
CHDI Child Health and Development Institute	MATCH-ADTC Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems	SUD Substance Use Disorder
DBT Dialectical Behavior Therapy		

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ABOUT CHDI

The **Child Health and Development Institute** provides a bridge to better behavioral health and well-being for children, youth, and families. We collaborate with policymakers, providers, schools, and partners to advance system, practice, and policy solutions that result in equitable and optimal outcomes in Connecticut and beyond.