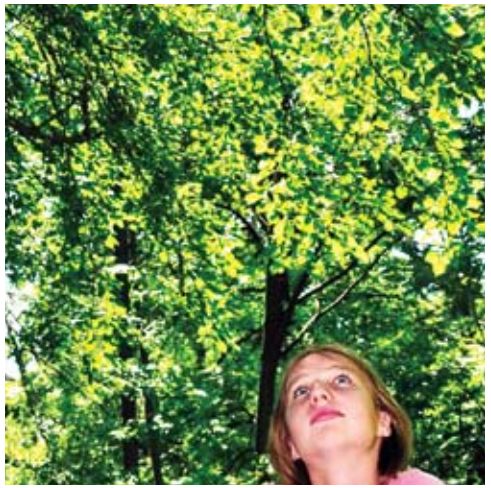
# THE INTENSIVE IN-HOME SERVICES DECISION TREE:

## Guidance for Choosing Among Connecticut's Intensive In-Home Treatment Models



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# INTRODUCTION

Research shows that mental health problems among children and adolescents are highly prevalent, yet **availability of effective treatment options for children are limited**. An important factor underlying limited access to children's mental health treatment is the need for a comprehensive mental health service continuum for children and adolescents. Traditionally, service systems have relied on inpatient hospitals, residential facilities and center-based outpatient services provided in community mental health centers or hospitals. These services are fundamental to the children's mental health system but often struggle to achieve consistent client attendance and family engagement. **Alternative treatment approaches are needed to reduce access barriers and improve child and family outcomes.**

**Intensive in-home services are a category of community-based mental health treatments designed to increase access to treatment, reduce out-of-home placements, and improve outcomes for children and families.** Such services provide treatment in the homes of children who have serious emotional and behavioral disturbances using a child-centered and family-focused treatment approach. Connecticut has among the most extensive array of evidence-based in-home treatment models of any state in the country. **Intensive in-home treatment models for children in Connecticut include:**

- Brief Strategic Family Therapy (BSFT)
- Family Substance Abuse Treatment Services (FSATS)
- Family Support Teams (FST)
- Functional Family Therapy (FFT)
- Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)
- Multisystemic Therapy-Building Stronger Families (MST-BSF)

Despite the increasing presence of intensive in-home services in Connecticut, **there remains a need to educate the community, providers, families, and people who refer to in-home services about key distinctions among intensive in-home service models** and to advance strategies that will maximize the "fit" between the needs of the child and family and the in-home service to which they are referred.

This document is a brief version of a full report on referral decision-making for intensive in-home services, and offers guidance to help families, providers, and referrers understand the key differences between models. The in-home treatment models are described in Table 1 and ***The Intensive In-Home Service Referral Decision Tree*** is presented to supplement current decision-making practices.

## TABLE 1: OVERVIEW OF INTENSIVE IN-HOME SERVICES IN CONNECTICUT

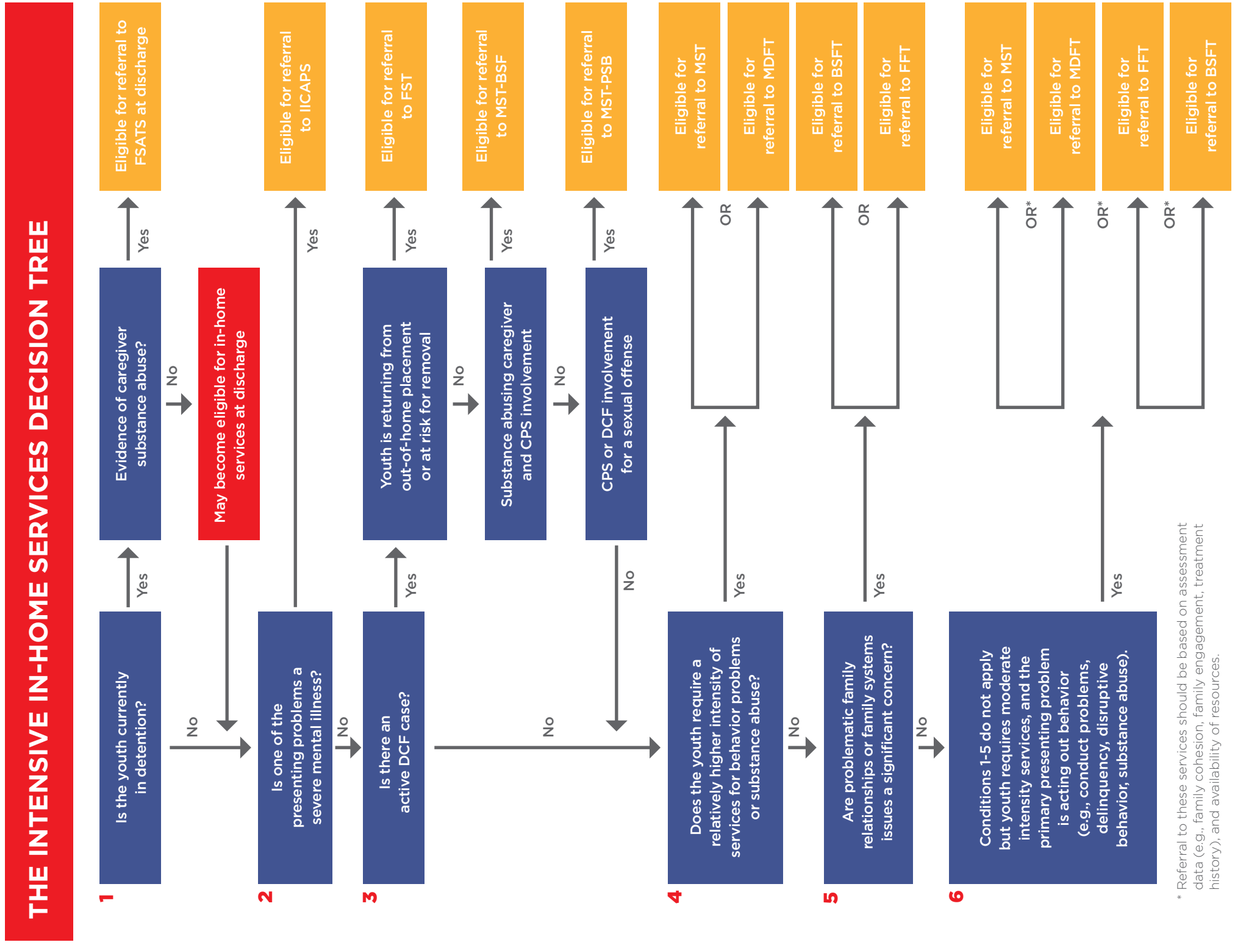
| Treatment Model | Funding Agency | Target Population | Presenting Problems | Target Age | Treatment Focus | Treatment Intensity and Duration |
|---|---|---|---|---|---|---|
| Brief Strategic Family Therapy (BSFT) | Court Support Services Division (CSSD) | May or may not be DCF-involved. | Substance abuse, conduct problems, delinquency. | 8 to 18 years old | Targets maladaptive family interactions using structural and strategic family therapy techniques. Incorporates ecological influences. | Weekly sessions for 60-90 minutes each session. 12-15 total sessions over 3 months. |
| Family Substance Abuse Treatment Services (FSATS) | DCF | Children in detention with evidence of parental substance abuse. | Substance abuse, behavior problems, delinquency. Also, parental substance abuse and family systems issues. | 11 to 17.5 years old | Targets parental substance abuse as a key contributing factor to observed child behavior problems or juvenile justice involvement. | Up to 12 months. |
| Family Support Teams (FST) | DCF | DCF-involved children only, including Voluntary Services. Children returning from out-of-home care or at risk for placement. | Children with psychiatric, emotional, or behavioral difficulties, and their families. | 3 to 19 years old | Uses a multidisciplinary team approach, including a child's psychiatrist, nurse, clinician, case manager, and others (e.g., teacher, recreational therapist). Offers 24-hour crisis response. | 9 to 15 months or longer depending on case complexity and need. |
| Functional Family Therapy (FFT) | DCF (treatment slots shared with CSSD) | May or may not be DCF-involved. | Violence, aggression, delinquency, substance use. | 11 to 18 years old | Multisystemic approach with reliance on family therapy. Treatment organized around three phases (engagement and motivation, behavior change, generalization). | 8 to 12 sessions provided over 3 months, or up to 30 hours direct contact for more complex cases. |
| Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) | DCF CSSD | May or may not be DCF-involved. Children returning from or at risk of out-of-home placement due to psychiatric symptoms. | Primarily psychiatric symptoms including psychotic symptoms, bipolar, and mood disorders. Also treats a wide range of behavior problems secondary to psychiatric symptoms. | 3 to 18 years old | Coordinated child-centered and family focused treatment that addresses causal and maintaining factors related to parenting, family, school, and community. 24-hour crisis response. | Direct clinical treatment for at least 5 hours a week for approximately 4 to 6 months. |
| Multidimensional Family Therapy (MDFT) | DCF (treatment slots purchased by CSSD) | May or may not be DCF-involved. | Behavior problems, conduct problems, substance abuse. Also, parenting and family systems issues. | 11 to 17 years old | Multisystemic ecological framework. Relatively stronger emphasis on family therapy than parent training. Treatment progresses in three sequential phases. | Average of 2-3 sessions per week, 1-2 hours per session, for a duration of 4 to 6 months. |
| Multisystemic Therapy (MST) | DCF CSSD | May or may not be DCF-involved. | Behavior problems, conduct problems, substance abuse. Also, parenting and family systems issues. | 11 to 17 years old | Multisystemic ecological framework. Relatively stronger emphasis on parent training than family therapy. | Average of 2-3 sessions per week, 1-2 hours per session, for a duration of 4 to 6 months. |
| Multisystemic Therapy-Building Stronger Families (MST-BSF) | DCF | Child must be involved with DCF Child Protective Services (CPS). | Delinquent behaviors and/or substance abuse problems. | 11 to 18 years old | Multisystemic ecological framework is used to address child maltreatment and parental substance abuse as the causal and maintaining factors in child behavior problems. | Average of 2-3 sessions per week, 1-2 hours per session, for a duration of 9 to 12 months. |
| Multisystemic Therapy-Problem Sexual Behavior (MST-PSB) | DCF | Child must be involved with CPS or DCF Parole. | Sexual acting out behavior. | 11 to 18 years old | Multisystemic ecological framework to address issues such as substance abuse, peer influences, and parenting behavior. | Average of 2-3 sessions per week, 1-2 hours per session, for a duration of 5 to 7 months. |

**Note.** Adapted from *Intensive In-Home Service Models* created by Connecticut DCF (R. Plant)

## Requirements for intensive in-home services:

- children and youth age 11 to 17 (or age 3 to 17 for the IICAPS and FST programs);
- who require intensive services for serious emotional and behavioral problems;
- have been recently discharged from or are at risk for out-of-home placement (e.g., inpatient hospitalization, residential treatment), OR whose level of treatment needs exceed what is available in lower levels of care (e.g., outpatient therapy);
- due to its emphasis on family-oriented services, youth must have at least one stable caregiver (parent or other) who is willing to actively participate in treatment.

## THE INTENSIVE IN-HOME SERVICES DECISION TREE




* Referral to these services should be based on assessment data (e.g., family cohesion, family engagement, treatment history), and availability of resources.

# ADDITIONAL FACTORS THAT AFFECT IN-HOME REFERRAL DECISION-MAKING

The decision tree offers relatively strict guidelines that are helpful in decision-making and uses rule out criteria to help those who refer to these services determine eligibility and appropriateness for specific services. **A number of additional factors can be equally important to referral decision-making** but difficult to incorporate into a decision-tree format. Some of these key factors are described below.

1. **Variations in geographic availability.** Many of the intensive in-home treatment models are not uniformly available across Connecticut and thus are not easily accessible for some families.

2. **Treatment history.** Many children already have received a course of treatment in a particular home-based intervention, and thus referrers should examine the likely effectiveness of a second course of the same treatment or a course of treatment using another in-home service.

3. **Family preference.** Families must have a significant voice in selecting the treatment they receive. A child or family's connection to a particular treatment agency or clinician and the services they provide can be a determining factor in the type of in-home service that ultimately is received.

4. **Waitlists.** Our findings suggest that the nine in-home services vary in the average length of their waitlists. In addition to waitlists, the acuity of child and family needs must be considered when referring to an in-home service.

5. **Juvenile justice involvement.** Children with court or probation involvement often are court-ordered to receive immediate treatment. Under such circumstances, a premium is placed on what is currently available, not necessarily on what is clinically indicated.

6. **Types of therapeutic modalities.** Often referrers match a child's demographic or clinical characteristics to a particular in-home service based on the availability of certain model components (e.g., amount of individual therapy available in one model versus another). Referrers should exercise caution in such cases because perceptions of certain model characteristics can be based on assumptions rather than true differences and/or empirical data.

7. **Matching child and family characteristics to clinician characteristics.** An appropriate match between race/ethnicity and language of clinician and child/family must be considered in treatment selection.

# RECOMMENDATIONS

1. **Train all individuals that make referrals to intensive in-home services** in the use of this decision-making framework. Training should take place for a wide range of people, including but not limited to:

   - DCF staff
   - Teachers and school officials
   - Probation officers
   - Care specialists at the Connecticut Behavioral Health Partnership (CT BHP)
   - Care coordinators in the community-based system of care
   - Outpatient clinicians
   - Reviewers who authorize in-home treatments at CT BHP
   - All others that are likely to refer youth to intensive in-home services

2. **Ensure consistent standards for collecting, reporting, and tracking data** for the purposes of quality improvement and evaluation of intensive in-home services.

3. **Expand intensive in-home services to enhance statewide capacity** and eliminate geographic disparities.

4. **Community-based collaboratives should promote and support the consistent use of multidisciplinary teams** to make treatment referral decisions using the Wraparound process to inform care coordination. Wraparound is a treatment planning and service delivery process and philosophy that emphasizes family-driven and strengths-based treatment and supports.

5. **Conduct systematic research** using the Intensive In-Home Services Decision Tree to determine 'value-added' in the children's mental health system.

6. **Explore the appropriateness of adopting intensive in-home services for a variety of difficulties,** including the possible adaptation of existing models to meet the needs of more children and families.

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