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TITLE: LEWIS'S CHILD AND ADOLESCENT PSYCHIATRY : A
 COMPREHENSIVE TEXTBOOK / EDITORS, ANDRES MARTIN,
 FRED R. VOLKMAR.

PUBLISHER/PLACE: Lippincott Williams & Wilkins Philadelphia :

VOLUME/ISSUE/PAGES: 2007;():878-887 878-887

DATE: 2007

AUTHOR OF ARTICLE: Rowland

TITLE OF ARTICLE: INTENSIVE HOME-BASED FAMILY PRESERVATION
 APPROACHE

ISBN: 9780781762144

OTHER NUMBERS/LETTERS: Unique ID.: 101299354
 25527302

SOURCE: Unique Key

MAX COST: \$20.00

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CHAPTER 6.3.2 ■ INTENSIVE HOME-BASED FAMILY PRESERVATION APPROACHES, INCLUDING MULTISYSTEMIC THERAPY

MELISA D. ROWLAND, JOSEPH L. WOOLSTON, AND JEAN ADNOPOZ

The origins of intensive home-based family preservation treatments can be traced to services provided by our nation's first social workers in the early 1900s. Gleaning knowledge and experience from volunteers or "friendly visitors" of charitable organizations, these social workers helped impoverished families maintain custody of their children, primarily through the provision of concrete and pragmatic services. Home-based family visits were used to engage families and increase the accuracy of needs assessments. By focusing on the mobilization of help networks and emphasizing the coordination of services, these social workers laid the early foundations for today's home-based services (1).

While child welfare agencies experimented with home-based services, a similar trend was developing to serve families

of delinquent youths. Juvenile courts were developed in both Chicago and Boston at the turn of the century to help manage the needs of delinquent children. While some of the court's services involved the suspension of parental rights and placement of children away from their homes, other services were community based and aimed to improve parental supervision. The early youth probation officers providing these services were charged with trying to help the parents maintain the youth in the home and community before recommending placement. Yet, despite the early focus on family preservation in both child welfare and juvenile justice, child protection (removal from the home) and incarceration strategies have dominated the field for most of the twentieth century. Furthermore, the psychoanalytic movement supported this process as it contributed

substantially to an individually oriented treatment approach in social work practice and a shift away from recognizing the critically important roles of families and the social context in childhood problems (2).

It wasn't until the 1970s and '80s that the social and political climates, enhanced by new theoretical and treatment models, began to change in ways that supported the development of home-based family-centered treatments for youths with serious clinical problems and their families. Important political proponents of this development included the Department of Health and Human Services Children's Bureau's leadership and financial funding to support program development as well as research and resources for the expansion of family-based services. The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) required that states take reasonable efforts to prevent placement, hence further accelerating the growth of family-preservation programs. The Edna McConnell Clark Foundation became instrumental in promoting one model, the Homebuilders Program; and the Child Welfare League of America helped to establish prevention and reunification as necessary parts of the service continuum (3). These factors, among others, combined with a growing theoretical knowledge base that conceptualized human problems as contextually driven (4, 5) and amenable to intervention (6-8) laid the foundation for the growth of short-term, largely home-based family strengthening programs designed to support family capacity to care for their own children and to reduce the out-of-home placement of children (1).

DEFINITIONS

Unifying Themes

The term "intensive home-based family preservation" actually refers to a variety of treatment services and interventions provided in various formats, often with very different underlying treatment models and implementation strategies. Moreover, several different terms are used in the literature to denote these types of interventions, including family preservation services (the most common), intensive-in-home services, and home-based family therapy. Yet, despite the multiple terminologies, these interventions share a common theme and goal of trying to preserve the home and family. Indeed, several aspects of the underlying model of service delivery and corresponding ideologies generally serve to unify these programs and set them apart from other interventions.

STRUCTURE

The intensive home-based family preservation model of service delivery differs from traditional office-based interventions in several ways. Specifically: Services are provided in the home and community at times convenient for family members, treatment is time limited (1-5 months), therapists have low caseloads (two to six families) and make multiple visits weekly, and team members are available to families around the clock to respond to crises and treatment needs.

THEORETICAL UNDERPINNINGS

The vast majority of services provided within the intensive home-based family preservation model of service delivery base their intervention and implementation strategies on one or several compatible theoretical models of human behavior. These theories include social learning theory (6, 8); structural (9),

strategic (5), or problem-focused (10) family therapy; crisis theory; and behavioral theories (11). As a group, intensive home-based family preservation services tend to offer present-focused, family-centered interventions designed to empower the youth's caregiver(s) to provide an appropriately nurturing and structured environment, thus reducing risk of placement.

DIFFERENCES: THREE MODELS

Within the broad category of intensive family preservation services, three relatively distinct practice models have been identified (3, 12).

Crisis Intervention Model

The *crisis intervention model*, exemplified by the Homebuilders approach, was the first family preservation model developed. Based on social learning principles, interventions in this model are very brief (4-6 weeks) and emphasize concrete services (food, clothing) and counseling that targets family communication, behavior management, and problemsolving skills (13).

Home-Based Model

Services provided under the rubric of the *home-based model* tend to be more clinically oriented than crisis models, are often provided by masters' level therapists, and are longer in duration (3-5 months). Interventions in this model frequently target problematic interactions among family members and between family members and the community (14). Clinical procedures are more complex than those in the crisis intervention model and involve a range of family, behavioral, and parent training intervention strategies. Multisystemic therapy (MST) (15) is an example of this type of treatment program.

Family Treatment Model

Although services provided under this model share similar theoretical underpinnings and treatment goals with the two home-based models mentioned, they differ in that concrete services are generally provided by case managers rather than therapists, and therapists generally provide clinical services in the outpatient office. Functional family therapy is an example of this type of intervention (10). Given this chapter's intended focus on the home-based treatment setting, the two types of intensive home-based family preservation that are primarily provided in home and community-based settings, the crisis intervention and home-based models are highlighted.

FAMILY PRESERVATION SERVICES IN CHILD WELFARE

Background

The first home-based family preservation services were provided in the early 1900s to families at risk of losing their children due to poverty and neglect. While these types of services fell by the wayside during the early part of the century, they reemerged in the 1970s, largely due to political concerns for youth in the child welfare system. In response to national unease about the rising numbers of children without permanent placement in foster care, the Adoption Assistance

and Child Welfare Act of 1980 (Public Law 96-272) brought new focus and resources to home- and family-based intervention programs. Foundations (e.g., the Edna McConnell Clark Foundation's support of the Homebuilders model) played substantial roles in dissemination of these services (3). Yet, like most psychotherapeutic and psychosocial interventions, dissemination of home-based services preceded evidence of their effectiveness.

Research Findings

Early evaluations of intensive home-based family preservation programs consisted largely of descriptive information and quasiexperimental studies, primarily of the Homebuilders model. Homebuilders is a short-term (30-60 days) crisis intervention model variety of home-based treatment consisting mostly of concrete case management and behavioral interventions provided by bachelors' level child protection workers. While some of the early outcome data concerning these programs seemed promising, closer observation revealed substantial methodological problems in many of the evaluations (selection bias, nonequivalent control groups). As these methodological issues were addressed and more rigorous research was performed, the early positive findings did not hold. Two comprehensive reviews on the effectiveness of intensive home-based family preservation services for children at risk of out of home placement due to abuse or neglect (2, 16) indicate that crisis intervention types of intensive home-based family preservation services have had little impact in averting out-of-home placement. For example, in what is considered to be the most substantial, comprehensive, and methodologically sound evaluation of a family preservation project for child welfare youths to date; (17) researchers of a program in Illinois found that the 995 families that received the crisis intervention family preservation intervention fared no better than the 569 families that received regular services. No significant differences were found between the groups in terms of types and duration of out-of-home placement or subsequent child maltreatment. Three additional large studies (18-20) also considered to be methodologically sound and comprehensive, have found that crisis intervention family preservation services failed to produce statistically significant outcomes. Thus, despite widespread dissemination, crisis intervention family preservation services have not proven to be effective on closer evaluation.

Challenges

A number of factors have been proposed (21) by researchers and policymakers to explain the apparent lack of effectiveness for crisis intervention types of intensive home-based family preservation services for children in the child welfare system. Lindsey, Martin, and Doh (16) have outlined five explanations that summarize current thoughts in this regard. First, intensive home-based services in the child welfare sector have largely relied on casework intervention and, thus, might be founded on intervention models that do not have established effectiveness with youth and families experiencing significant difficulties (22, 23). Second, the intensive home-based family preservation treatment models employed in these studies might not have been flexible and comprehensive enough to meet the complex needs and problems often presented by the families. Third, the programs might not have been capable of addressing the severe psychosocial difficulties associated with the poverty experienced by many of the participating families. Fourth, the interventions might have been too brief as most problems presented by these families were chronic and enduring. And finally, it is notable that most studies did not actually succeed in

targeting children truly at risk of placement (17). In summary, a general consensus is developing that suggests that children and families served by the child welfare system have needs that outstrip those provided by intensive home-based family preservation programs that employ the crisis intervention model.

Promising Directions

Rather than serving as a setback, this research provides helpful information that can be used to chart new courses for developing effective home-based interventions for youths in the child welfare system. Project 12-Ways (24) and multisystemic therapy (25) are two examples of intensive family and community-based interventions provided within the home-based model of service delivery that are promising for working with this population. Project 12-Ways is a systemically focused intervention, based on the eco-behavioral model, designed to work with families at risk of having their children placed due to abuse or neglect. The model defines intervention targets across the family's social ecology and implements interventions in the home and social contexts to address these behaviors. Program evaluations indicate that in the short term, families served by Project 12-Ways were less likely to be rereported for child maltreatment or have children removed than comparison families (26, 27). MST is also founded in ecological theory (4) and involves the implementation of empirically validated interventions to youth and family members with attention to the contexts within which they are embedded. An early randomized trial with maltreating families demonstrated that MST was more effective than parent training for improving family interactions (28). Importantly, a recently completed National Institute of Mental Health-funded randomized clinical trial compared MST with parent training plus standard mental health services (29) for adolescents at risk of placement due to physical abuse. Short-term results from this study suggest that MST holds promise for reducing youth out-of-home placement, and symptoms of depression as well as increasing youth perceptions of safety and parental use of nonphysical discipline (30).

MST, and the home-based service model within which it is delivered, differs from the intensive home-based family preservation programs that employ the crisis intervention model in several key ways that address the aforementioned challenges noted by Lindsey et al. (16). First, MST is well grounded conceptually and several randomized clinical trials support its effectiveness with juvenile delinquents and substance-abusing youths at risk of out-of-home placement (31). MST therapists are masters level and receive substantial supervision and ongoing training from doctoral-level clinicians who are trained in evidence-based practice. As adherence to the MST treatment model has been linked with improved youth and family outcomes (32-34), an ongoing quality assurance process (35) is used to support therapist fidelity to the treatment model. Thus, MST involves trained professionals implementing evidence-based practice in an environment that provides ongoing support and evaluation of outcomes.

Also addressing the challenges noted by Lindsey and colleagues (16), MST interventions can flex to meet the complex needs and problems often presented by families in the child welfare system. Interventions are based on the therapist and family's shared understanding of the drivers of the referral problems. Therapists are trained to be generalists who can assess and provide evidence-based interventions to individuals within and across the multiple systems that affect families (36, 37). For example, MST therapists working with families at risk of losing their children due to physical abuse must be able to provide interventions that address individual and family safety, abuse clarification, and psychopathology

and substance abuse in the youths and their family members, as well as peer, school, and community difficulties that are contributing to the identified problems. A third concern expressed by Lindsey and colleagues (16) was that the severe psychosocial difficulties and poverty often found in child welfare populations adversely affects attempts to provide family preservation services. While it is certainly true that these factors often serve as barriers to intervention on MST teams, the model promotes therapists doing whatever it takes to help families achieve sustainable outcomes. Thus, MST therapists are encouraged to provide case management as well as treatment interventions when indicated. For example, therapists might help families secure better housing, apply for financial assistance, obtain transportation, enroll in vocational training or any number of interventions as long as they are considered key in promoting clinical goals. This broad view of clinical services is designed to help lessen the impact of poverty and other adverse social circumstances that often surround families who qualify for intensive home-based services.

A fourth limitation regarding the crisis intervention model of intensive home-based family preservation programs is that their short duration of intervention is not sufficient to address the chronic and enduring problems often found in families served by child welfare. To address this issue, MST teams serving child welfare populations have averaged 6 to 8 months of treatment, and research to better understand the length of treatment needed to adequately serve this population is currently underway (38). Finally, to deal with the issue that many youths in the early child welfare studies were not truly at risk of placement, studies of MST for this population have taken great care to involve youths who are already targeted for potential placement, as evidenced by the 29% placement rate for youths in the control condition of the aforementioned randomized MST trial with child welfare youths (29). Hence, MST as modified for physically abused youths in the child welfare system at risk of out-of-home placement serves as an example of one potentially effective home-based method of treating these families. Importantly, key features of MST address some of the critiques of the early family preservation treatment models.

HOME-BASED FAMILY PRESERVATION IN JUVENILE JUSTICE

Background

While innovative programs to separate juveniles from adults in the prison systems of Boston and Chicago at the turn of the last century set a promising tone for the potential of community-based services for delinquents, these rapidly devolved to current practices that largely consist of probation officers monitoring youths for compliance to court orders (2). This individualistic and often family-alienating focus prevailed throughout the 1900s, helping to create a multibillion-dollar juvenile prison industry that currently consists of more than 3,600 facilities estimated to house more than 110,000 juvenile offenders on any given day (39). Far from evidence based, current probationary and incarceration services are available nationwide. In contrast, it is estimated that fewer than 10% of families of youths on probation have access to evidence-based programs in their community, despite a growing national trend to make such services available (40, 41).

Family preservation services for delinquents first gained a foothold alongside similar services for youths in the child welfare programs in the 1970s and '80s. Given the prevalence of intensive home-based family preservation services utilizing

the crisis intervention service delivery model at that time, this model also quickly became the most common type of home-based services provided for delinquents. Yet, unlike child welfare, a more intensive family preservation service, utilizing the home-based model of service delivery, emerged in the mid- to late 1980s. From the onset, this service, MST, was based on research findings in the field of child psychopathology and integrated intervention strategies that had emerging empirical support (15). MST has continued to expand its research base through almost 3 decades.

Research Findings

Initial research results of intensive home-based family preservation treatments for youths at risk of placement due to delinquency largely mirror those of similar services for youths in the child welfare system. That is, while initial reports were promising, more empirically sound evaluations showed that short-term crisis intervention models did not prevent out-of-home placement and rearrest for youths in the juvenile justice system (2). On the other hand, research concerning MST has demonstrated this model's substantial success in significantly reducing youth criminal behavior, incarceration, and out-of-home placement (31). Three randomized trials published during the 1990s and involving more than 400 families established the short- and long-term effectiveness of MST in reducing antisocial behavior, arrests, and incarcerations, as well as improvements in family functioning, and decreases in youth substance use (42-45). Moreover, a very long-term followup (46) of one of the projects (42) demonstrated that MST participants had 54% fewer arrests and spent 57% fewer days of confinement in adult detention facilities than their counterparts 14 years after entering the study.

Another important finding for MST involves its replication in community-based settings. MST has been transported into community-based settings as an intervention for juvenile delinquents since the mid-1990s. This has provided an opportunity for independent evaluations of the effectiveness of MST in treating adolescent antisocial behavior. Two of these replications have been published in peer-reviewed journals. The first evaluation was conducted in Norway and included four sites in a trial that randomized delinquent youths to MST or usual services. Results from this study revealed significant short- (6-month) and long-term (2-year) decreases in out-of-home placements and internalizing symptoms and externalizing symptoms for MST youths relative to their counterparts (47, 48). In the United States, Timmons-Mitchell and her colleagues (49) have also provided an independent replication of MST effectiveness with juvenile offenders in community settings. In this randomized study youths in the MST condition evidenced significantly fewer rearrests than their counterparts at 18-month followup. These results provide further support for the capacity of MST to achieve favorable outcomes when implemented in community practice settings.

To summarize, across several trials with violent and chronic juvenile offenders, MST produced 25% to 70% decreases in long-term rates of rearrest, and 47% to 64% decreases in long-term rates of days in out-of-home placements (31). A recent metaanalysis that included most of these studies (50) indicated that the average MST effect size for both arrests and days incarcerated was .55.

Overview of MST for Delinquents: Clinical Components

Originally developed as an alternative to incarceration for serious juvenile offenders, MST is an intensive home- and

community-based intervention grounded in social ecological theories of behavior (15). As described previously, MST is delivered utilizing the home-based model of family preservation services. Hence, services are intensive, provided in the home and community to the entire family, and are available 24 hours a day, 7 days a week. Several key aspects of MST, however, differentiate this model from most family preservation services. Importantly, MST therapists are nested within an extensive quality assurance system designed to promote therapist capacity to provide effective interventions and facilitate treatment fidelity. As such, a typical MST team consists of four masters' level therapists, supervised by an experienced, 50% time, preferably doctoral level, mental health professional trained in MST supervision procedures. MST supervisors play an active, integral role in treatment, providing weekly group supervision, field-based assistance, and ongoing promotion of therapist skill development. MST supervisors are, in turn, supported by MST expert consultants. These doctoral level mental health professionals provide weekly team consultation as well as initial and quarterly booster trainings and ongoing assistance with implementation difficulties that can arise.

In terms of the specific work provided, MST therapists typically treat four to six families for 4–5 months, averaging approximately 60 hours of face-to-face contact per family during treatment. Initially, therapists engage with family members and others in the youth's ecology (teachers, peers, neighbors) to determine the drivers of the youth's referral behaviors across school, neighborhood, peer, and family systems. Once the therapist and caregivers have a shared understanding of the factors sustaining the problem behavior, evidence-based interventions are developed targeting these drivers. Therapists draw from a number of intervention techniques including behavioral, cognitive-behavioral, parent management, behavioral family systems, and pharmacological treatments. Interventions may be conducted with or target any number of individuals within and across these systems. For example, if an MST therapist determines that the most proximal driver of a particular youth's delinquent behavior is association with deviant peers and that poor parental monitoring and low youth engagement in school are drivers of this problem, then she would develop interventions based on this information. As such the therapist may work to help caregivers develop an appropriate monitoring plan with age-appropriate rewards and consequences, and be prepared to address barriers that arise in implementing that plan. Common barriers include youth behavioral outbursts, poor social support, parental skill deficits, or parental mental health problems. The therapist might help the parents learn to monitor peers more closely, interface with parents of peers, facilitate prosocial activities, and restrict access to deviant peers. Interventions involving the school might include helping the parent establish a cooperative relationship with the school, assistance in obtaining appropriate testing and placement, and facilitating a behavioral plan to reward appropriate school behavior and punish inappropriate behavior. In turn, should family or individual problems arise that impede therapeutic progress (marital discord or maternal depression) the therapist would endeavor to treat these problems as well with evidence-based interventions such as behavioral marital therapy, cognitive behavioral therapy, or psychiatric consultation for evidence-based pharmacotherapy to treat, for example, maternal depression. In summary, though short term, MST interventions are designed to bring intensive clinical focus and expertise to problems presented by antisocial youths and their families. An extensive quality assurance system built into this model helps to sustain clinical integrity and prevent program drift. Both the intensive focus of evidence-based

clinical expertise and the careful monitoring of treatment fidelity are core features underlying MST's success in treating delinquents (35).

Promising Directions

While MST is the leading intensive home-based family preservation treatment for juvenile offenders that utilizes the home-based model of service delivery, two other intensive family preservation treatments that utilize the family treatment model have shown substantial promise in serving this population as well. Both multidimensional treatment foster care (51) (MTFC) and functional family therapy (10) (FFT) have data supporting their effectiveness in diminishing youth problem behavior and preserving community placement for youths with serious behavioral problems (52). While neither of these interventions is, technically speaking, a home-based family preservation program, both would fall under the category of family treatment model programs designed to treat youths at risk of placement due to delinquency.

Youths receiving MTFC are placed with highly trained foster parents as an alternative to residential placement. A treatment team consisting of the foster parents, a full-time case manager, individual and family therapists, and other resource staff provide intensive care over a 6- to 12-month period. MTFC interventions are based on social learning theory and strive to provide a) close supervision, b) fair and consistent limits, c) predictable consequences for rule breaking, d) a supportive relationship with a mentoring adult, and e) reduced exposure to delinquent peers while encouraging prosocial youth relationships. The ultimate goal of MTFC is to transition the youth to the family of origin by the end of treatment (53). One quasiexperimental investigation and two randomized controlled trials (54–56) have demonstrated the effectiveness of this model in decreasing youth delinquency and reducing out-of-home placement.

FFT consists of a behavioral family therapy targeting delinquent youths, their families, and aspects of the ecology that impact outcome. Treatment is provided by a therapist in the office and community, with most families averaging 12 sessions over 3 months. FFT relies on evidence-based interventions such as parent training and communication skill interventions to help families change the behaviors that are sustaining youth delinquency. One randomized controlled trial with juvenile status offenders and two quasiexperimental interventions with serious juvenile offenders have supported the efficacy of this intervention in improving family functioning and reducing delinquency (57).

Common Themes and Next Steps

Themes common to all three of these established treatment models (MST, MTFC, FFT) include a) a foundation in social-ecological and social learning theories, b) a problem-centered pragmatic approach, c) a strength-focused view of caregiver importance in treatment, and d) a quality assurance program designed to establish and help maintain therapist fidelity to the treatment model. These similarities, along with each program's unique way of applying evidence-based practice to empirically proven drivers of delinquency (poor family and school functioning, deviant peers), suggest a formula for success in treating delinquents (53). An important direction for future research focuses on determining the conditions needed to transport effectively these empirically tried interventions into the community to serve real-world populations without losing efficacy.

HOME-BASED FAMILY PRESERVATION IN MENTAL HEALTH

Background

Home- and community-based interventions for youths served by the mental health sector have their origins in the system of care (SOC) movement. This movement began with a seminal publication, entitled *Unclaimed Children* (58), which uncovered substantial inadequacies in our national mental health system's response to the problems encountered by children with serious emotional disturbance and their families. *Unclaimed Children* served as a rallying point for advocates, who ultimately helped to facilitate congressional funding of the Child and Adolescent Service System Program (CASSP), the Comprehensive Community Mental Health Services for Children and Their Families Program, and numerous other federal-, state-, and foundation-led initiatives to tackle mental service system inadequacies (59). These factors, combined with the forces of healthcare reform, rising psychiatric placement rates, and the realization that 50% of the nation's child mental health dollars were being spent on inpatient and residential treatments (60), served as catalysts to promote the development of alternative community-based services for youths with serious mental health problems.

Several important treatment trends or processes developed during this time. One was the dissemination of SOC initiatives into numerous communities. These initiatives were funded by foundation as well as federal dollars and were designed to provide a well organized and comprehensive spectrum of mental health and other necessary services to seriously emotionally disturbed youths and their families (61). As these initiatives emphasized the importance of providing a full spectrum of treatments that centered on caregiver empowerment and family involvement, they helped to promote the development of intensive home-based family preservation services. Another important trend was the introduction of the wraparound services concept. Wraparound is a process used to pull families, agencies, and service providers together to tailor or create services for children with significant needs. Composed of a multiagency team including the wraparound team leader and a family member, the goals of the team are to broker services and clinical treatment. While often confused with the family-based services that might be brokered by the team, wraparound is not, in and of itself, a home-based intervention (62).

Research

Research on the effectiveness of crisis family preservation services to prevent out-of-home placement by youths in the mental health sector has focused on the prevention of psychiatric hospitalization and residential placements. Given the high costs of such placements and lack of empirical data to support their effectiveness, it is surprising how little research has been done in this area. A handful of small studies, published between 1968 and 1982 (63-66), suggested that intensive family-based services had potential in reducing the rates of hospitalization for children and adolescents presenting with serious clinical problems. Likewise, researchers in New York City (67) demonstrated that psychiatric hospitalization can be avoided by providing intensive Homebuilders Crisis Intervention Services for youths not perceived by hospital staff as posing a danger to themselves or others. While

these evaluations are informative, they do not directly address the question of the viability of intensive home-based family preservation services to address the clinical and safety needs of youths who qualify for emergent psychiatric hospitalization.

To address this issue, the National Institute on Mental Health (NIMH) funded a randomized clinical trial including 156 families to examine the capacity of home-based MST to serve as an alternative to the emergency psychiatric hospitalization of youths in psychiatric crisis (68, 69). In this study, youths who lived in the catchment area; were 10-17 years of age; had Medicaid or no funding; and were about to be admitted to a university-based hospital due to suicidal, homicidal, at-risk, or psychotic behaviors were randomized at the intake office of the hospital to receive either MST home-based services or psychiatric hospitalization with usual aftercare services. The clinical portion of this trial was conducted between 1995 and 1999, and the specific adaptations made to the MST model are highlighted in the Promising Directions section following. Initial post-treatment (4 months) outcomes were favorable, with youth who received MST demonstrating a 75% reduction in days hospitalized and a 50% reduction in days in other out-of-home placements compared to youths in the hospitalization condition (69). Youths in the MST condition also exhibited significant improvements in externalizing symptoms, family relations, school attendance and higher consumer satisfaction compared to the controls (68). At approximately 1 year posttreatment, MST was significantly more effective at decreasing rates of attempted suicide (70). On the other hand, youths in both treatment conditions generally improved to subclinical ranges on indices of individual psychopathology (youth internalizing and externalizing symptoms) by 12 to 16 months, with no significant differences in final outcome, although the groups reached improved symptoms with significantly different trajectories. Similarly, for functional outcomes such as school- and community-based placements, the gains initially found for MST at 4 months slowly dissipated. By 16 months postreferral, youths in both treatment conditions showed an overall deterioration in time spent living in the community and attending school (71).

These data are important, as they represent the first large well controlled trial of an intensive home-based service used as an alternative to emergency psychiatric hospitalization. The initial 4-month outcome studies (68, 69) provide solid evidence that an intensive well specified and well validated family- and home-based intervention can serve as a safe and clinically effective alternative to emergency psychiatric hospitalization. Importantly, the authors noted that considerable clinical resources were needed to stabilize safely and effectively psychiatric crisis situations; and hospitalization was still needed to ensure the safety of some MST youths, albeit in an altered form and on a less frequent basis. This suggests that psychiatric hospitalization has an important role to play in the continuum of services provided to youths with serious emotional disturbance, and services designed to avert or minimize hospitalization need to be well conceptualized, evidence based, and implemented with fidelity. Long-term functional outcomes for youths in this study were somewhat disappointing, as MST for delinquent youths has a track record for significantly reducing criminal behavior and out-of-home placement as long as 14 years posttreatment (46). Yet, these mental health findings are consistent with the broader literature concerning the longitudinal course for youths with serious emotional and psychiatric symptoms (72-74), which indicates that while measures of individual psychopathology tend to normalize over time, the youths continue to be at high risk for failure to meet critical developmental challenges. Thus, poor academic and job performance, criminal behavior, low

financial achievement, high rates of early pregnancy, divorce, substance abuse, and mental health problems are potential outcomes for many of the youths represented in this study. The severity and chronic nature of problems found in this population have impacted the modifications to the MST mental health (MST-MH) model described below.

PROMISING DIRECTIONS

MST

The developers of MST for mental health populations or MST-MH have moved into community-based settings to test the effectiveness of this intervention. A study of MST-MH services in Hawaii of 31 youths randomized to MST or the integrated Hawaiian Continuum of Care yielded results at 6 months that are similar to those found in the hospitalization study: significantly reduced days in placement, externalizing symptoms, and risk-taking behavior. While followup data were not collected, this small study is promising and has provided a clinical venue for the developers to further hone the model adaptations (75). These adaptations are substantial and consist of both administrative and clinical additions (76, 77). Administratively, modifications include the integration of psychiatrists and psychiatric services into the team clinical structure, and the addition of a crisis caseworker to provide crisis intervention and case management assistance for MST therapists. Therapists are required to have a master's degree, and their time with the doctoral level team supervisor is increased both in the office and in the community. Therapist caseload is reduced from a maximum of four families (rather than five), and treatment is often extended from 4-6 to 6-8 months. Clinical modifications include additional training in crisis intervention; supplementary booster trainings and ongoing supervision in contingency management interventions for both youth and adult substance abuse; and additional training in assessment and evidence-based treatment of common psychiatric disorders in both youth and adults, such as attention-deficit hyperactivity disorder, mood, and thought disorders. These adaptations are provided within the context of basic MST; hence the core treatment principles and process for training, supervision, and quality assurance remain intact, but are supplemented by the adaptations.

Importantly, other promising home-based programs are being developed for youths with serious mental health problems. These programs are noteworthy, as each has specified treatment protocols and evaluations are being conducted in real-world settings to test the effectiveness of these interventions for youths with serious emotional problems and their families.

Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS)

The Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) was developed in 1997 at the Yale Child Study Center as an intensive, psychiatric home-based intervention for children and adolescents with serious emotional and behavioral problems at risk of requiring institutional-based care or unable to be discharged from such care without intensive services (78). The IICAPS model is manualized and uses concepts and findings from developmental psychopathology to understand the multiple determinants that contribute to child and families presenting problems. Interventions are grounded in three broad sets of constructs: developmental psychopathology; psychology of motivation, action and problem-solving; and systems of care philosophy. Concepts from developmental

psychopathology further the understanding of the child who is the focus of the IICAPS treatment.

Services are provided using the home-based model of service delivery with a master's-level clinician and bachelors' level mental health counselor providing services to the youth and family in the home and community for approximately 4-6 months. The services provided include assessment, evaluation, treatment, service coordination, and advocacy. Supervision and training are essential components of the IICAPS model. All individuals working in IICAPS complete 15 hours of training. A senior mental health clinician supervises the two-person clinical team weekly and a child and adolescent psychiatrist functions as medical director and coleader of regularly scheduled multidisciplinary rounds.

Fidelity to the IICAPS model (79) is measured by the degree of clinician adherence to the IICAPS tools and structures of treatment. Evidence supporting the continuous and simultaneous use of the engagement, assessment, treatment and quality assurance tools is required for programs to maintain their status as a recognized IICAPS site. IICAPS intervention outcomes are monitored with the help of a Web-based data collection system. This is used to collect both outcome and process measures for each site in the IICAPS network and can be used to evaluate the effectiveness of IICAPS in improving functioning and reducing the need for out-of-home placement. IICAPS services have been replicated in 14 sites within Connecticut, and steps are currently being taken both to develop measures of fidelity to the model and to evaluate its effectiveness.

While IICAPS appears to be a promising practice to maintain children at risk of hospitalization in their homes and communities safely, it has yet to be empirically evaluated. A pilot study with a comparison group is currently underway to begin assessment of the efficacy of IICAPS in impacting the serious mental health symptoms of youth at risk of psychiatric hospitalization and the parenting practices of their caregivers. This research represents an important step in helping to ensure that intensive home-based family preservation treatments maintain high standards to help ensure that the best possible care is provided to youths and families.

The Mental Health Services Program for Youth (MHSPY)

The Mental Health Services Program for Youth (MHSPY) is located in eastern Massachusetts and was established in 1998 to treat children and adolescents with severe and persistent mental health needs who failed usual service care and were at risk of placement. The theory of change underlying MHSPY is based on "continuity of intent theory" and grounded in CASSP principles (80, 81). MHSPY services are designed to provide a highly coordinated, individualized combination of mental health and pediatric care; substance abuse treatment; special education and social services to at-risk youth and their families. This treatment approach involves creation of a care planning team, made up of the family, a MHSPY care manager (a masters'-level clinician who chairs the team), and those providers or informal supports identified by the family as involved in their child's care. These additional provider team members may include: traditional therapists (psychologist or social worker), a child psychiatrist, family therapists (psychologist or social worker), and in-home "family skill builders."

The team engages with the family to define treatment goals and to determine how interventions will be delivered. These interventions may be implemented by the members of the clinical team, or brokered from other service providers. The classic intensive family preservation home-based model of service delivery is partially followed in that care managers carry

a low caseload, provide services in the home and community, and are available around the clock. Two differences are that the timeframe is substantially longer (16 months) than the usual 3–6 months typically found in home-based programs, and services are implemented by a number of different providers, some of which are purchased by dollars under control of the case manager, which is more consistent with teams using the crisis intervention model or wraparound services concept.

A formal audit process exists to ensure quality and inform ongoing training and support of clinical staff, as well as evaluation of program implementation and outcomes. All purchased services are supervised and monitored for quality by the MHSPY care manager, who in turn receives weekly supervision and support from a clinical site supervisor (a senior clinician, usually a LICSW), as well as regular access to consultation from a child psychiatrist. All staff participate in monthly training and program development support. Outcome measures consist of data collected at baseline and every 6 months to assess functional outcomes, as well as level of care, service utilization and cost and care experience data. Aggregate analyses based on 6 years of multiwave, longitudinal data from the initial site, as well as replication results from a second site implemented in 2003, show that over 88% of days in the MHSPY program are spent at home and the majority of youths display clinical improvement, including a 45% reduction in risk to self and others. Hospitalization and other placement rates are lowered postenrollment by 55%, primary health maintenance visits are higher compared to similar Medicaid populations, while emergency room usage is lower. Importantly, the program has a 95% retention rate among previously “noncompliant” families. While these findings are encouraging, an important next step will involve further evaluation with a control group. The developers of the model are currently pursuing funds to assist with evaluations (81).

The programs highlighted in this section are important, as they represent emerging treatment approaches for trying to bring empirically validated intensive home-based family preservation services to youths with serious mental health problems and their families. While each of the programs still has substantial work to do toward reaching this goal, early findings are promising. Some of the challenges faced in developing, implementing, and evaluating empirically grounded home-based treatments are outlined below.

Challenges and Next Steps

Clinicians and researchers face a number of barriers in their attempts to validate and disseminate community and home-based interventions for youth presenting serious mental health problems and their families. Many of the challenges result from the unconventional nature and relatively novel approach represented by home-based services in the context of services and systems that have been parceled out and delivered with an individual focus for more than a century. These barriers include difficulties finding funding streams for relatively new and unconventional services, organizational and administrative adjustments needed to support home- rather than office-based therapists (cell phones, overtime, realistic safety training), and lack of prior training for therapists educated in traditional treatment models. Likewise, research of these interventions is difficult to conduct due to the complex nature of both the treatments and the real-world settings in which they are delivered and evaluated. For example, the first step is to develop and specify the treatment protocols. This involves the creation of a treatment manual, training program, and clinical process to facilitate clinical integrity to the model. Likewise, a measure of treatment fidelity must be established and validated. Once treatment is specified, the process of conducting research

with heterogeneous samples of children and families presenting multiple problems in complex treatment, service and funding environments can be daunting in terms of methodological, clinical, and systems barriers.

CONCLUSION

Although home-based services for families of youths presenting serious clinical problems in the child maltreatment, juvenile justice, and mental health service systems have just recently become established, there are increasing signs that the use of these interventions will continue to grow. A confluence of factors currently exist that may help to promote the adoption of these interventions. Clinically, there is growing national interest in promoting evidence-based practice; which bodes well for empirically supported home-based interventions that offer alternatives to existing services (prison, foster care, and hospitalization) that have little demonstrated effectiveness. Financially, home-based interventions have the potential to produce substantive cost savings to service systems if they can be targeted at youths who are truly at imminent risk of placement. Ethically, home-based programs are consistent with the SOC movement and appeal to family-strengthening proponents on both sides of the political agenda. Yet it is important that empirically supported home-based services not fall into the same traps that ensnared their predecessors, that is, care must be taken to ensure the treatments provided are safe and effective. Families and youths with serious clinical problems have complex needs that are multiply determined and effective solutions require sophisticated, well implemented, evidence-based strategies. Critically, an infrastructure must exist that provides therapists and supervisors who are well trained and adequately paid, with strong organizational support; and funding streams must facilitate rather than hinder clinical progress. Most important, a quality assurance system must be in place to help ensure that the services provided continue to meet adequately and safely the growing and shifting needs of these complex clinical populations. As we enter the twenty-first century, with continued careful research, empirically supported home-based services may become a much-needed mainstream intervention.

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CHAPTER 6.3.3 ■ COMMUNITY-BASED TREATMENT AND SERVICES

ANDRES J. PUMARIEGA AND NANCY C. WINTERS

HISTORY AND CHALLENGES IN CHILDREN'S COMMUNITY MENTAL HEALTH SERVICES

The early origins of mental health services for children in the United States emphasized a community and even a systems orientation. The context for the birth of these services was America in the 1890s, which, much as today, was undergoing rapid sociocultural changes due to immigration, industrialization, and urbanization. These social strains and their impact on children and families led to marked increases in juvenile crime and status offenses. Enlightened reformers saw the need for detaining young offenders separately from adults and adjudicating them in a separate court system (juvenile courts) that provided an opportunity for rehabilitation. The first community-based mental health services began in response to the perceived need for counseling juvenile offenders and their families. Thus, the new juvenile courts in Chicago and Boston established clinics that comprised the first child mental health services in the nation (1).

Their success led the Commonwealth Foundation to commission a study in the 1920s (and later start-up funding) that promoted the development of child guidance clinics throughout the nation, staffed with interdisciplinary teams

of professionals who could serve children and their families. These clinics were first primarily staffed by social workers, but later attracted psychosocially oriented pediatricians, psychologists, and later psychoanalysts (as they emigrated from Europe) and psychiatrists (as the specialty grew and developed). These clinics later served as the bases of the first child psychiatry programs in the nation. They were removed from the specialty-oriented, hospital-based medical system evolving at tertiary medical centers. They provided low-cost services oriented to the needs of the child and the family, with treatment modalities evolving to include individual psychodynamic psychotherapy, family therapy, crisis intervention, and even day treatment programs. Many have survived to this day, and they even served as the model for the community mental health centers advocated in the 1960s community mental health legislation championed by the Kennedy administration, and later implemented throughout America in the 1960s (1).

The "medicalization" of psychiatry, starting in the 1970s and '80s, served to move child and adolescent psychiatric services toward a more hospital-based, tertiary care model. This left the child guidance clinics, and the community mental health centers that followed them, without significant child psychiatric input, adding to the relative neglect of the development of children's services. Many of the children previously served in these clinics were served in inpatient