Intermediate Levels of Care for Children with Behavioral Health Needs:

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

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Child Health and Development Institute of Connecticut, Inc.

Project Overview

The importance of intermediate levels of care (ILC) to the children's behavioral health system was raised frequently in behavioral health plan implementation workgroups held in 2021 and 2022.

CHDI was funded by DCF to Address the following questions regarding *center-based* ILC services…

1. What does the research indicate are best practices in implementing ILC services for children? Successful evidence-based practices and/or milieu models?
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? Any specific to EDT?

For purposes of this work, the following *center-based intermediate levels* were included: intensive outpatient, partial hospitalization, extended day treatment, and PRTF

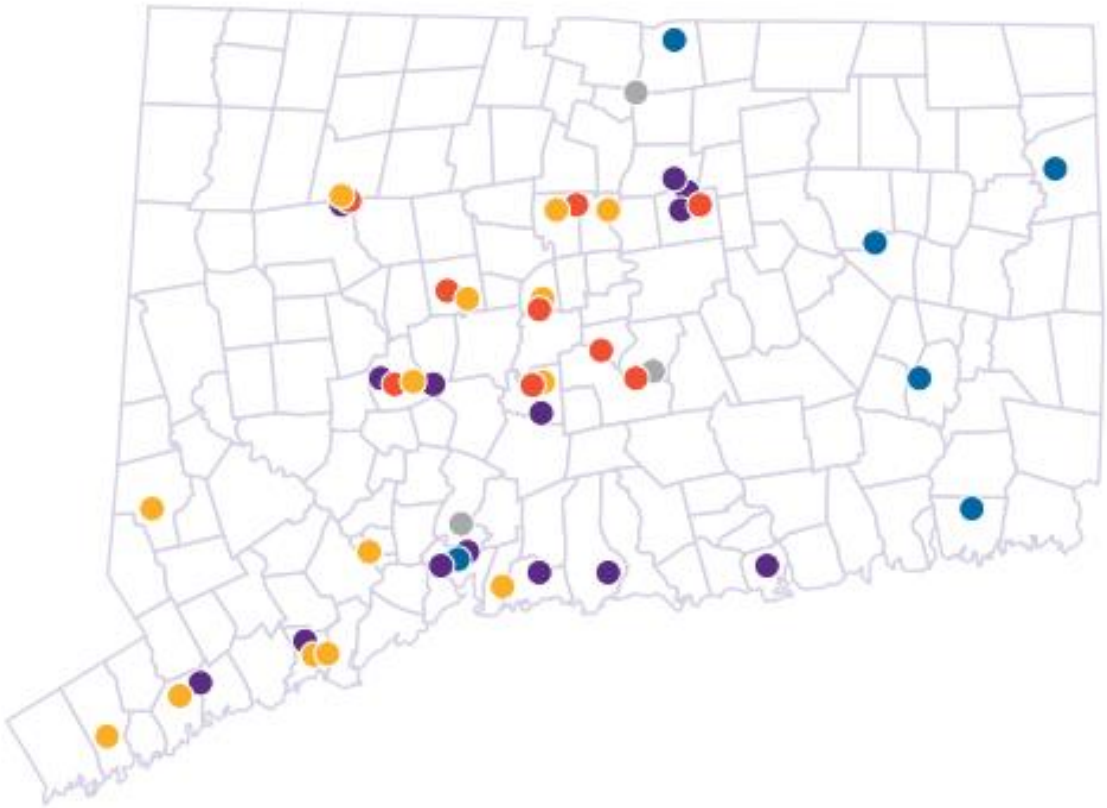
Process

- Literature review of ILC best practices for children and youth
- Survey of ILC programs in Connecticut regarding implementation practices
- 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
- Analysis of EDT data collected in DCF's Provide Information Exchange database
- Focus group with ILC staff

ILC Literature is Limited

- Dr. Amber Childs (Yale) completed a review of available literature review in 2022.
- More literature available for PHP and IOP programs, less for PRTF and almost none on EDT.
- Multiple studies that assessed effectiveness of PHP or IOP with reducing specific symptoms
- Gaps in national literature: equity across outcomes, services for children with intellectual or developmental disabilities, substance use disorder, dosage or treatment components, cost-effectiveness, and long-term outcomes

ILC In Connecticut



Legend

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

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Care Guidelines

	Treatment Model	Target Length of Stay	Acuity
EDT	≥3 hrs/day; 2-5 days/wk ≥2.5 hrs therapeutic services Recreational therapeutic services are primary focus; client may require medical observation, monitoring, or adjustment	Up to 6 months	Moderate symptoms; symptoms are persistent in nature; may have been unsuccessful in shorter-term or other community-based programs
IOP	≥3 hrs/day; 2-5 days/wk ≥2.5 hrs clinical services Recreational therapeutic services can be incorporated; client may require medical observation, monitoring, or adjustment	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	≥4 hrs/day; 5 days/wk ≥3.5 hrs clinical services Recreational therapeutic services may be incorporated; client may require intensive nursing or medical intervention	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	24-hour care Individual, family, and group therapy, parent guidance, must include schooling	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

Strengths

1. Program implementation largely aligns with the broader (but limited) literature and the BHP level of care guidelines.
2. There is some use of EBTs in ILC programs (more consistently 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 symptom improvement, with greater improvement among children of color.
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

1. Programs are in high demand but are operating with significant staffing shortages, waitlists and staff burnout
   - Programs are down an average of 1/3 of their staff
   - Reported wait time for services was 2-6 weeks
   - Staff report 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.

Challenges

5. There is very limited use of measurement-based care.
6. Staff report limited opportunities for training (among IOPs and PHPs particularly).
   - Programs are challenged to send staff to training given workforce shortages
   - Per the survey results, staff are seeking training on: EBTs, single-session/brief interventions, first-episode psychosis, vicarious/secondary trauma, cultural humility, intellectual and developmental disabilities, and measurement-based care.
7. Quality improvement support is offered from DCF and Carelon. However, there is an opportunity for increasing coordinated, continuous quality improvement to support more standardized training and data reporting to evaluate and improve outcomes for children.

EDT-Specific Challenges

1. Programs report inconsistent access to comprehensive diagnostic evaluations.
2. While family engagement is a component of all programs, there is variation in extent of family engagement strategies.
3. EBTs were implemented at lower rates for children of color than for White children.
4. There were lower rates of job satisfaction reported among EDT staff than staff from other program types.

Overall Findings

- Demand for ILC services is increasing
- State ILC programs align with care guidelines
- Data on racial and ethnic disparities related to ILC services is mixed
- EBTs and measurement-based care are not consistently used across Connecticut ILC programs
- ILC programs are experiencing staffing shortages

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

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

2. Implement Measurement-Based Care

3. Pilot Implementation of a Standardized Model

4. Expand Other Training Opportunities

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

6. Continue Review of PRTF

EDT-Specific Recommendations

1. Ensure Access to Full Diagnostic Evaluations

2. Continue and Expand Equity-Focused Quality Improvement Efforts

3. Address Staff Wellness and Job Satisfaction

Thank you!

Full report available at:

Intermediate Levels of Care for Children with Behavioral Health Needs :: The Child Health and Development Institute of Connecticut (chdi.org)

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