IICAPS

Strengthening families through connection

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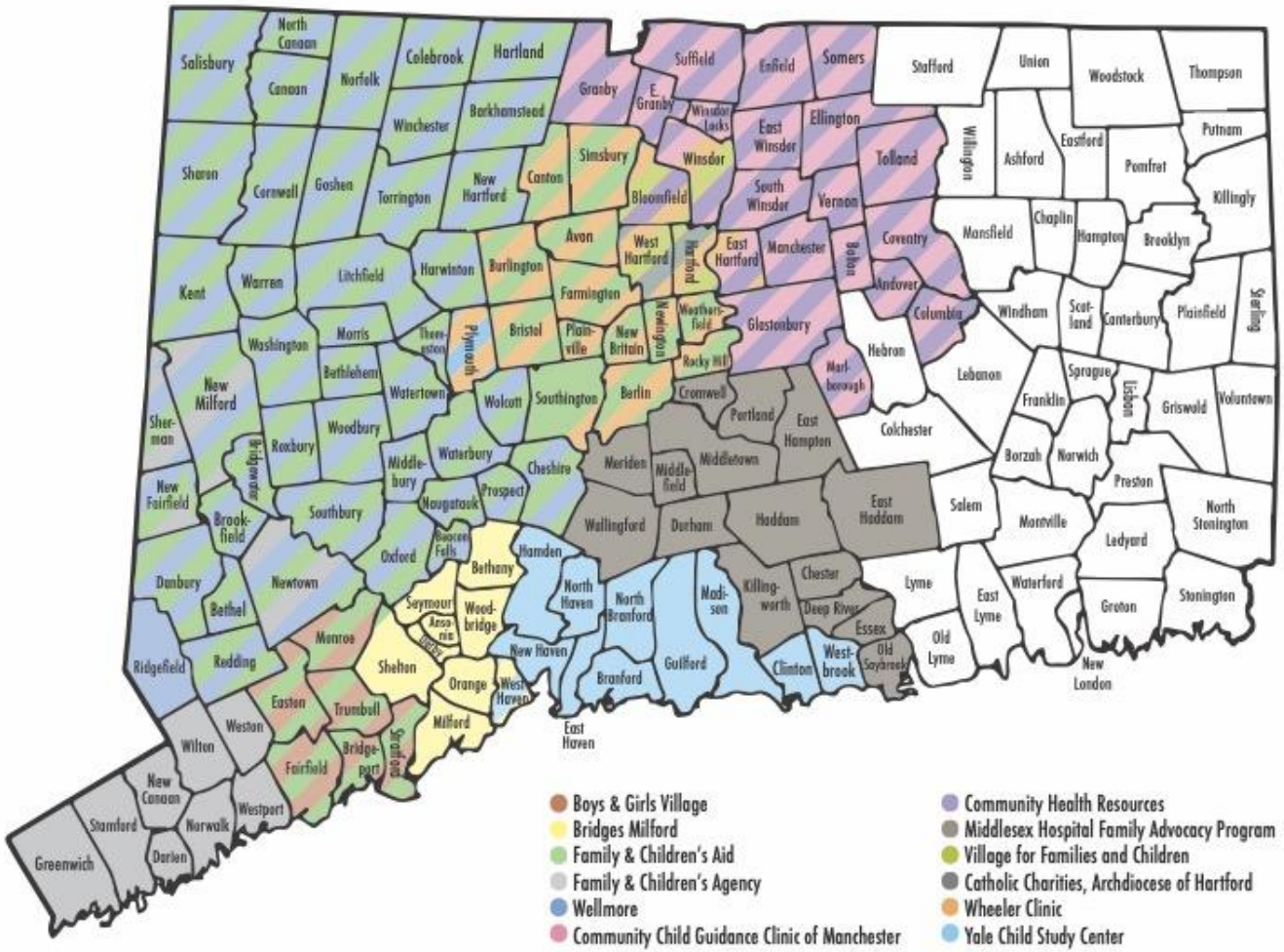
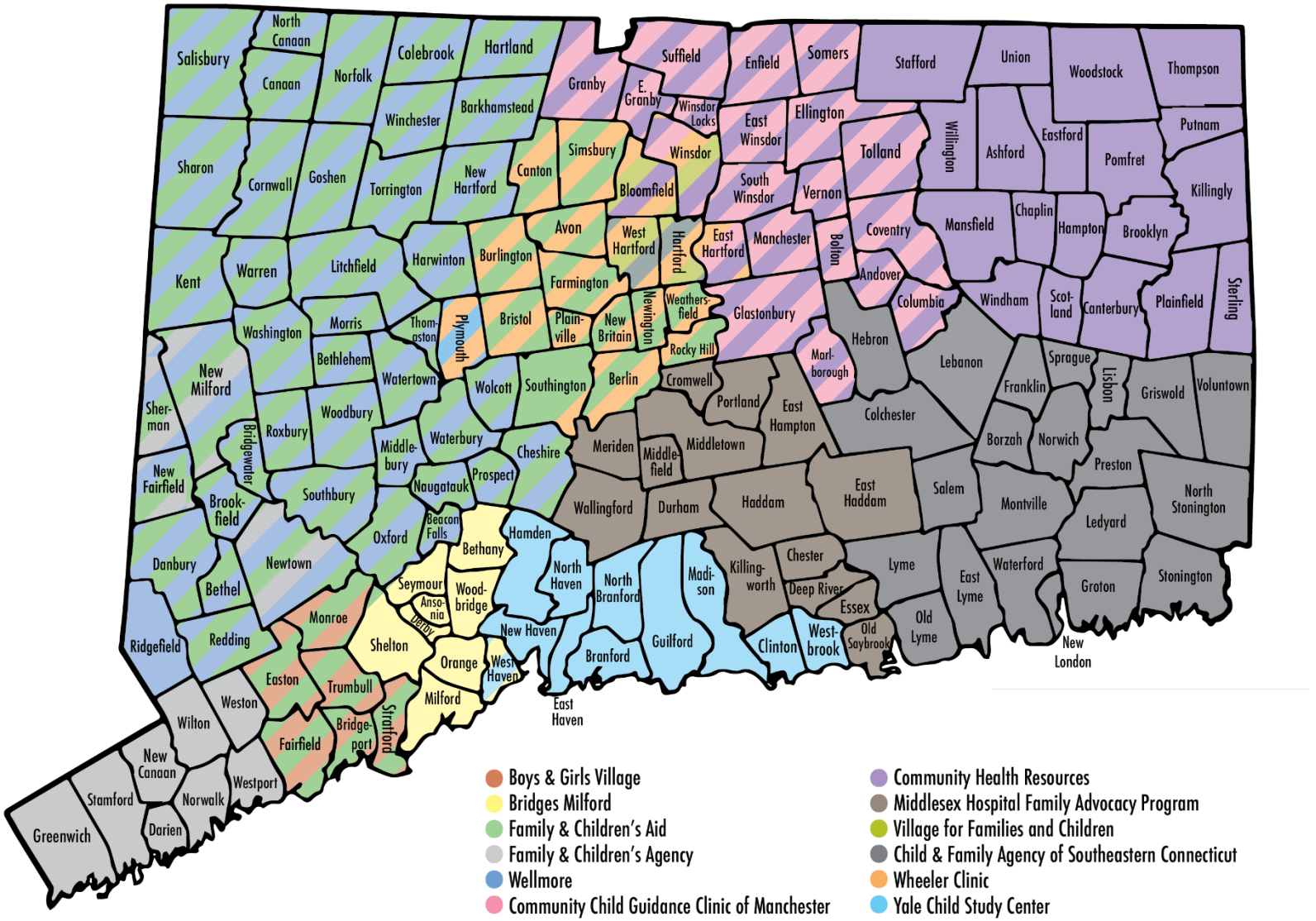
IICAPS Network 2023

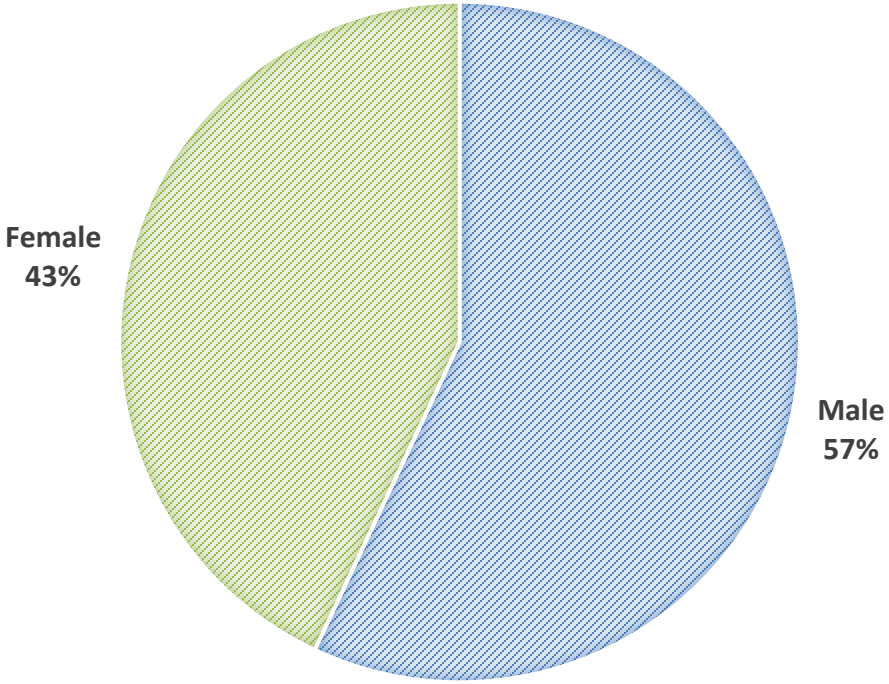
-Post pandemic annual families served decreased to ~700 from ~ 2,000+ in the years prior
- Most sites experienced full staff turnover
- Catholic Charities and Child and Family Agency New London closed. Wheeler Clinic and Community Health Resources were on the edge of closing.

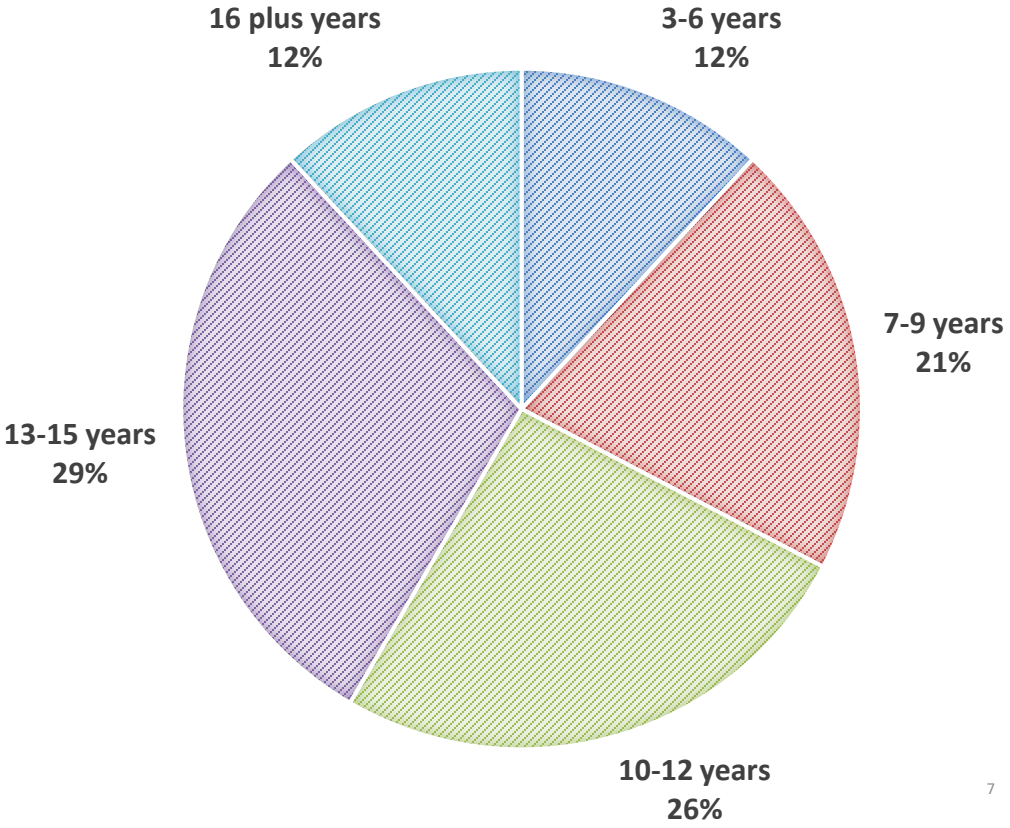


IICAPS Network 2026



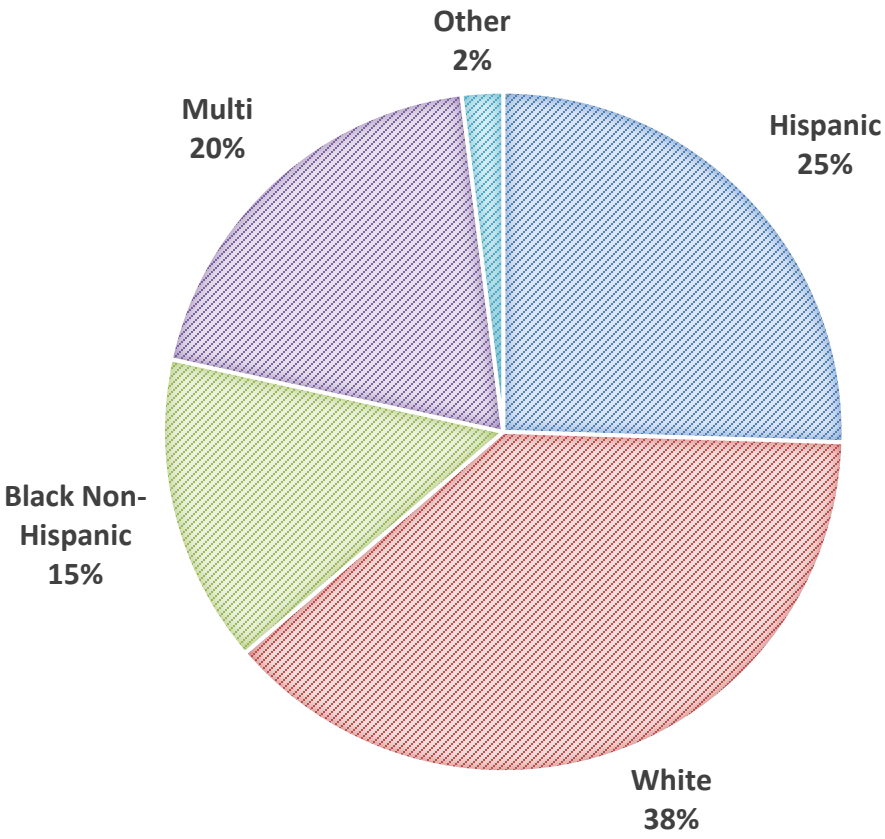
Sex and Age (2014-2019 = 12,602)

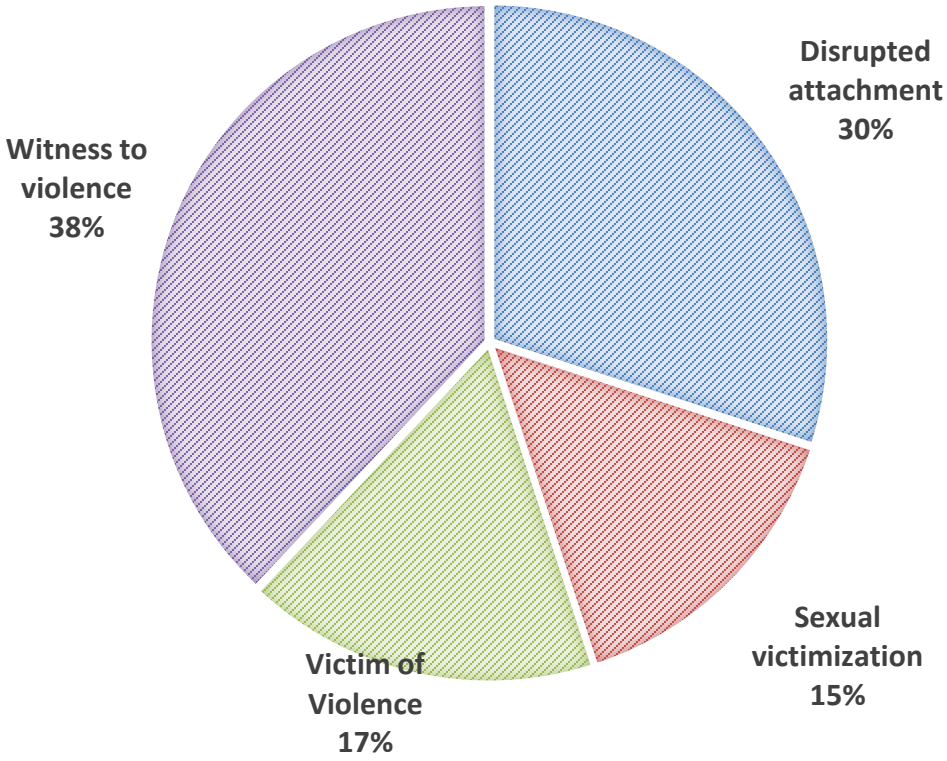




* Beginning to collect and analyze data about gender variance and hope to present this soon

Race and Complex Trauma (2014-2019 =12,602)





- 67% of children and adolescents report one or more experiences of complex trauma
- Diagnosis data is extremely variable, and most kids have multiple diagnosis
- Roughly half of IICAPS parents endorse 4+ adverse childhood experiences

Outcomes for 2014-2019 =12,602

Significant reduction in Ohio scale symptom severity and improvement in Ohio scale functioning for treatment completers.

- 50% of cases on average showed clinically reliable changes
- Treatment completion rate: 73% trending upwards

Significant reduction in service utilization for treatment completers.

- > 60% reduction in hospital admissions
- >50% reduction in inpatient days,
- 40% reduction in ED visits

For the 73% of families who discharge having successfully completed treatment, these improvements have been shown to be maintained 6 months after discharge.

Outcomes for Q1FY2026

- The percentage of cases identified as Treatment Completers in the 1st quarter was 76.9%.

- 64.9% decrease in psychiatric inpatient admissions
- 79.6% decrease in psychiatric inpatient days
- 51.4% decrease in emergency department visits

- following IICAPS intake compared with the six months prior to IICAPS intake.

- Statistically significant average decreases in Problem Severity scores per parent report (10.8 points), youth report (6.6 points) and worker report (10.4 points)
- Statistically significant average increases in Functioning domain scores for parent report (8.7 points), youth report (4.2 points) and worker report (9.1 points).

Satisfaction for FY2025 = 889

Of those who complete the treatment satisfaction survey (85.4%)

86.9% report Agree or Strongly Agree that they had a positive experience, felt the intervention improved the parent/child relationship, and that the team was respectful of their cultural/ethnic background and religious beliefs.

Funding Mechanism

- Fee-For-Service through Connecticut Behavioral Health Partnership
- Medicaid and some Private Insurance
- IICAPS Model Development and Operations funded through DCF grant

Current Waitlist: 548 families across the state. ~2-3 month wait

Recent News in IICAPS

1. Building Sustainability Through Evidence

TTE Study	Purpose	Impact
Evaluate outcomes & system impact	Build evidence aligned with federal standards to ensure braided funding through DCF	Support workforce training, onboarding, leave coverage, quality assurance, private insurance access

GOAL: Demonstrate effectiveness and support long-term sustainability of IICAPS statewide.

PARTNERS: Yale * DCF * Department of Education * Court Support Services Division * DSS * DataLinkCT

2. Replication in Rhode Island

3. Addition of new clinical tools to support parent-child co-regulation

Update Connecticut's IICAPS Level of Care Guidelines to remove the lower age restriction and clarify that chronological age alone is not a basis for admission or exclusion.

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

- 4-6 hours of support weekly including parent, child, and family sessions
- Two-person team – MHC and Masters Level Clinician
- Mentalization based, and attachment and multigenerational complex-trauma informed
- Addresses both parent and child mental health and regulation
- Clinical work in 4 domains: Child, Family, School, Community
- Referrals from Inpatient units, Emergency Departments, Department of Children and Families, IOP/PHP, PRTF, Schools, Child Guidance Clinics, Probation, Pediatricians, Parents

Why This Matters

- IICAPS has served children under the age of five since its inception.

- Young children can present with severe psychiatric and relational disturbance despite not meeting traditional crisis markers.

- Current interpretation of Level of Care criteria may unintentionally create barriers for preschool-aged children to access necessary care.

- Families are often left with outpatient services that they may not be able to access and cannot adequately address caregiver-child dysregulation, attachment disruption, multigenerational complex trauma, or severe family impairment.

Clinical Rationale

Examples of presentations that may warrant IICAPS:

- Severe caregiver-child dysregulation
- Attachment disruption
- Developmental regression
- Chronic aggression
- Preschool/daycare expulsion risk
- Relational trauma or other developmental trauma exposure
- Sexually reactive behavior
- Significant family impairment and risk of out-of-home placement

Target Population

Children and adolescents with severe emotional/psychiatric disturbance (Axis I) who are:

1. Who are at risk for psychiatric institutional-based treatment, and/or
2. Who are stepping down from psychiatric institutional based treatment, and/or
3. Who are unable to benefit from clinic-based ambulatory treatment, and/or
4. Who have returned or are returning home from out-of-home care and require a less intensive level of treatment.

Target Population continued

Must have a parent or caretaker who is committed to working with child and team as partners in the clinical work.

Cannot have primary diagnosis of conduct disorder or substance misuse

Can have primary psychiatric diagnosis with secondary conduct disorder and/or substance misuse

Can have secondary diagnosis of intellectual disability

Can have secondary diagnosis of autism spectrum disorder

Policy Recommendations

1.Remove the age range language from the current IICAPS definition and maintain the upper age limit (18 years).

2. Add language stating that eligibility and medical necessity should be determined by clinical need, functional impairment, family impairment, and risk of deterioration.

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