EVALUATION OF MICHIGAN'S INFANT MENTAL HEALTH MODEL

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History of IMH Services

- 1971 MI Dept. of Mental Health paid for 12 CMH staff to be trained (UM) Selma Fraiberg's Child Development Project
- 1973 MI-AIMH formed by trainees held first conference
- 1974 small state grants to CMHs for IMH services
- 1986 MI Mental Health Code required service,1996 optional service
- 1983-84 Objective-Problems Checklist (OPC) developed

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IMH History & Funding

- 1996 – IMH consultation w/ child care programs
- Medicaid Home-based Services for babies, young children & parents - most IMH services funded under H-B option, requires 2 hours week face to face or collateral contact
- Another option is Medicaid Prevention Direct Service Model – no criteria for contact
- Both require endorsement at Level II by Mi-AIMH.

Michigan - Supporting Competencies and Reducing Risks in the First Years of Life

Basic Beliefs -
Infants, toddlers & parents develop optimally within the context of nurturing relationships

The birth of a baby offers the hopefulness of a new relationship & possibility for growth & change.

All parents want what is best for their babies, including a wish for health & relationships that are stable & mutually satisfying.

Basic Beliefs

- Parents must feel nurtured in order to nurture their infants; fed in order to feed; comforted in order to comfort.
- Attachment relationships provide a secure base from which infants & young children grow physically, emotionally, cognitively & socially.
- Early relationships serve as prototypes for later relationships.

Basic Beliefs

- All families have capacities. It is up to us to support them as they develop.
- Early developing attachment relationships may be disturbed or interrupted by parental histories of unresolved losses or traumatic life events.
- The therapeutic presence of an IMH specialist may reduce the risk of relationship failure and offer the hopefulness of nurturing responses.

Beliefs become practice

- The practitioner is an ally who stands beside the parent and infant to help them bring what is best to one another.
- The practitioner offers a therapeutic alliance as the instrument for support and change.

IMH Services

- Concrete Resources/Assistance
- Emotional Support
- Developmental Guidance
- Early Relationship Assessment/Support
- Advocacy
- Therapeutic Intervention with Infant or Toddler and Parent(s)

Concrete Resources/Assistance

- Accessing services to meet basic needs.
  - Offer to set up medical appointments.
  - Arrangements for transportation or child care
  - Participate in family service meetings for enrollment in early intervention (Early On)
  - Problem solving to reduce immediate stress

Emotional Support

- Emotional support related to an immediate crisis, e.g. the birth of a premature infant, hospitalization of a baby, mother's early return to work.
- Invitation to talk about present realities, care of the baby, crisis of parenthood.
- Thoughtful listening, with compassion for family's immediate realities.
- Empathic response.

Developmental Guidance

- Offer information specific to each baby's unique pattern of growth, encouraging parental attention, interest & response.
- Make informal observations about the baby & invite each parent to do the same.
- Watch infant & parent together; ask parent what she or he sees that the infant is doing; support parent's developmental awareness; think together about "what next."
- Speak for the baby, identifying pleasures, wants or needs.

Early Relationship Assessment & Support

- Keep infant/toddler & parent(s) in the room & at the center of your work.
- Ask for & listen to parent's observations, questions about the baby, & concerns.
- Observe & assess capacities, alerting parent to infant's accomplishments/needs
- Informal/formal assessment guides/instruments used for diagnosis & treatment planning.
- Create opportunities for parent-infant interaction & exchange.
- Remain attentive & fully emotionally available, inviting each parent to set the agenda & take the lead with the baby.
- Wonder about the baby's capacities to elicit interest & care; each parent's responses.
- Reinforce each parent's positive interactions & baby's contributions to the exchange.

Infant-Parent Psychotherapy

- Use the therapeutic relationship to explore each parent's thoughts & feelings about the infant or toddler, care-giving responsibilities, & relationships, past & present.
- Attend & respond to parental histories of abandonment, separation & loss as they affect the care of the infant, the parent's emotional health, & the developing relationship between parent & infant.
- Allow core conflicts & emotions to be expressed; hold, affirm, & contain them.
- Stay emotionally available, curious, open, & reflective.

Infant Mental Health Services

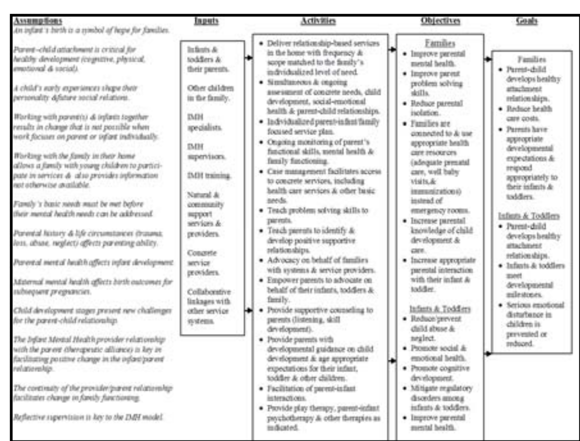
- Meeting with parent(s) & infant together, most often in their own home
- Thoughtful questioning & listening
- Guidance & psychological support
- A secure & trusting relationship as a base for shared understanding, guidance & support about the infant, the parent, relationships past & present, & adjustment to care-giving role
- Enhanced capacity for self-observation & reflection through supervision

IMH Strategies

- Focus on emotional health & development of the infant & parent(s)
- Focus on relationships, past & present
- Require a safe & nurturing context in which parent(s) & specialist may think deeply about the care of the infant & the multiple challenges of parenthood
- Wonder about each parent's thoughts & feelings related to the presence & care of the infant
- Listen for the past as it is expressed in the present

IMH Strategies

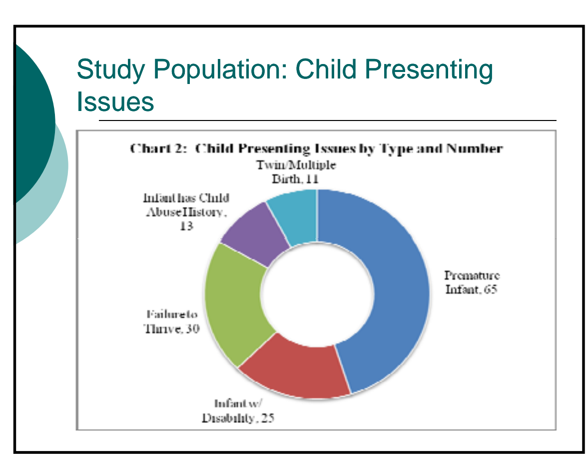
- Allow relational conflicts & feelings to be felt & expressed
- Attend & respond to parental histories of loss & grief
- Attend & respond to the infant's history of early care
- Identify, treat and/or collaborate with others (if needed) in the treatment of disorders of infancy, delays, disabilities, parental dysfunction
- Remain open, curious & reflective



Identifying Characteristics

- Who are the infants/toddlers served?:
  - premature, underweight, medically fragile
  - irritable, difficult to hold or soothe, unresponsive
  - difficult to feed, failing to gain or thrive
  - difficult to engage, avoidant, depressed
  - suspected developmental delays (social, emotional, cognitive, motor)
  - sensory processing or regulatory disorders
  - prolonged grief reaction
  - identified disorders, e.g. traumatic stress, reactive attachment

Study Population: Child Presenting Issues



Identifying Characteristics

- Who are the parents?:
  - Single, adolescent by age of behavior
  - Unprepared for the care of a baby, overwhelmed by parental responsibilities
  - Alone or unsupported; inattentive or unresponsive to baby's needs; anxious, ambivalent, avoidant, abandoning
  - Depressed, stressed by economic deprivation or personal/social conflicts
  - History of unresolved loss(es) & grief
  - History of neglectful or abusive care
  - Diagnosis of significant mental illness

Study Population: Caregiver Characteristics (N=432)

- All but 12 of caregivers were females
- One-fifth pregnant at intake
- All but 8 birth parents of infant/toddler
- Mean age 24.7
- Slightly more than 40% Caucasian, slightly less than 40% African-American
- Two-thirds never married

More Caregiver Characteristics

- Two-thirds DSM-IV diagnosis (n=255) mostly depression/depressive disorders, bi-polar & adjustment disorders
- 70 diagnosed low functioning or developmentally disabled
- Majority (88.6%) high school education or less
- 37.7% on TANF & 21% on SSI/SSD
- 40% infant/toddler their 1st child

IMH Evaluation Purpose

Process, Outcome & Cost Study of Michigan's IMH Model

- To determine the efficacy of infant mental health services with two different at-risk populations:

1) families with first time births/adoptions,
2) families with subsequent births/adoptions

- Assess impact of (worker to family) caseload ratio & service duration on outcomes
- Cost analysis evaluation objectives are determining model's distributive efficiency

Data Collection Schedule

Data Collection Points	ASQ-SE	OPC	Consumer Satisfaction Survey	Treatment Plan Goal Attainment Measure	FILE
Baseline/Intake	X	X			
1st Quarter of Service		X			
2nd Quarter of Service	X	X			
3rd Quarter of Service		X			
4th Quarter of Service	X	X			
Program Termination	X	X			
1 Month Post-service			X		
3 Months Post-service				X	
6 Months Post-service	X				
9 Months Post-service				X	X
12 Months Post-service	X				X

What are the Characteristics of IMH Staff? N=130

- All but one are females
- Mean age 38.28, range 22 - 64
- 92.4% Bachelors degrees & 98% Masters
- Mean years in field 5.24
- Ethnicity: Caucasian (69%)
- African American (18%)
- Latino (6.2%) & Middle Eastern (3.9%)

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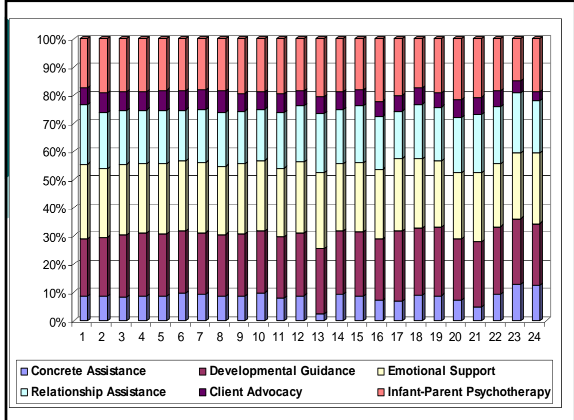
Other Process Results

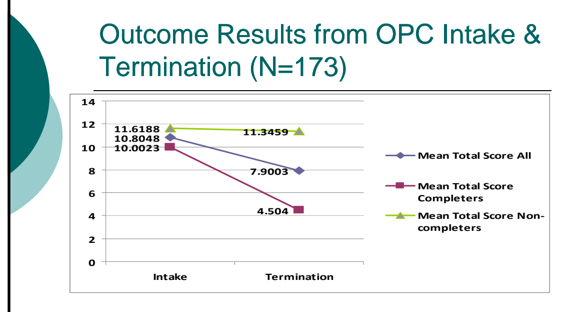
- Self/family/friends one-third of referrals
- Health care provider/local public health 40.8% of referrals
- Majority of caregivers report using what they learned in the program at home & being in the program was not difficult
- Two-thirds staff high model fidelity, 1.4% low
- No IMH staff with MI-AIMH endorsement scored low fidelity to model



Duration in Program & Costs per Family by Months in Service for All Cases, Completers & Non-Completers

Length of Service and Cost per Family	All	Completers	Non-Completers
Mean Length of Service Cost per Family	9.25 Months *$3,302*	12.33 Months *$4,402*	6.58 Months *$2,349*
Modal Length of Stay Cost per Family	4 Months *$1,428*	12 Months *$4,284*	4 Months *$1,428*
Range Low End Cost per Family	2 Months *$714*	2 Months *$714*	2 Months *$714*
Range High End Cost per Family	31 Months $11,067	31 Months *$11,067*	19 Months *$6,783*

Outcome Results from OPC Intake & Termination (N=173)



Paired Sample T-tests significance between Intake & Termination scores on all 9 OPC scales for Completers (n=80, 46.2%)

Successful Completers Baseline vs. Termination

•Sub-Scale	•Mean Baseline	•Mean Termination	•Difference	•T-score	•DF	•P-value
•Family Needs	•.7826	•.4583	•.32427	•6.240	•75	•.000
•Caregiver's Social Support	•1.1096	•.5515	•.55811	•7.104	•75	•.000
•Caregiver's Psychological Well-being	•1.3471	•.6492	•.69796	•9.241	•75	•.000
•Infant/Toddler Related Family Issues	•1.2512	•.7072	•.54398	•6.135	•71	•.000
•Infant/Toddler Physical Needs	•.7950	•.3059	•.48904	•7.928	•72	•.000
•Infant/Toddler Age-Appropriate Development	•.7694	•.2759	•.49352	•6.351	•71	•.000
•Caregiver's Understanding and Promotion of Infant/Toddler Development and Behavior	•1.1945	•.4404	•.75411	•9.291	•72	•.000
•Infant/Toddler-Caregiver Relationship	•1.2694	•.4806	•.78889	•9.269	•71	•.000
•Infant/Toddler-Caregiver Psychotherapy Issues	•1.5856	•.7315	•.85417	•10.125	•71	•.000
•Total Score	•10.0023	•4.5040	•5.49836	•9.858	•69	•.000

Outcome Question Results

- *Does participation in IMH services promote attachment by increasing parents' appropriate interactions with infants/toddlers?*
- Completers scores on OPC subscale Infant/Toddler-Caregiver Relationship
- GAM attachment goal 55.5% maintained progress on goal, 50.0% report making additional progress on goal

Does participation in IMH services improve parental mental health status?

- 57 completed cases for whom a DSM-IV diagnosis was available, 32 or 56.1% had diagnosis at intake & 35.2% with DSM-IV diagnosis at termination
- Pairwise t-test analysis of FILE results show statistically significant reduction in mean number of stressful events post program for family stress composite measure
- GAM caregiver mental health 1st prioritized goal 71.4% reported that progress on that goal had been maintained

Do parents participating in IMH services demonstrate age appropriate expectations of child behavior?

- Caregiver Understanding of & Support for Positive Infant/Toddler Behavior/Development' scale. **S**ub-scale includes 5 items: Knowledge of infant/toddler needs, behavior & development; Expectations & promotion of child behavior; Verbal stimulation; Sensory stimulation; & Stability of child's environment
- Child development 1st prioritized goal, 69.2% maintain progress; 76.9% additional progress; 2/3rd therapist observation supports goal maintenance

Do families receiving IMH services reduce health care costs?

- 81.9% of caregivers reported no additional pregnancies while in the program
- At intake 15 families reported using a hospital emergency room in past four months - at termination 10 families reported using a hospital emergency room in past quarter
- Health stress items from FILE show some improvements in the adults' & children's physical well-being post-service

Does participation in IMH services reduce child abuse and neglect?

- FILE results reduction in physical abuse & violence in home during post-service period
- OPC self-report data for completers, 8% had children previously removed, non-completers 13% had children previously removed
- CPS registry checks for 71 completers & non; 13 cases investigated during/after IMH services only 3 of 13 new investigations were on completers; none of these cases were substantiated

Does participation in IMH promote age appropriate social-emotional development in infants/toddlers?

- Two OPC sub-scales measure these concerns 'Infant/toddler's physical needs' the other sub-scale is 'Infant/toddler/caregiver psychotherapy issues'
- ASQ-SE results - children that were a part of the program at an earlier age did better on the ASQ-SE, mean differences in change scores move in the direction of positive change & with each successive administration, the gains are greater

Questions &
Resources
Resources:
www.mi-aimh.org
www.zerotothree.org