

**Getting it Right: A Closer Look
at Home-Based Treatment Responders**



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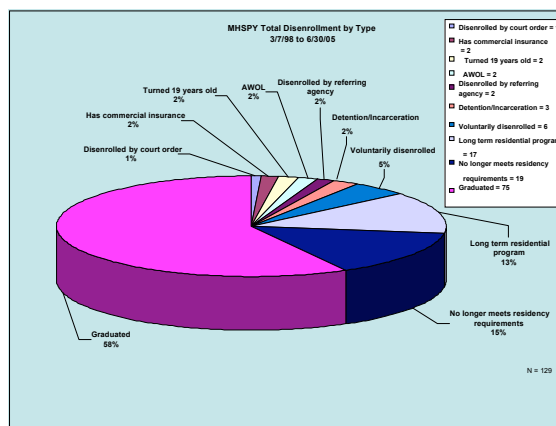
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Overview

- Mental Health Services Program for Youth (MHSPY) is an intensive, interdisciplinary home and community based treatment program in Massachusetts
- Defines program “graduation” based on multi-source, family-driven, assessment of mission achievement for individual youth
- Graduates, 58%, are largest group and at top of continuum of “Responders”

Overview (cont.)

- Other disenrollees, 42%, are further away from graduates in the response continuum and are considered here to be part of broad group identified as “NonResponders”
- So-called NonResponders may also show some improvement; but they are not felt by the family Care Planning Team to have achieved mission
- Overall positive engagement; only 5% MHSPY youth or families drop-out of program



Differential Effectiveness

- MHSPY graduates (“responders”) identified by the family-based care planning team using qualitative measures of goal achievement
- CAFAS change not a criterion for graduation
- Graduation associated with five times greater percent improvement on CAFAS scores vs. non-graduates
- Follow-up analyses done comparing
 - demographics
 - family risk factors
 - diagnoses
 - treatment exposure

Differential Effectiveness

- Seek to identify contributing variables which may help to predict responsiveness to home-based treatment
- Understand who is helped most with this intervention to help facilitate access for “responders”
- Learn about who is not helped to improve access to more appropriate interventions
- Better understand internal processes of care to “shift the curve” so that more are helped

Background

- Home and community-based treatments received scientific attention as alternatives to restrictive, out of home placements (Burns, 1996)(Evans, 1996)
- Program structure varies but conceptual underpinning for home based interventions, influenced by the CASSP principles, appears consistent for programs reporting positive youth outcomes

Conceptual Framework

- Recognition of the primary role of the family in the care of the child
- Importance of access to clinically intensive services, integrated within the child and family team
- Individualized, strength-based work with child that allows care to be delivered in the least restrictive setting (Sheidow, 2003) (Demidovich, 2004) (Grimes, 2004).

Method

- The Mental Health Services Program for Youth (MHSPY) is a demonstration project for a specific clinical intervention which integrates home and community-based treatment
- Medicaid youth, ages 3 -18, with severe, documented, mental health impairment, currently reside in, or at risk for, out of home placement
- Data analysis occurs via a longitudinal, multi-wave study design, with results stratified on child age, race/ethnicity, sex, intervention site and source of referral

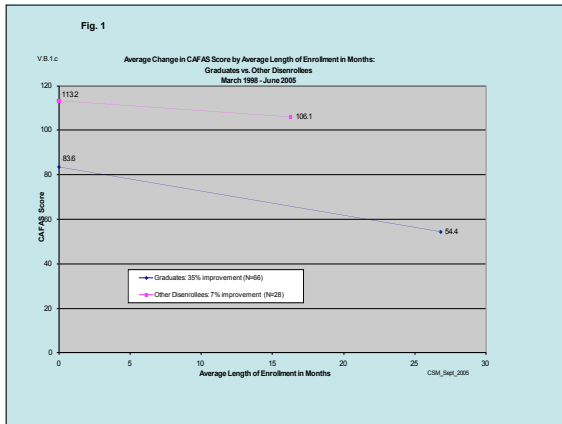
Data

- Two communities have had access to the intervention for seven years, with MHSPY available to the other three communities for three years
- The combined tally of those no longer in the program yields: Total N = 129
- Graduates (“responders”) met Care Planning Team definition of achievement of mission, N=75
- Other disenrollees (“non-responders”), otherwise heterogeneous group, many with improvement, N=54.

Primary data collection, including demographic information and referral source, was collected from all study participants at program entry. Self-report was used for race/ethnicity data. Baseline and every six-months follow-up functional measures (CAFAS, CGAS and PAT) were performed throughout enrollment in the program to evaluate clinical progress. Length of stay, or exposure to the intervention, as well as location of the child (level of care) at the time of termination were also measured.

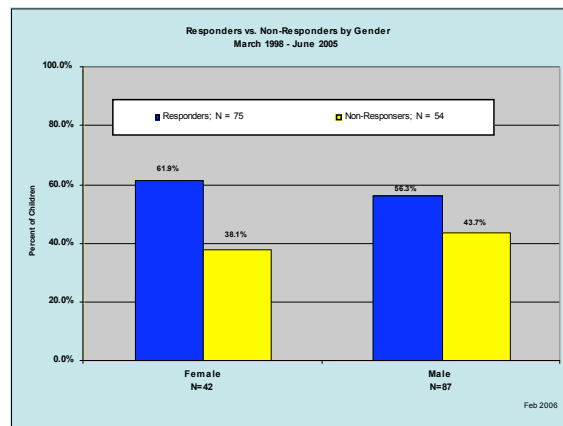
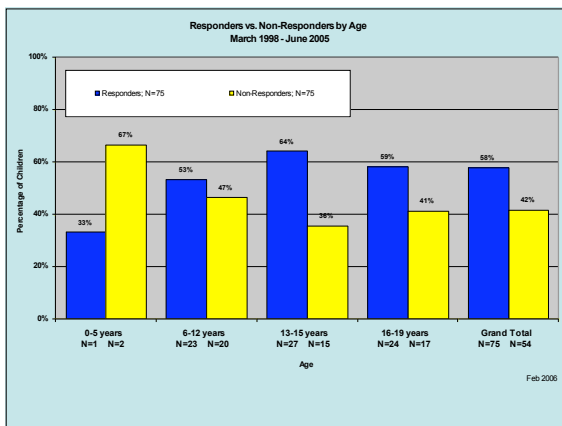
Results: CAFAS

- Baseline CAFAS scores grouped by “responders” and non-responders indicates that responders average lower beginning scores (83.6) than non-responders (113.4)
- Responders average 26 months in the program, whereas the average enrollment for non-responders was 17 months
- Percent improvement for responders on CAFAS from baseline to graduation was 35% vs. 7% for non-responders



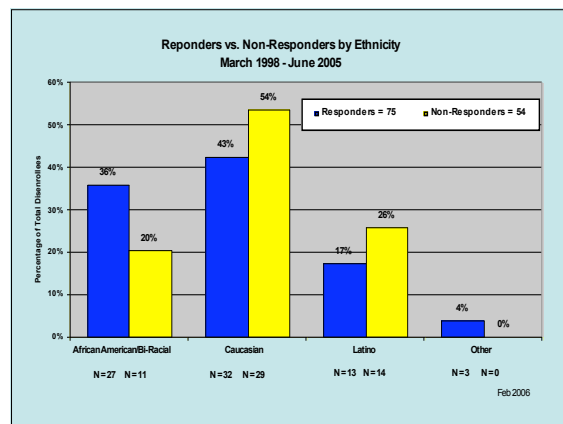
Results: Age and Gender

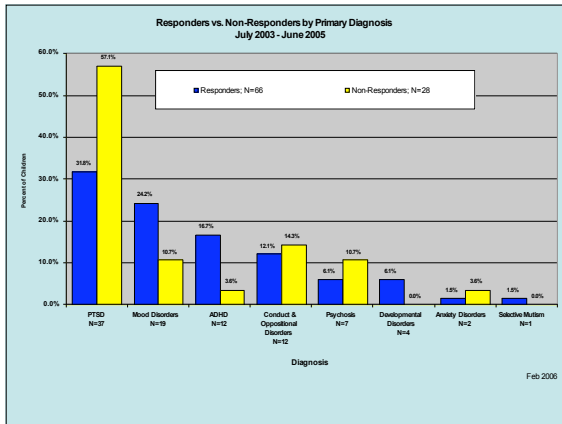
- Age comparisons show study participants who met criteria for graduation were slightly younger than the other disenrollees at entry (11.6 years vs. 12.2 years)
- Responders were slightly older at exit than non-responders (13.8 vs. 13.1)
- The responders were more likely to be female than male: 62 % of female participants graduate vs. 56% of males



Results: Race and Diagnosis

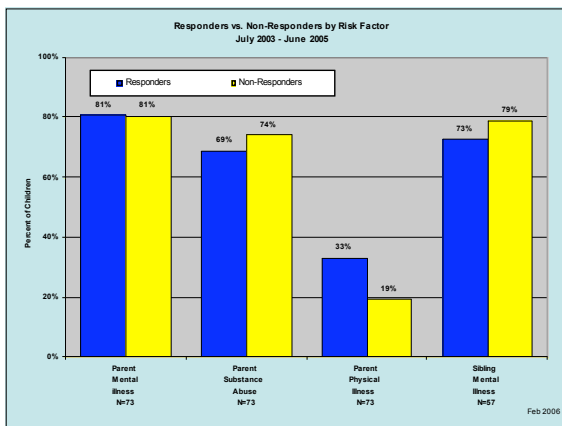
- Analysis of race/ethnicity shows large differences:
 - African- American and bi-racial youth respond at the highest rate (2:1 graduates vs. non-graduates)
 - White children and adolescents graduated (52%) of the time
 - Latino youth were less likely to graduate (45%) than not to graduate (55%)
- Diagnostic breakouts reveal higher percentage of ADHD as the primary diagnosis for the responders than the non-responders (16% vs. 6%)
- The reverse is true for PTSD as a primary diagnosis (31% vs. 53%) responders versus non-responders.





Results: Family Risk Factors

- Equivalent rates of parental mental illness for both responders (81%) and non-responders (80%)
- Lower percentage of responders (69%) reported parental substance abuse than non-responders (74%)
- Presence of parental physical illness did not prevent response to the intervention: (33%) vs. (19%)
- Frequent finding in both groups, but having a sibling with mental illness slightly lower in responders (73%) than non-responders (79%)

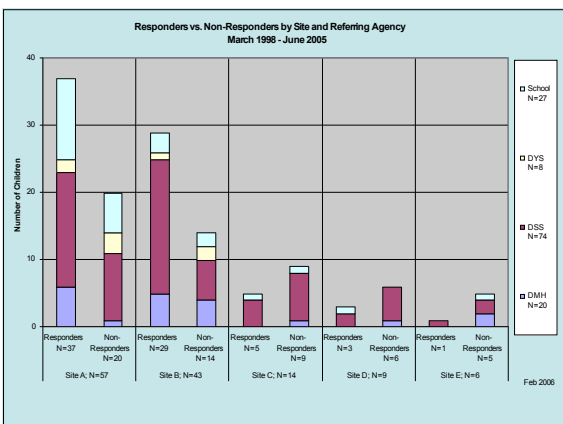


Results: Referral Source

- Youth referred to the program by the schools graduated at the highest rate (65%)
- Next highest were those referred by the state's Child Welfare system (60%)
- Those referred by the state Mental Health system came next (55%)
- Referrals from the Juvenile Justice referrals were least likely to graduate (38%)

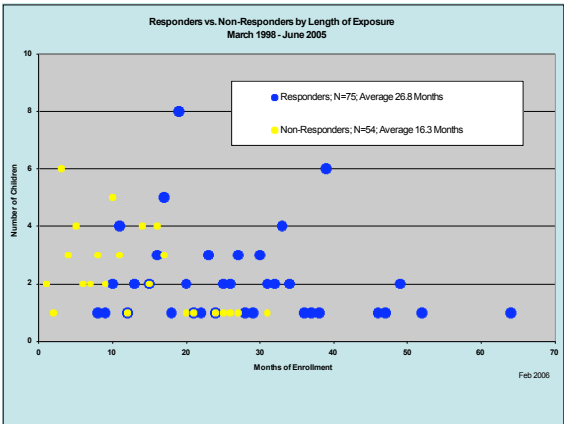
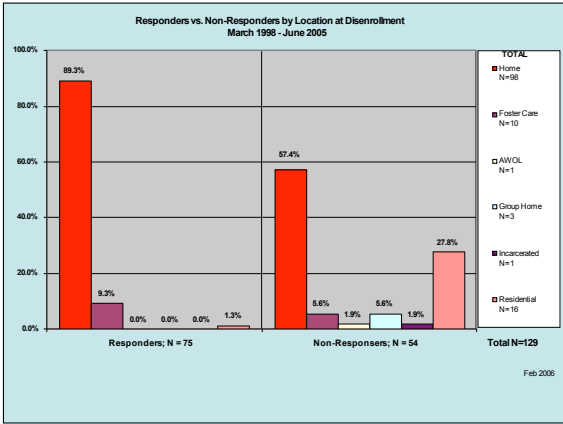
Results: By Site

- When the two groups are compared on the basis of community of residence, there is a remarkable spread across the five sites
- Responders vs. Non-responders range from a high of 67% in Site B to 17% in Site E
- Based on number of graduates, Site A, the earliest site, has the largest total number of responders



Results: Intervention Exposure

- Overall, any exposure to MHSPY appears to correlate with living at home at the end of the treatment period
- Responders have a longer length of stay than Non-responders
- Analysis of location after disenrollment data shows 89.3 % of Responders living at home, versus 57.4 % of the Non-responders



Conclusions

- Overall improvement in both groups but difference in slope of CAFAS improvement for Responders vs. Non-responders
- Non-responders include few “drop-outs” (5% of total, 11% of other disenrollees); 89 % participated to the best of their capacity, and many actually improved
- Degree of responsiveness to home-based intervention may be more of a continuous variable than the binary “responder/non-responder” labels imply
- Youth with greatest gains during treatment have a twenty-point lower baseline CAFAS score than the Non-responders

Conclusions (cont.)

- Possibly running up against true limitations for applicability of home and community based treatment
- Responders appear to benefit from youth, family and community/school factors powerful enough to offset usual predictive forces, such as racial disparities, on outcomes.
- Future investigation of the “non-responders”; duration of intervention can be both an engagement as well as a severity indicator
- More research need to deepen knowledge of what youth, family and community characteristics contribute to treatment response

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