The Best of Two Models: Integrating a Home Based Crisis Intervention Model within a School Based Mental Health Program

Samantha Schindelheim, LCSW

Kimberly Kleinman, PsyD

Annual Conference on Advancing School Mental Health

Austin, Texas

Columbia University
Department of Psychiatry
College of Physicians and Surgeons

Division of Child & Adolescent Psychiatry

NewYork-Presbyterian
Morgan Stanley Children's Hospital

Presentation Outline

- Introductions
- Understanding the Community Before Creating the Model
- Our Tiered SBMH Model
- The Case for Integrated Systems Approach
- Integrating a Tiered Approach
  - Preventative Interventions
  - Targeted Interventions
  - Integrated Interventions
  - Intensive Interventions
- Home Based Integration
- Creating an Integrated Treatment Plan
- Wrap Up

Objectives

- To understand how to utilize a home based model within a school-based treatment approach.
- To learn strategies to support children and their families with acute mental health concerns.
- To measure the effectiveness and feasibility of a crisis intervention model for elementary-aged youth and their families in multiple settings (school and home).

Introductions

Understanding the Community Before Creating the Model

Washington Heights, NYC

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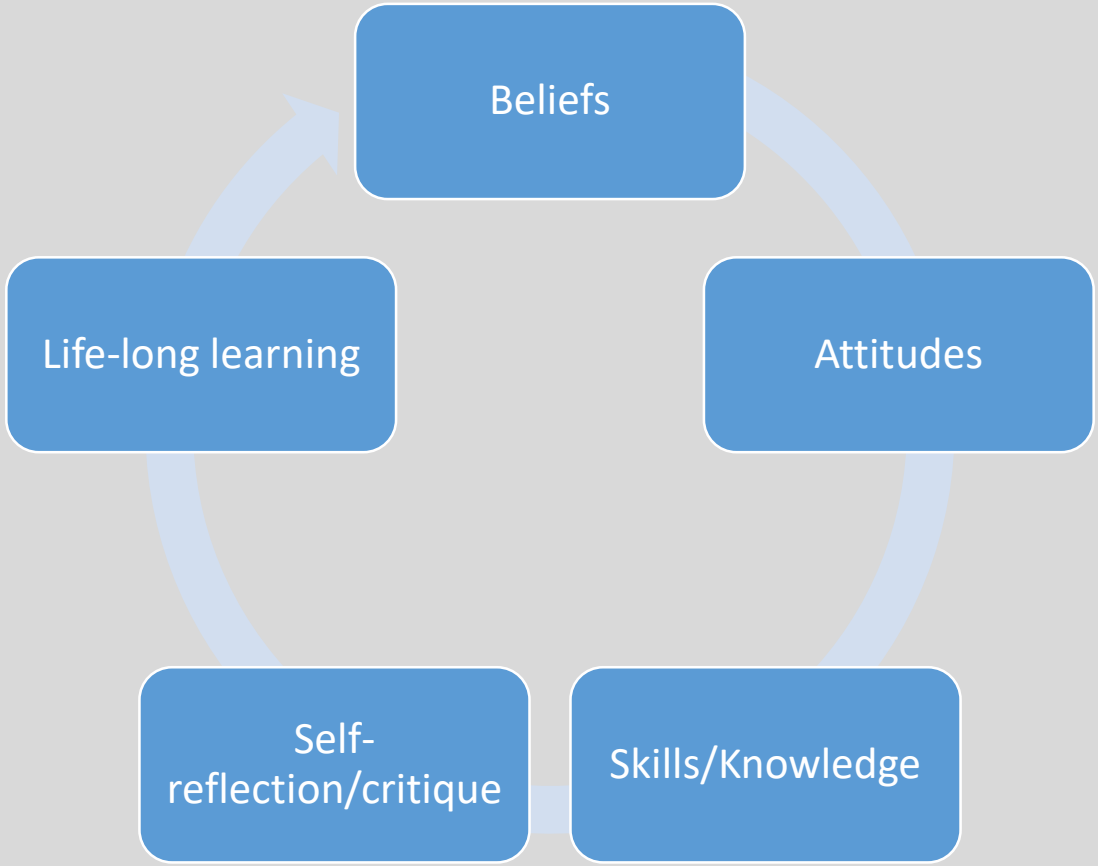
Cultural Humility Lens

- Improve student attitudes and commitment to therapist/patient alliance
  - Ex: Connect with patients around favorite ethnic foods, important holidays, cultural customs, etc.
- Improve clinical barriers
  - language, access to quality care
- Express validation of the impact of current sociopolitical events/environment
- Navigate discomforts in process of internal reflections of personal identities, (implicit) biases, power and privilege can improve rapport
  - Comfort in discomfort

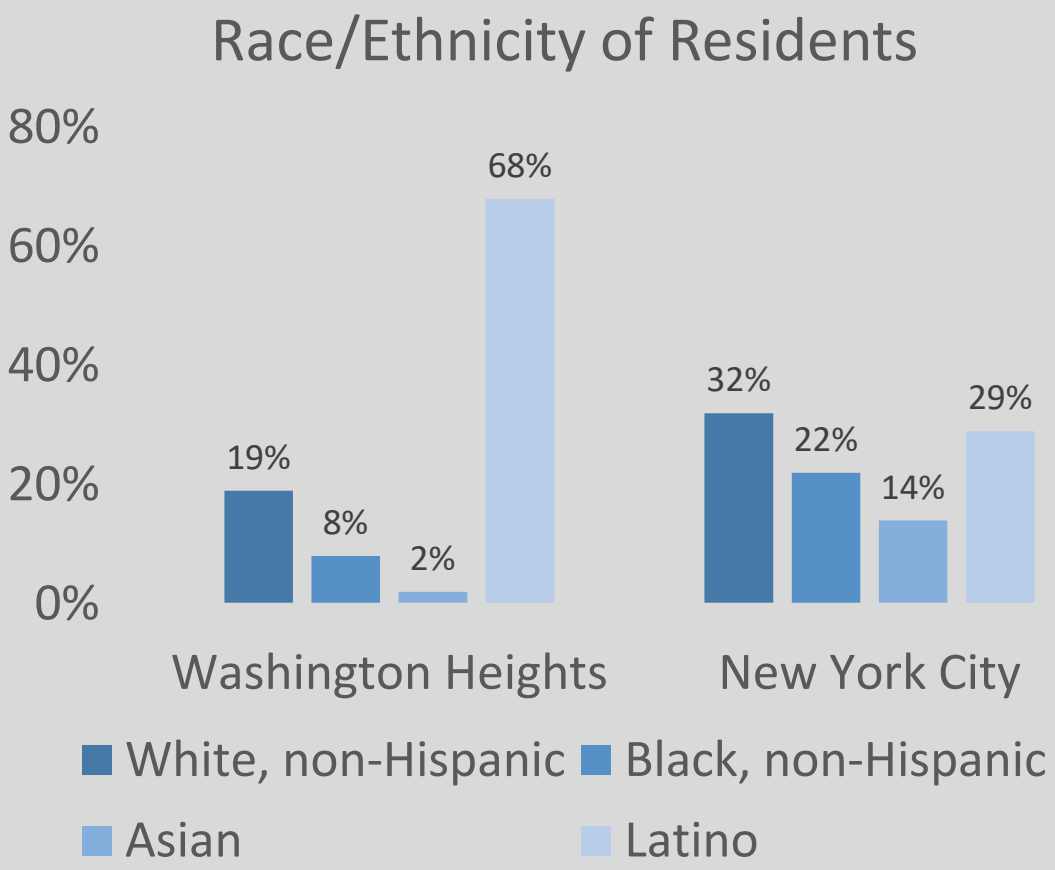


Our Community: Washington Heights

Washington Heights Resources and Strengths

- Extensive school system
- Multiple community based organizations
- Resources for extracurricular activities at no fee or low cost
- Expansive green space
- Cultural institutions
- Murals, graffiti, street names promoting a sense of identity

Culture and Language



- Population by Race and Ethnicity
  - Asian 3%
  - Black 7%
  - Latino 72%
  - White 17%
  - Other 1%
- 29% English Language Learners (DOE)
- 37% Limited English Proficiency
- 23% Linguistically Isolated Households
- 48% Foreign Born
- 25% Non-Citizens

Disparities

Economic

	Washington Heights and Inwood	Manhattan
Poverty (% of residents)	20%	14%
Unemployment (% of people ages 16+)	12%	7%
Rent Burden (% of renter-occupied homes)	53%	45%

Educational

	Less than HS	HS Graduate	College Graduate
Washington Heights and Inwood	29%	33%	38%
Manhattan	13%	23%	64%
Financial District, Greenwich Village, Soho	4%	12%	84%

Understanding Your Community

Food For Thought

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Food for Thought

- Describe your community (school, neighborhood, etc)
- What are the strengths?
    - Weaknesses?
    - Sights?
    - Smells?
- How would the children that you work with describe their community?

DISCUSSION

What did you learn about your partner's community?

What strengths or limitations from your community will influence a home and school collaboration?

The Case for an Integrated Systems Approach

To Improve Outcomes in At-Risk, Marginalized Youth

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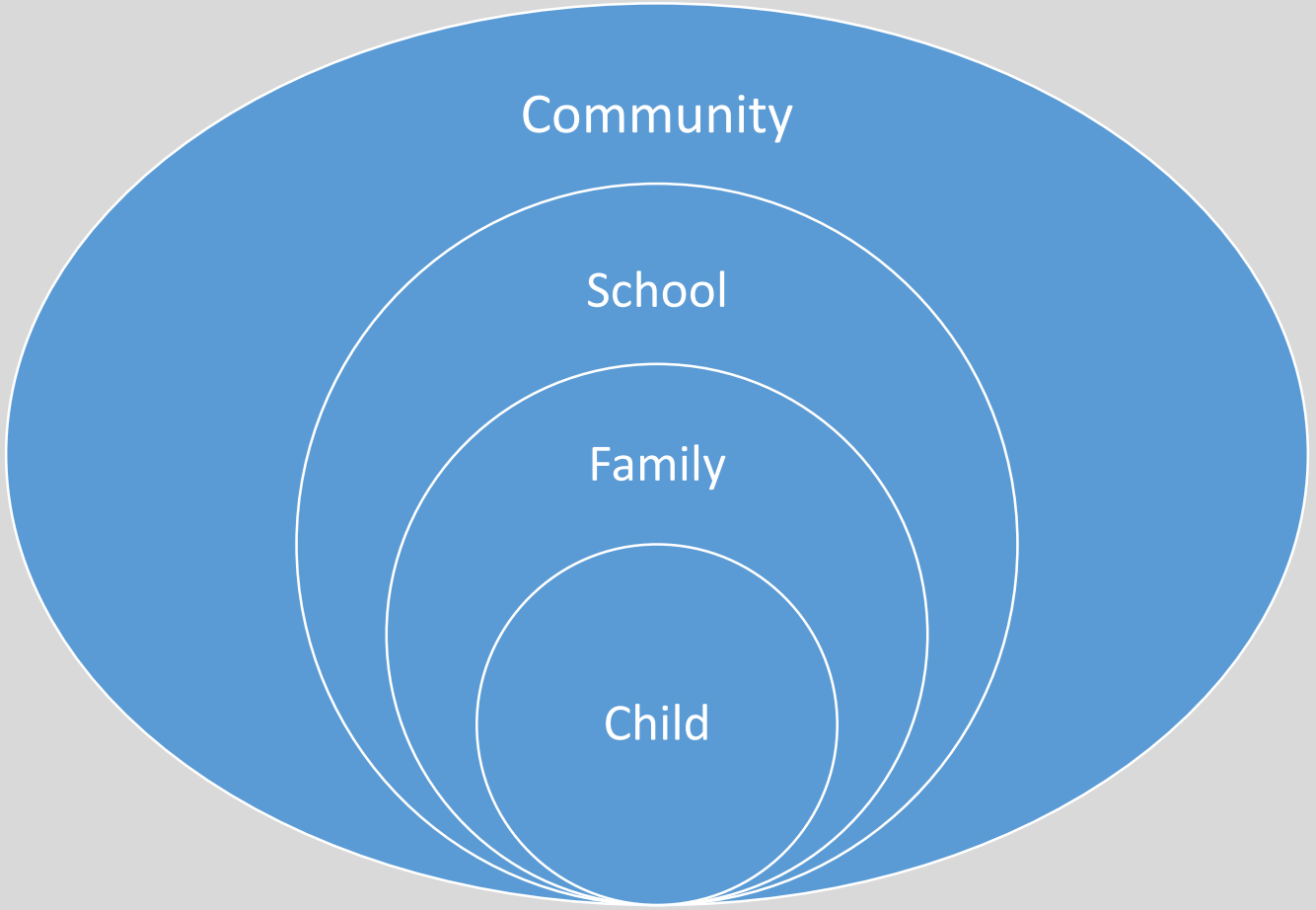
Facing the Odds

- Marginalized families have the greatest need and least access to high quality mental health care and education
  - Cultural, ethnic, and linguistic minority youth and families
  - Youth in foster care and with insecure housing
  - Families affected by poverty
  - Community violence and stress

Disparities in Education and Access

- Communities with high concentrations of marginalized youth have worse academic outcomes
- Minority youth are disproportionately affected by learning disabilities
  - Increased Risk for LD
  - Delayed Identification
  - Less effective intervention
- Higher rates of trauma and disruptive behavior
- Reduced opportunities for successful outcomes

An Ecological Model



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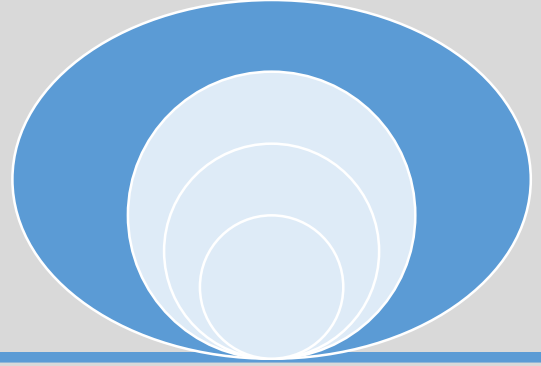

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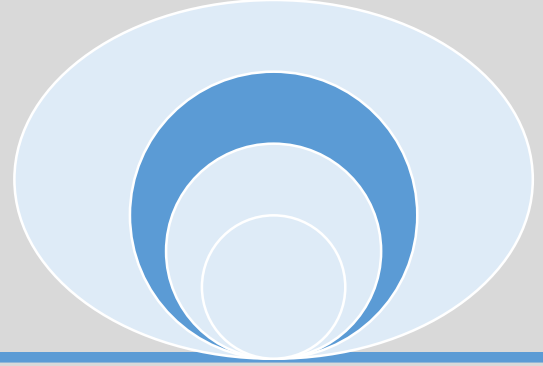

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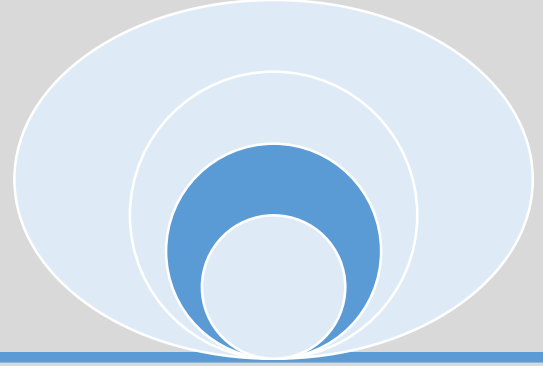

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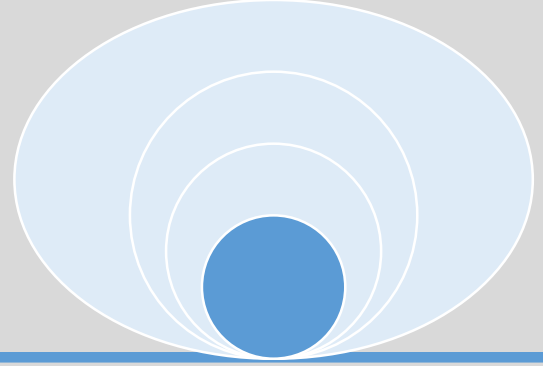

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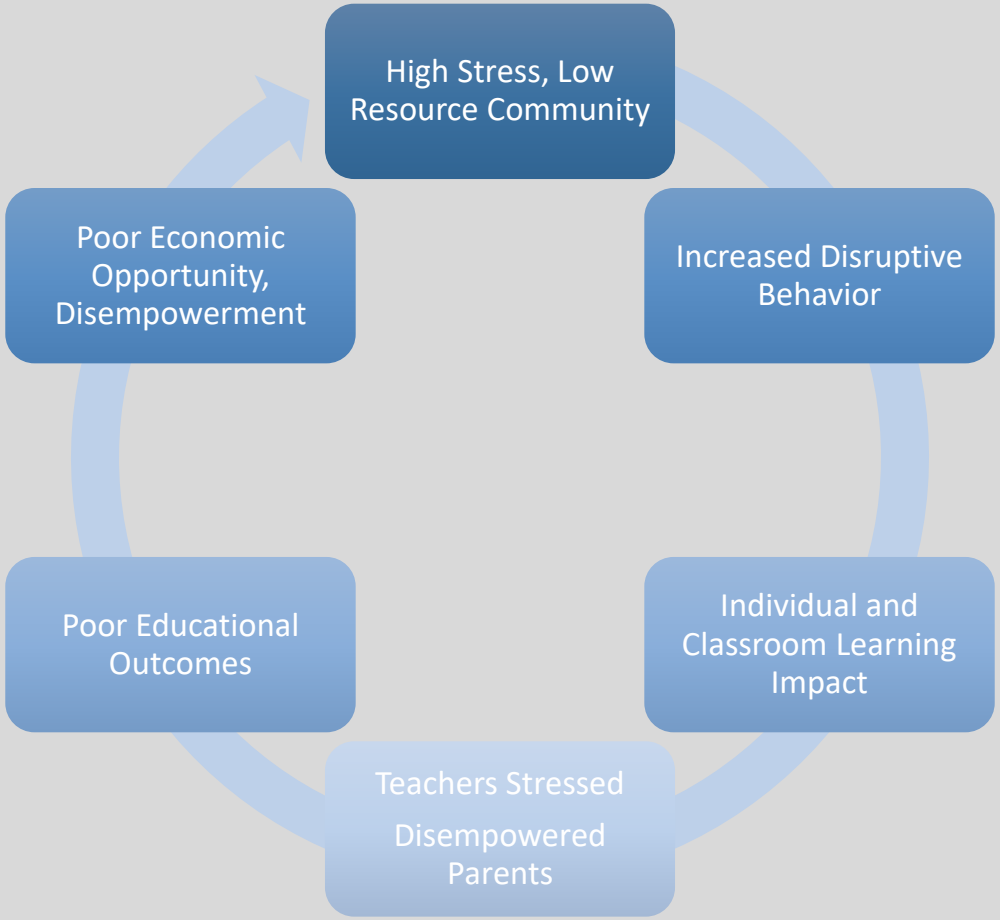
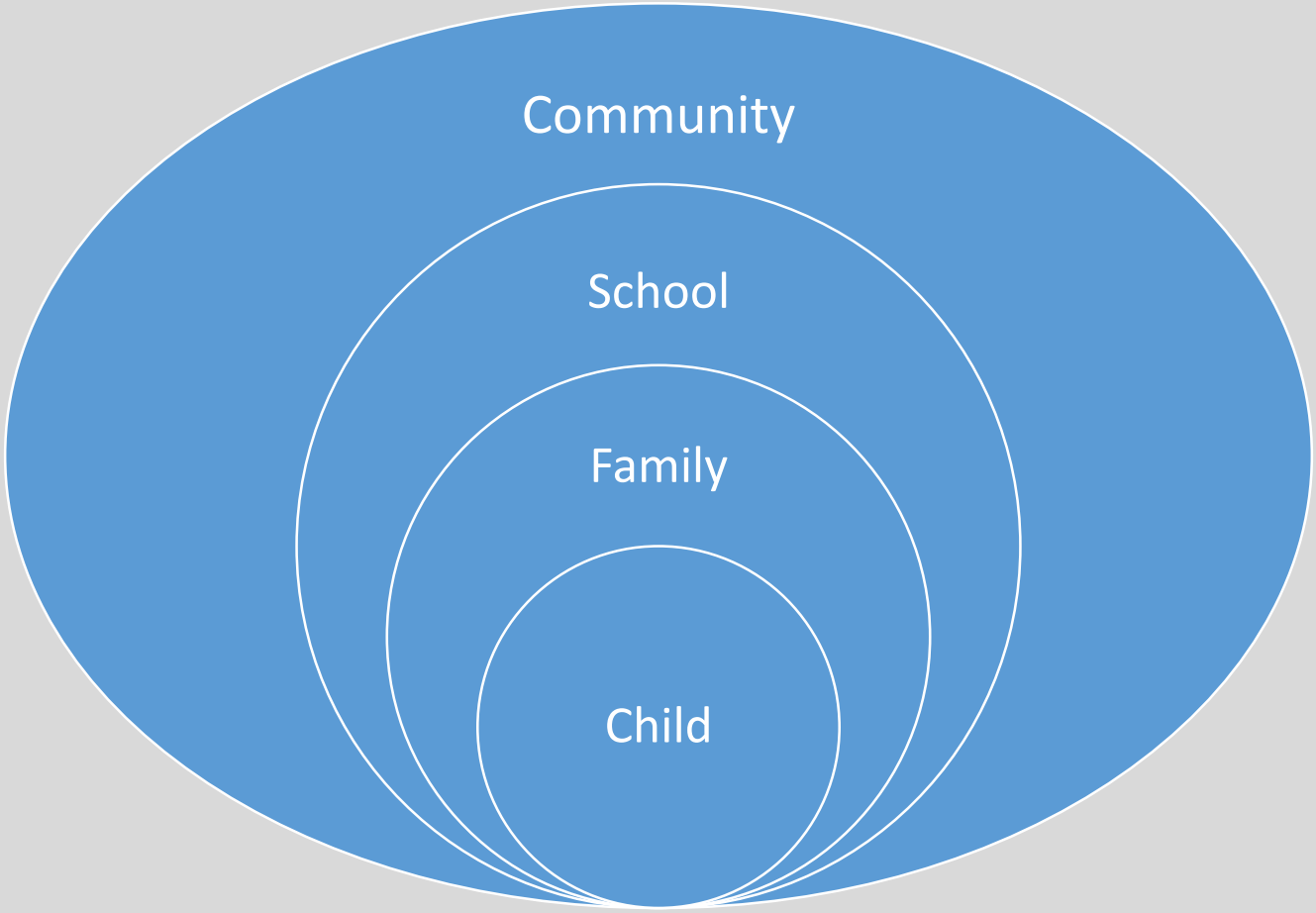
- **Family** stress can lead to crisis that increase involvement in foster and adoptive care, poor educational outcomes, delinquency, aggression, and worsening mental health functioning.
- **Children** exposed to chronic stress and trauma through learned and epigenetic process have greater needs and fewer resources

A Cycle of Poverty and Disruptive Behavior



Need for an Integrated, Tiered Approach

- Community Collaboration
- Tiered Care
  - Access
  - Early Intervention
  - Acceptability
  - Efficacy
- Based in Schools and Homes



NYPH SBMHP

Past, Present and Future

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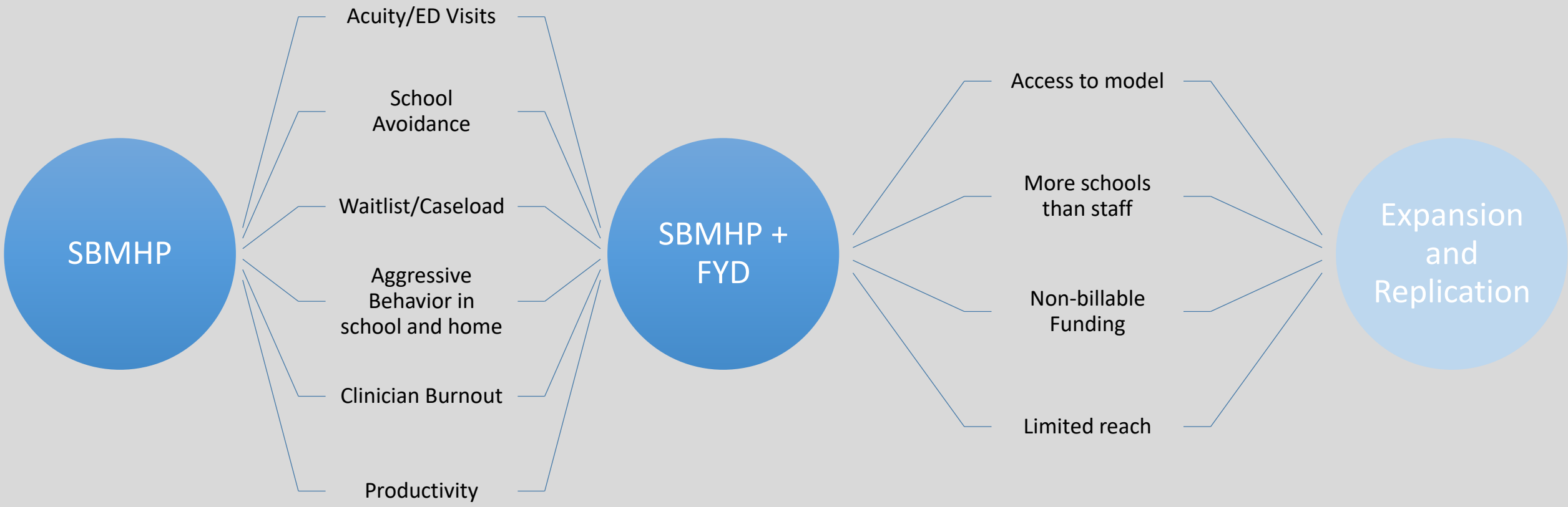
History of Service Delivery

- Psychotherapy
- Psychopharmacology
- Hospital based support

- Addition of Universal and Targeted Interventions
- Intensive Interventions
- Multidisciplinary Team

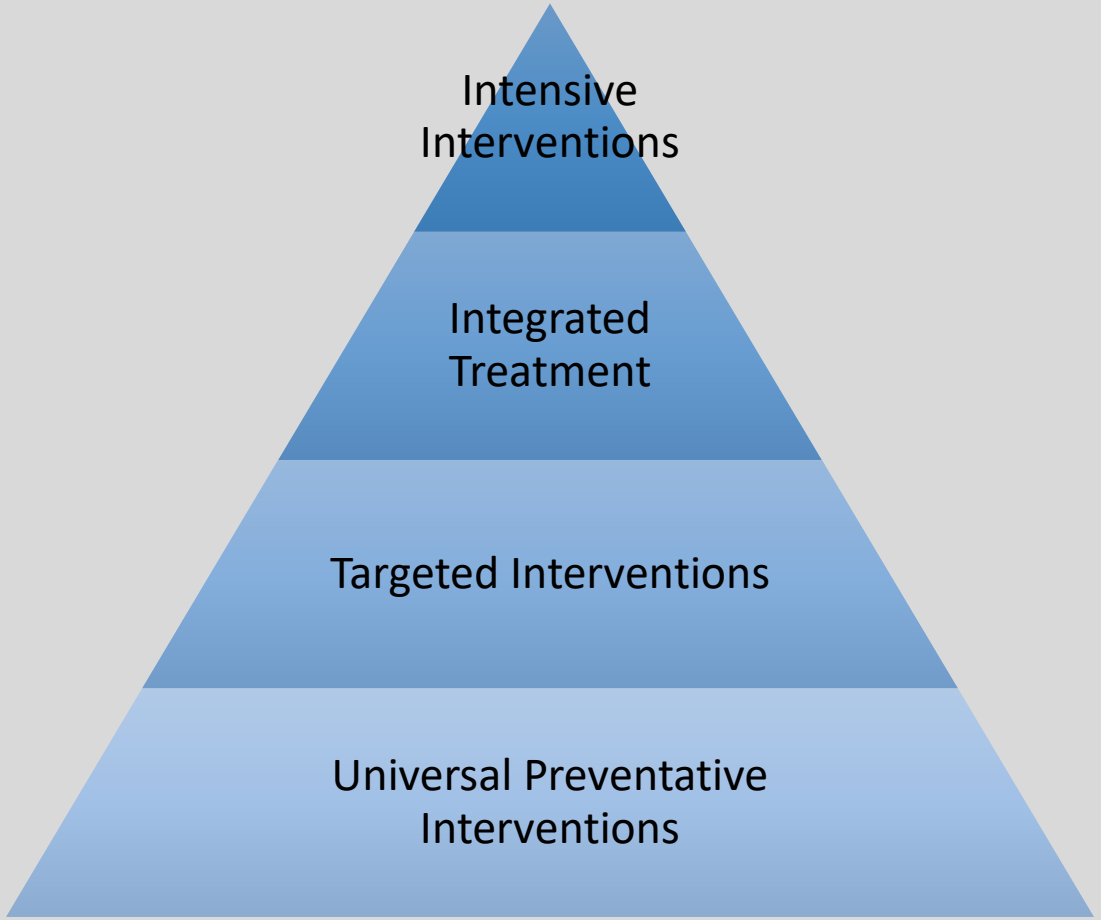
- Integration of Tiered Model

Program Needs and Development



Tiered Model of SBMH and FYD Program

- Current funding sources
  - NewYork-Presbyterian Hospital
    - Columbia University Irving Medical Center
    - New York State Psychiatric Institute
  - Robin Hood Foundation
  - District Attorney's Office of New York



NYPH School Based Mental Health Program

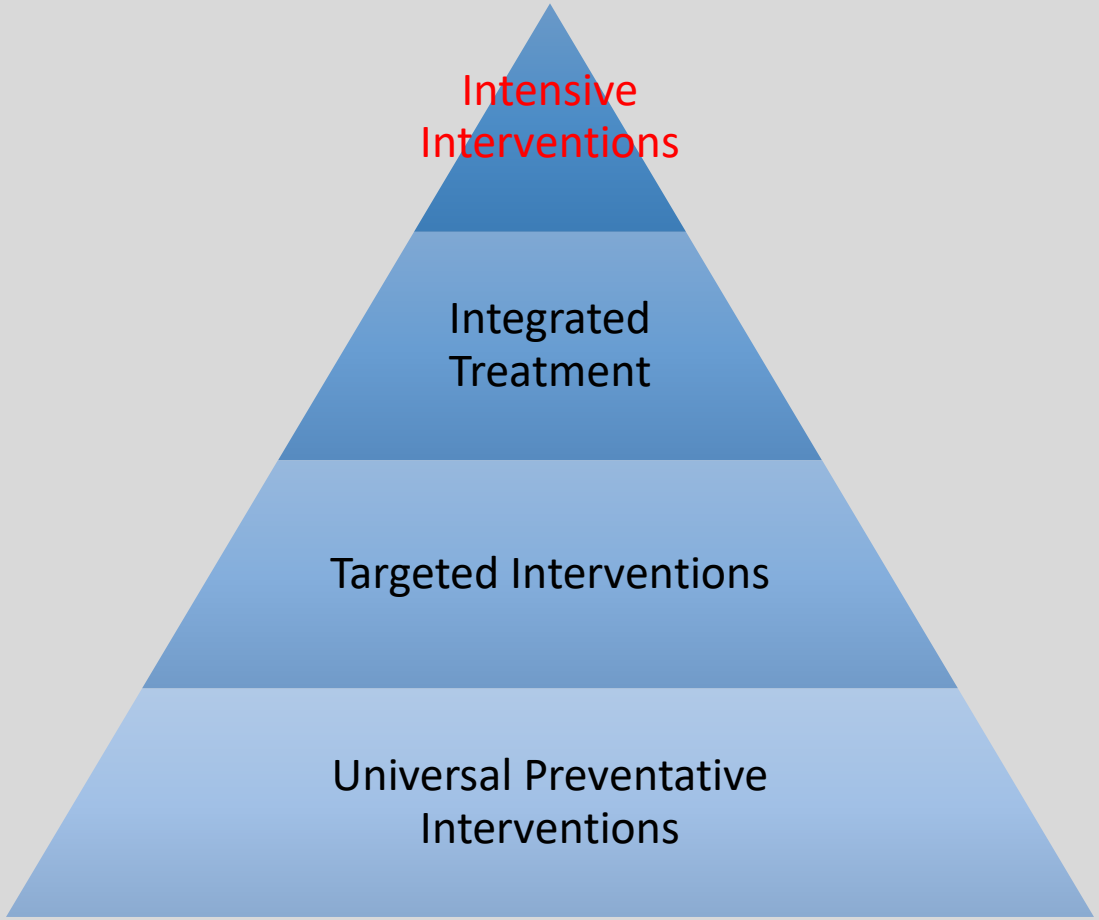
- **Schools Served**
  - 13 schools in Washington Heights and Harlem
- **Clinical Team and Services Offered**
  - 9 Psychologists, 3 Licensed Clinical Social Workers, 4 Psychiatrists,
  - Psychotherapy and psychopharmacology within schools
  - Additional pediatric psychiatry support and services
    - Clinical and administrative effort for Operational Leadership, Home-Based Crisis Intervention, Neuropsychology, Case Management and Educational Advocacy

FYD Tiered Program Expansion

- **Seven** of 13 schools identified for FYD program expansion
  - Receive an **integrated** and **tiered** approach to mental health care that expands upon existing SBMH services
- Additional team providers dedicated to supporting implementation of tiered approach
  - **Neuropsychologist, psychologist, data coordinator, HBCI social worker, postdoctoral fellow/part-time psychologist**
- Weekly multi-disciplinary care coordination team meetings
- Weekly leadership and planning meetings
- On-site consultation and supervision for school personnel and clinical staff

The Fourth Tier

- Unclear understanding of home environment
- Difficulty adapting clinical work to homes
- Increasing school avoidance
- Increasing aggressive/disruptive behavior
- Decreasing unnecessary ED visits



Home-Based Crisis Intervention

The Fourth Tier

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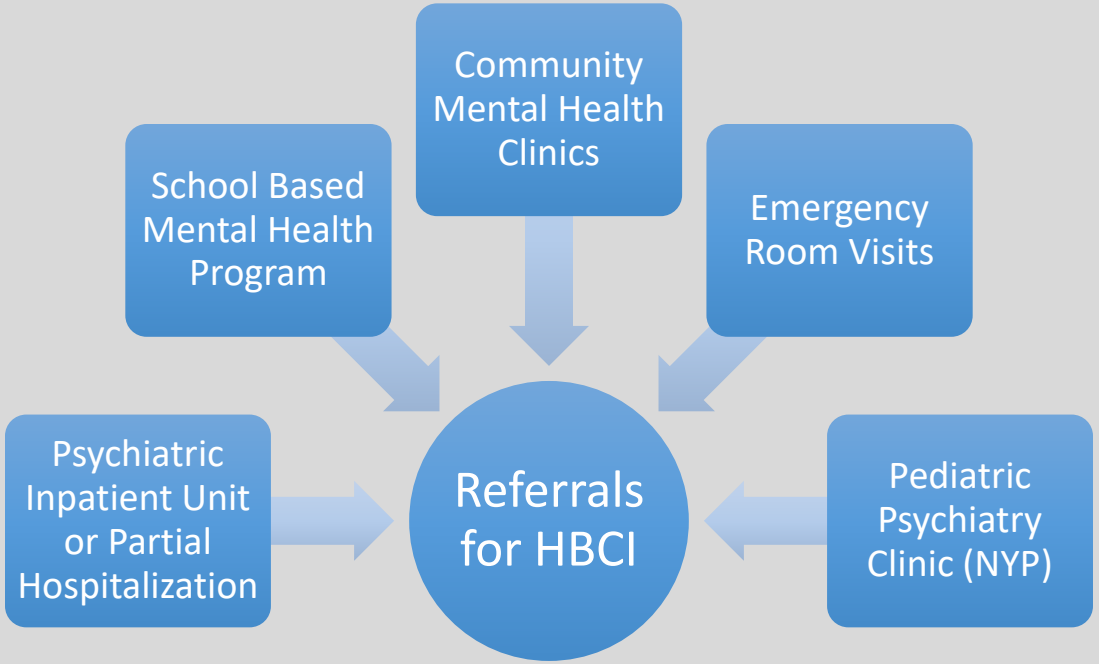
What is Home Based Crisis Intervention?

- Home Based Crisis Intervention (HBCI)
- Office of Mental Health (OMH) funded program
- Provides in home crisis services to families where a child is at imminent risk of psychiatric hospitalization
  - Intensive in home interventions for psychiatric crises for 4-6 weeks
- Goals:
  - Psychiatric admission diversion
  - Teaching problem solving skills to the family
  - Linking the child and family with community-based resources and supports

NYP HBCI Program

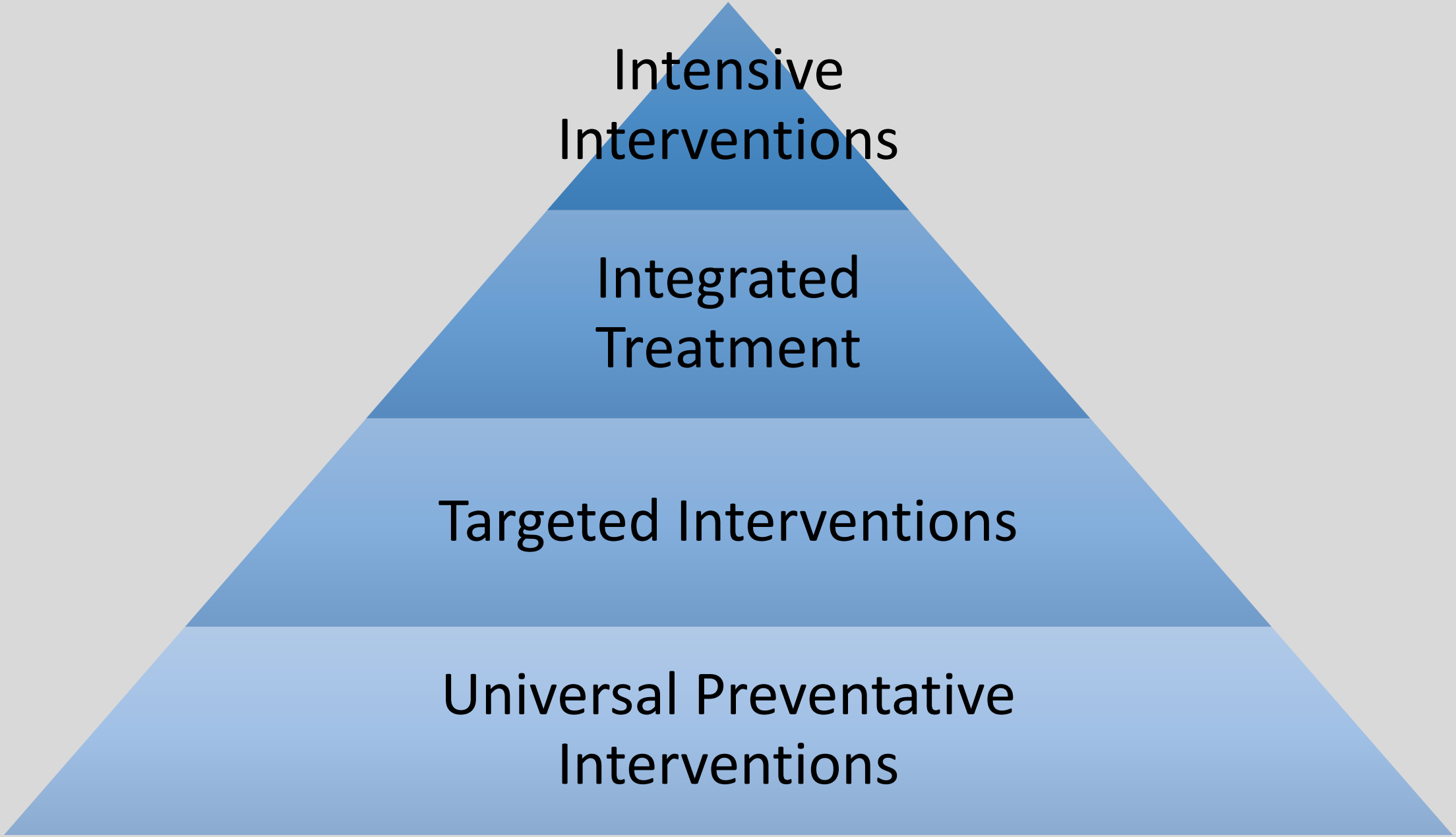
- Morgan Stanley Children's Hospital of New York
  - Housed within Pediatric Psychiatry Department of Outpatient Clinical Services
    - Close collaboration with Pediatric Emergency Room and Immediate Treatment Clinic
  - Present and running for approximately 17 years
- Bilingual Staff:
  - FTE Psychologist/Program Director, 3 FTE social workers, 1 FTE case manager, 1 part time psychiatrist
- Short term and intensive program for children 5-18
- Combines clinical and case management services
  - Intensive: Average of 3 visits a week (individual, collateral, family, school, community)
  - Short term: Average length of 5-8 weeks
  - 24/7 Crisis Line

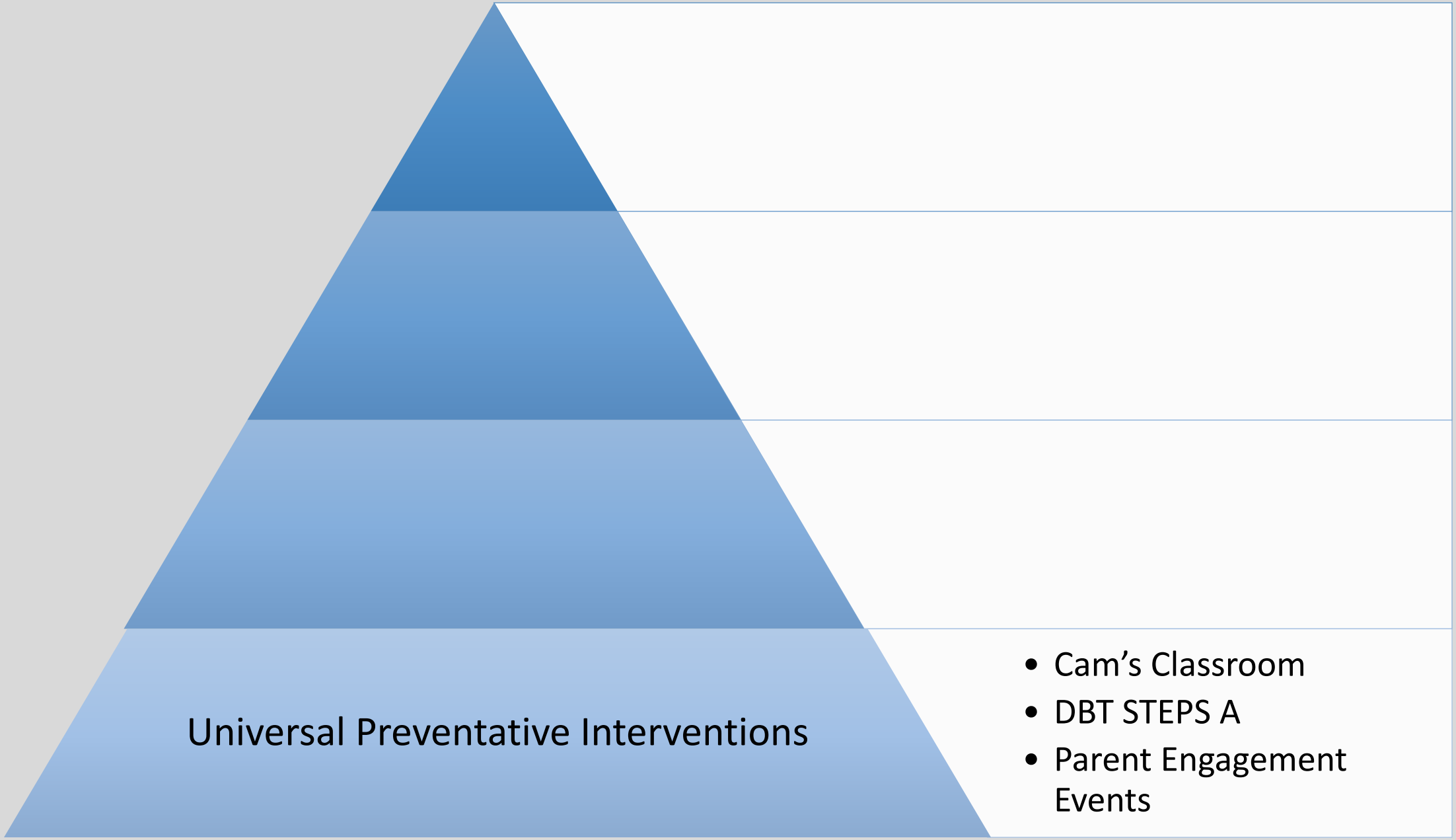
Referral Sources and Reasons

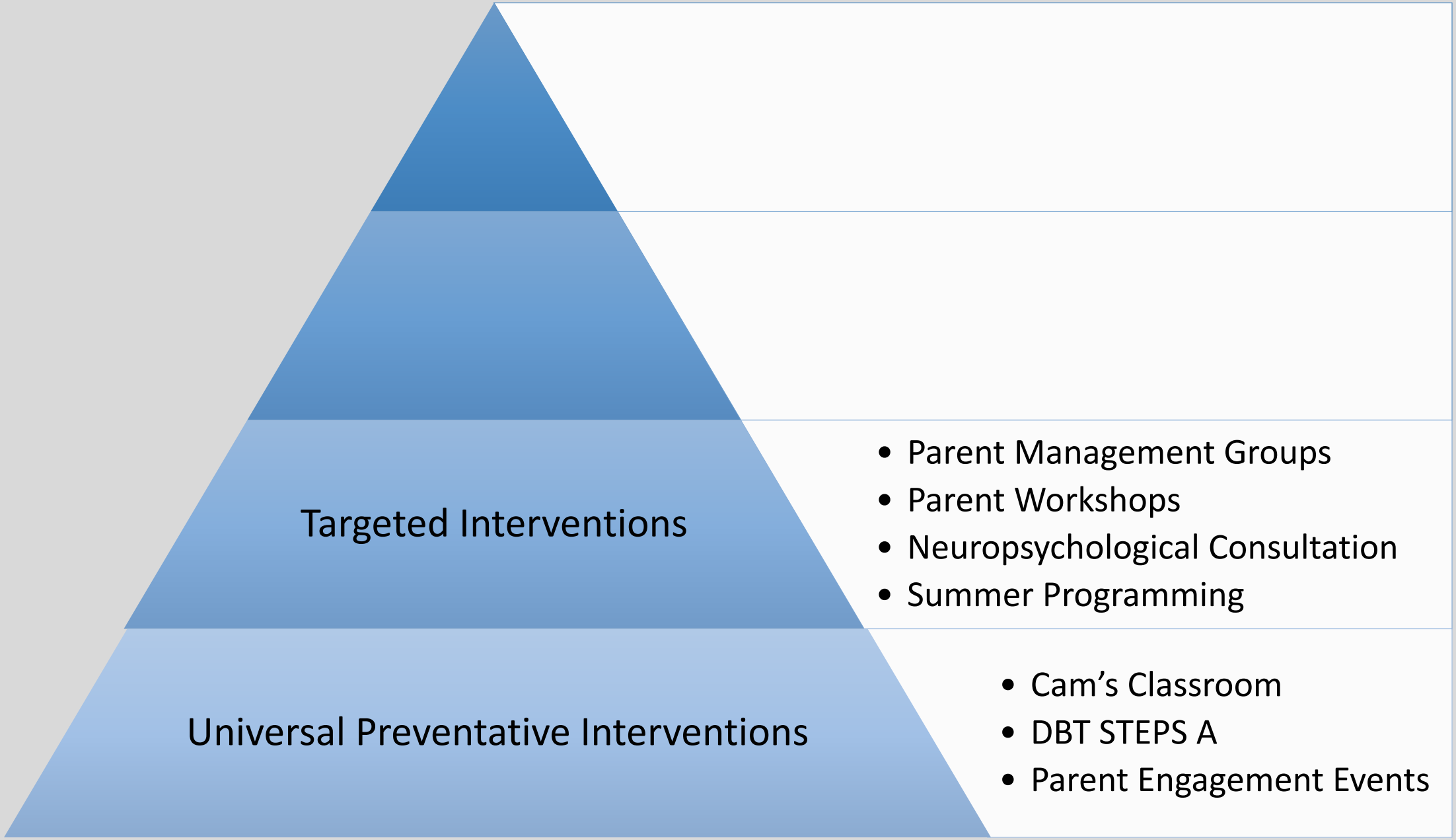


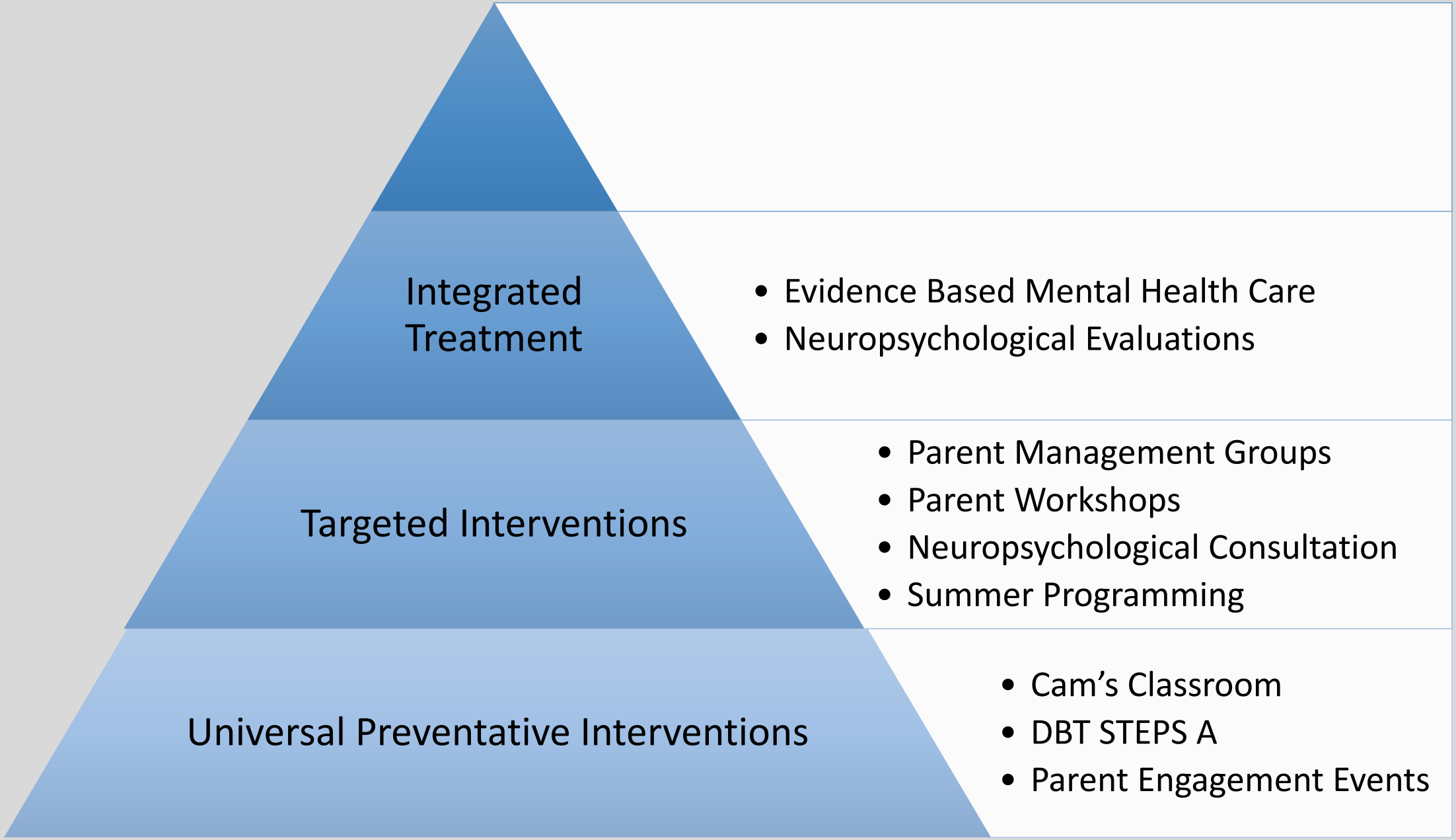
- Significant emotional dysregulation
- Active and elevated concerns from other providers
- Recent or repeat psychiatric visit(s) to emergency room
  - Typically males
- Trends
  - Typically Male
  - ADHD and Depression
  - Parental concerns over behavior at home
  - Significant behavioral dysregulation in school and home
  - School avoidance
  - Suicidal and para-suicidal behaviors

Integrating a Tiered Approach


Intensive Interventions
Integrated Treatment
Targeted Interventions
Universal Preventative Interventions


Universal Preventative Interventions
• Cam's Classroom
• DBT STEPS A
• Parent Engagement Events


Targeted Interventions
• Parent Management Groups
• Parent Workshops
• Neuropsychological Consultation
• Summer Programming
Universal Preventative Interventions
• Cam's Classroom
• DBT STEPS A
• Parent Engagement Events


Integrated Treatment
• Evidence Based Mental Health Care
• Neuropsychological Evaluations
Targeted Interventions
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• Parent Workshops
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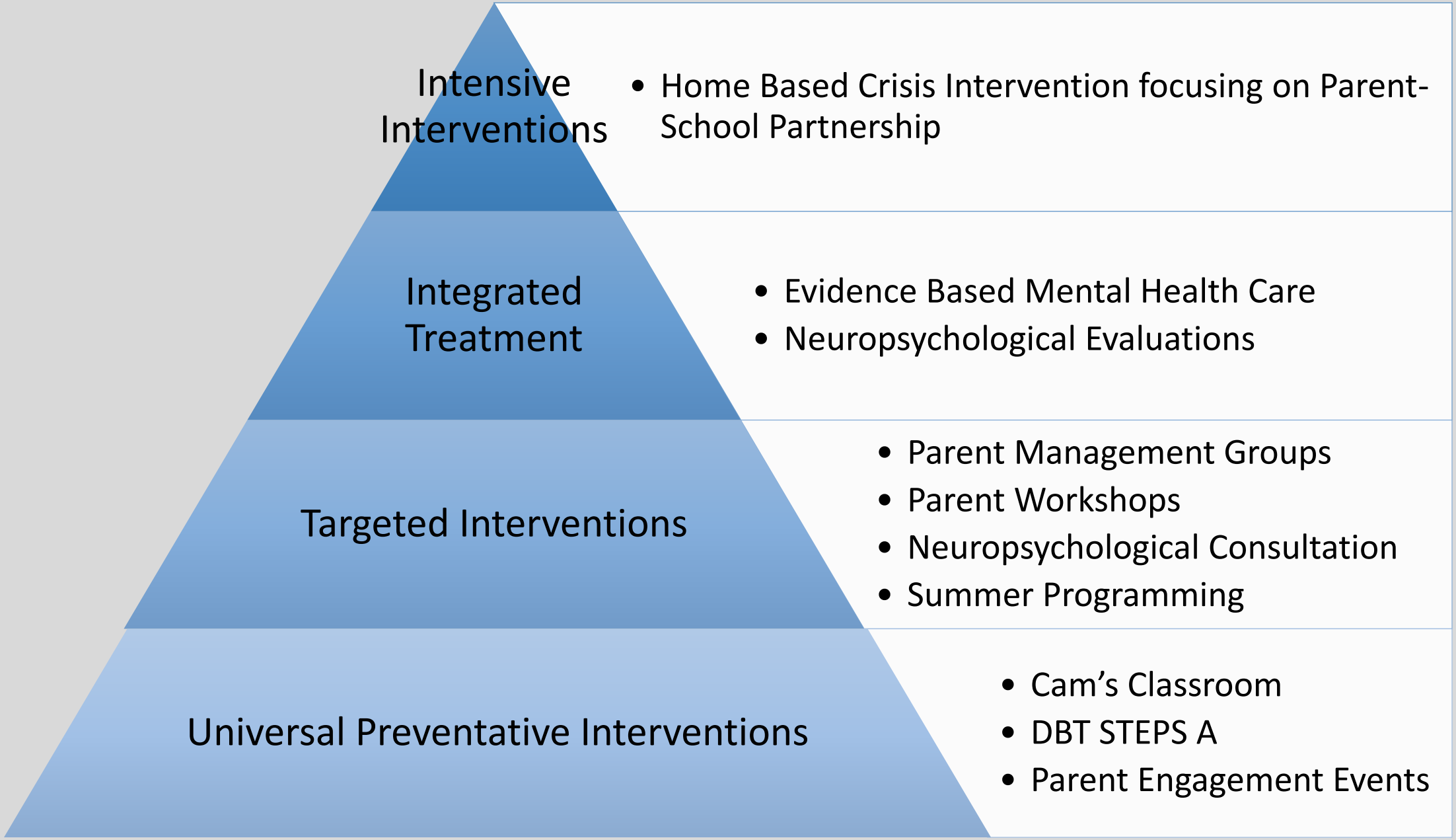
• Summer Programming
Universal Preventative Interventions
• Cam's Classroom
• DBT STEPS A
• Parent Engagement Events


Intensive Interventions
• Home Based Crisis Intervention focusing on Parent-School Partnership
Integrated Treatment
• Evidence Based Mental Health Care
• Neuropsychological Evaluations
Targeted Interventions
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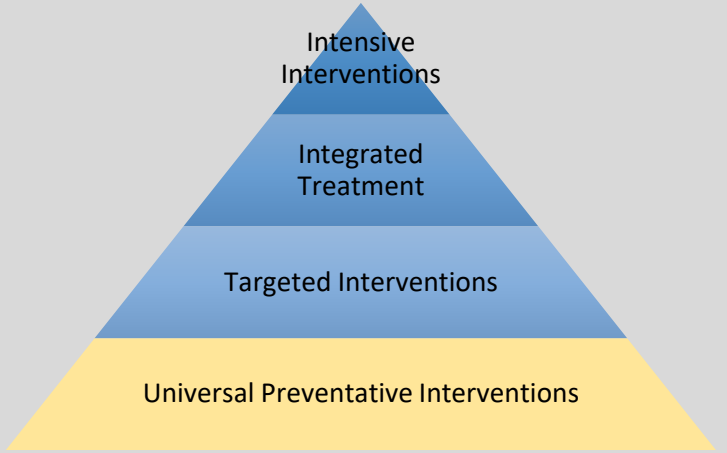

Universal Preventative Interventions

Cam's Classroom

Parent Engagement

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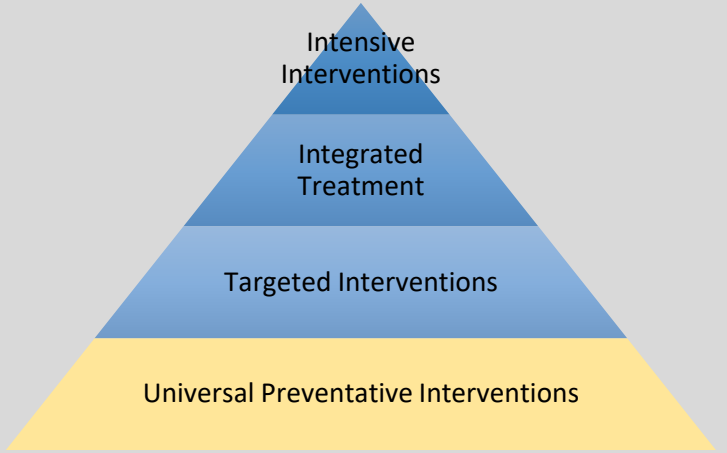

Cam's Classroom

A Trauma-Informed Universal Preventative Intervention for At-Risk Classrooms

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Background and Rationale

- Students attending urban and under-resourced schools are more likely to be exposed to repeated traumatic events.
  - Exposure to trauma, especially when untreated, often leads to poor school performance, interpersonal conflict and long-term mental and physical illness.

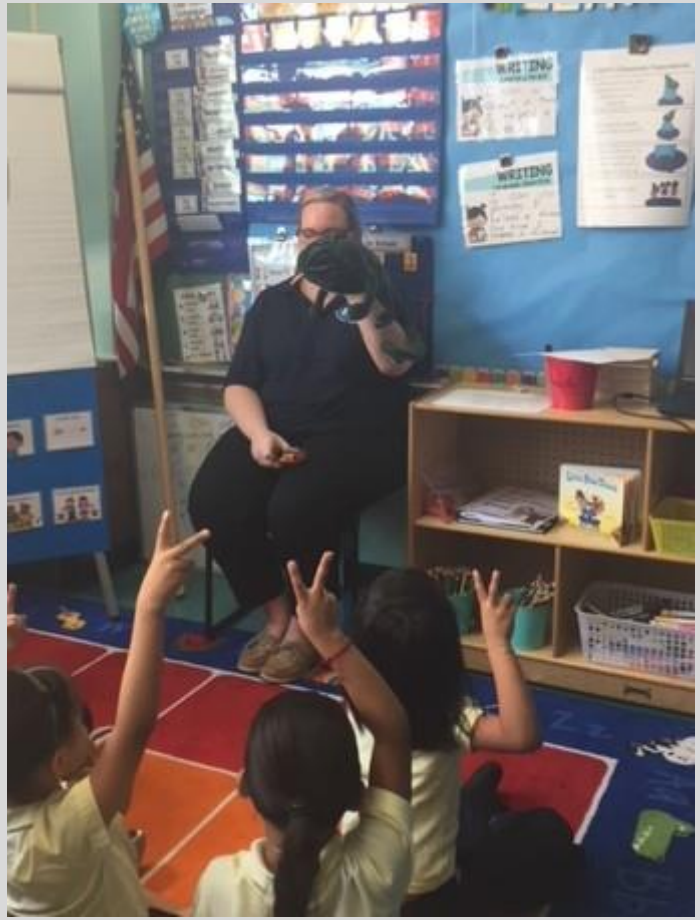
- What is the toughest part of teaching?
  - Teachers report behavior problems as the **most distressing aspect** of their profession
  - In a sample of 5,550 teachers, **four out of five** thought that he/she had not received sufficient training in behavior management
  - Teachers who receive less training in behavior modification tend to **blame their students** for their own inadequate technique in classroom management

Cam's Classroom

- A trauma-informed, positive behavioral, universal preventative intervention
  - Part One: Classroom Behavior Management
  - Part Two: Emotion Regulation in Students
  - Strategies for:
    - Increasing prosocial behavior
    - Decreasing disruptive behavior
    - Improving students' emotion regulation
    - Refining adults' emotionally responsive (trauma-informed) reactions to students
- Implemented bilingually (Spanish/English)

Positive-Behavioral Classroom Management

- Introduction of Cam and Classroom Expectations
- Use of a chime to gain student attention
- Interactive Modeling to teach Transitions
- Non-verbal “Silent Signs” for communication
- Compliments and Compliment Cards to be sent home



Cam's Classroom: Cam

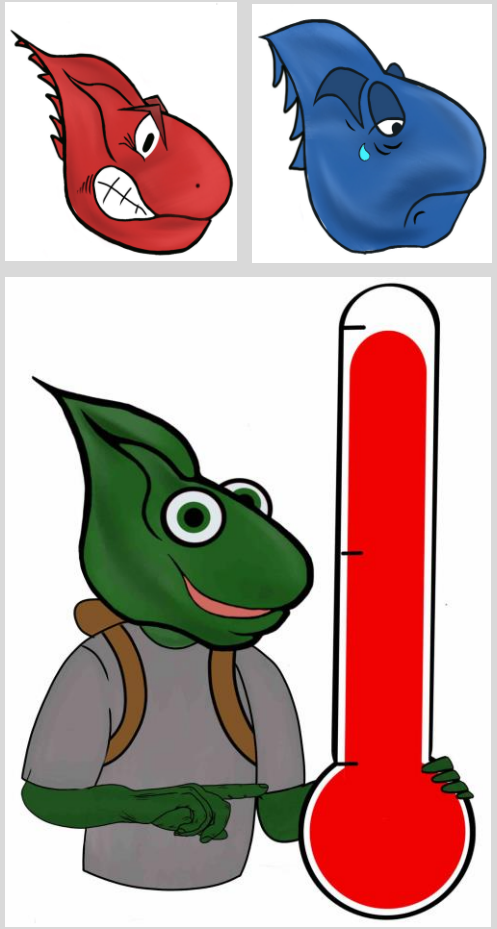
- Teachers "co-teach" with Cam, a chameleon puppet
- Students adopt and care for their own stuffed chameleon
  - Play and representation through symbolic objects
  - Model and express the values of connection and care.

Cam's Classroom: Game

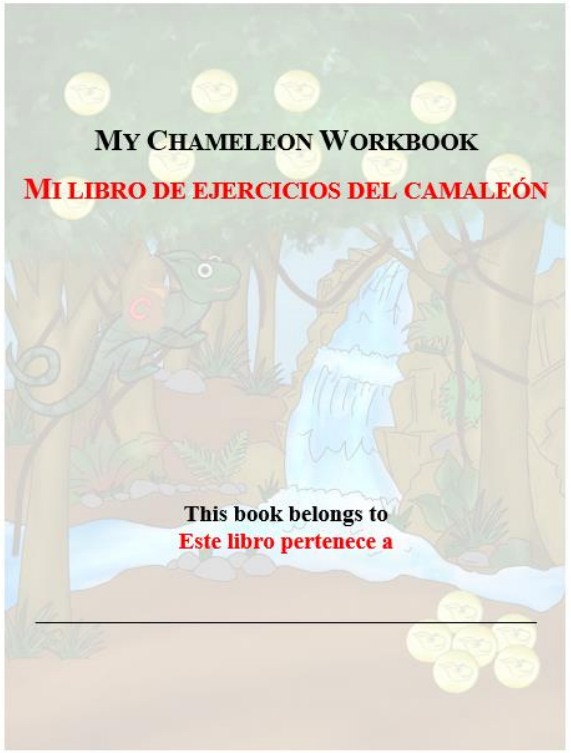
- Group oriented contingency
- Students compete to earn publically displayed coins for display of prosocial behavior
  - Adapted from the Good Behavior Game
- Teachers use compliment cards and labeled praise to recognize individual prosocial behavior.

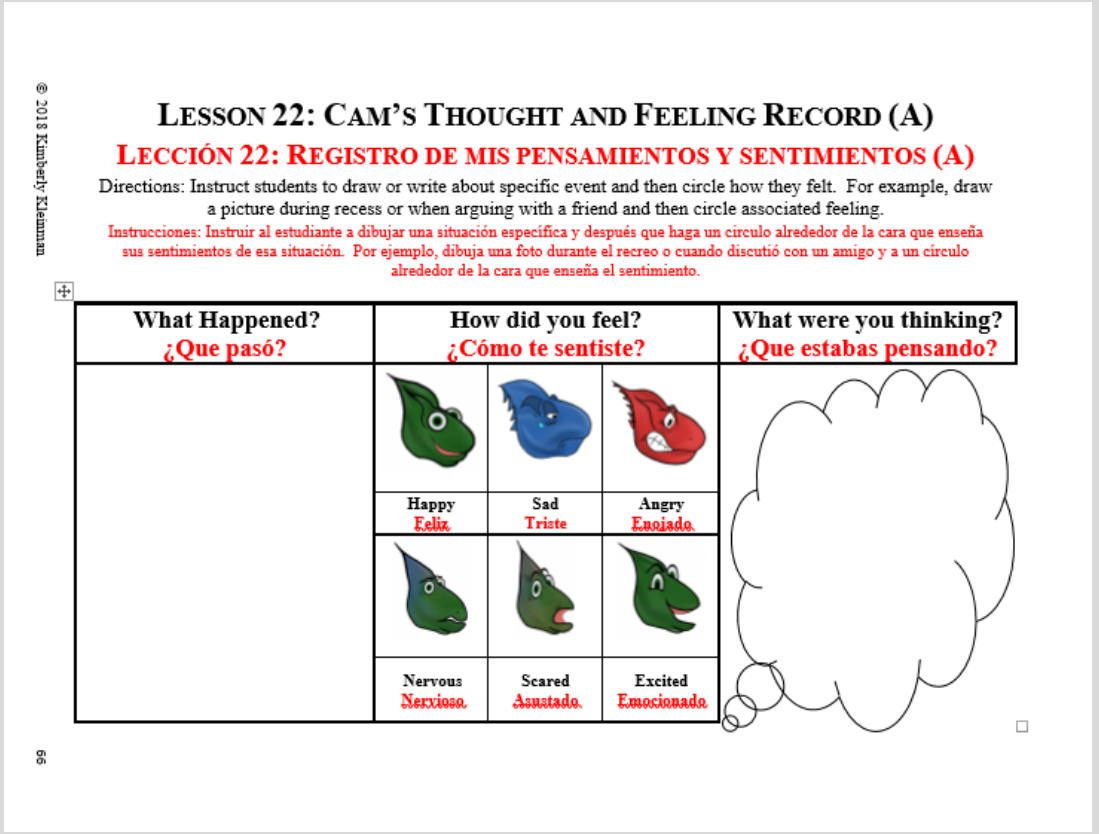
Cam's Classroom: Emotion Regulation

- 24 week multisensory, CBT informed preventative curriculum
- Uses "Cam" and taught by the classroom teacher
- Students "adopt" and care for their own stuffed chameleon to experientially learn emotion regulation strategies
- Teacher manual and student workbook includes:
  - Rationale
  - Sample script
  - Stories
  - Play
  - Worksheets
  - Physical activity.



Student Workbook





Student Workbook

LESSON 25: CAM'S BACKPACK COPING CARDS
LECCIÓN 25: TARJETAS DE AFRONTAMIENTO DE LA MOCHILA DE CAM

Cam's Coping Cards

Tarjetas de afrontamiento de Cam

Pizza Breathing:
smell the pizza, blow to cool the pizza

Respiración de pizza:
Huele la pizza, sopla la pizza

Thinking Machine:
Change your unhelpful though to a helpful thought

Máquina de pensamiento:
Cambia tu pensamiento inútil a un pensamiento útil

Big Problem? Or Little Problem?
Ask yourself if it is a big problem or a little problem

¿Problema grande? ¿O problema pequeño?:
Pregúntate si es un gran problema o un pequeño problema

LESSON 26: CAM'S THINKING MACHINE
LECCIÓN 26: MÁQUINA DE PENSAMIENTOS DE CAM

Preparation: Instruct students to fold the paper and cut ONLY along dotted lines.
Directions: 1) Read aloud the unhelpful thought. 2) Slide the unhelpful thought through the Thinking Machine. 3) Use your brain to power the machine and think of a helpful thought. 4) Slide out the helpful thought and read aloud.

Preparación: Indique a los alumnos que doblen el papel y corten SOLO a lo largo de las lineas punteadas
Instrucciones: 1) Lee a voz alta el pensamiento inútil. 2) Pon el pensamiento inútil en la Máquina de Pensamiento. 3) Usa tu cerebro para darle el poder de pensar en un pensamiento útil. 4) Saca el pensamiento útil y léelo en voz alta.

Unhelpful Thought

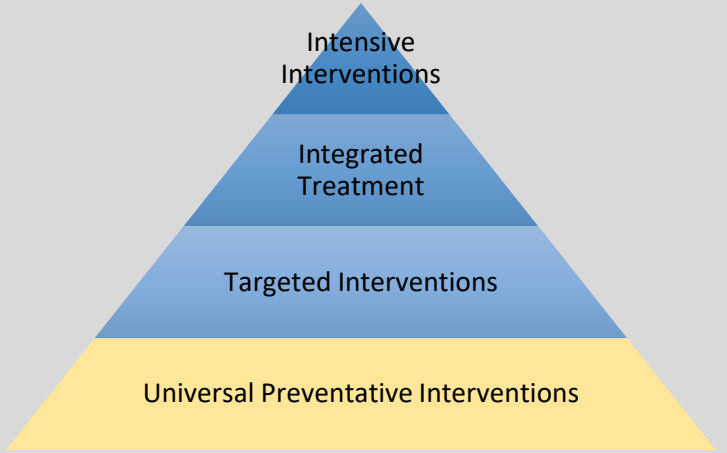
Slide through
Entre Aquí

Pensamiento Inútil

Helpful Thought

Slide out
Deslice

Pensamiento Útil



Universal Parent Engagement

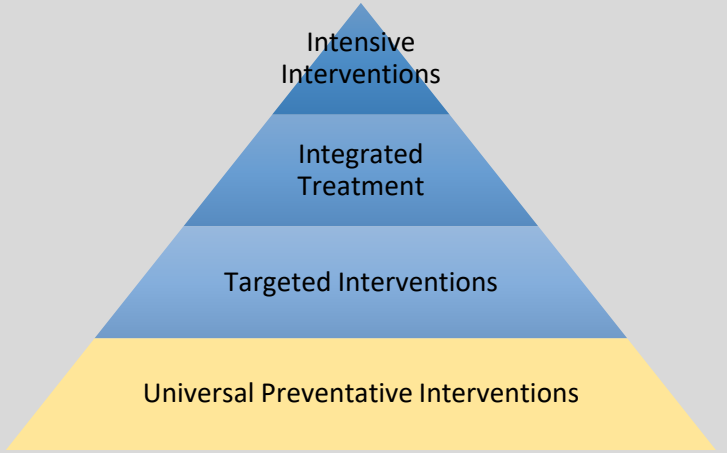
Parent Engagement

Workshops

- Positive Parenting: Discipline with Love
- Understanding your Child's Regular and Special Education Needs and Rights
- Signs and Symptoms of Common Mental Health Concerns in Children
- Empowering our Children: What To Do If Your Child is Being Bullied (or If Your Child Is the Bully)
- Summer Planning
- Understanding and Monitoring Safe Use of Social Media

Events

- Back to school night
- End of year celebration



Initial Findings

Universal Preventative Interventions

Initial Findings: Impact

FYD and SBMH/FYD Enhanced Interventions	Year One Impact	Year Two Impact	Year 3 Impact	
	July 2017-June2018	July 2018-June2019	July 2019-September 2019	October 2019 – June 2020 (Estimate)
Universal Classroom Intervention (# of children participating)	341	1145	1332	--
Universal Classroom Intervention (# of teachers participating)	20	69	92	--
Parent Engagement (# of parents who completed forms – more attended)	54	367	209	150
Parent Workshops (# of parents attended)	327	195	0	200

Initial Findings: Teacher Feedback

Teacher Favorability

- Lessons
  - I would recommend this lesson to fellow teachers.
    - Strongly Agree or Agree = 95%
    - *"This is a great lesson because we are teaching character's emotions and feelings and this lesson was another way to re-teach the concept." – K dual-language teacher*
- Training
  - How beneficial was the training to prepare you for the lesson?
    - Very Beneficial or Beneficial = 96%

Teacher Feasibility

- Lesson:
  - How would you rate your comfort in implementing this lesson?
    - Very Comfortable or Comfortable = 96%
- Training:
  - The lesson was well organized.
    - Strongly Agree or Agree = 96%
    - *"This lesson was clear and accessible to the students. The students clearly understood expressing how they experienced different feelings." - K teacher*

Initial Findings: Classroom Behavior

Ms. G	No CAM (n= 17)		CAM (n= 11)	
	Mean	*Range*	Mean	*Range*
% Ocr: Noise	47.83	*20-71*	32.45	*18-63*
% Ocr: Aggression	8.08	*1-17*	0.36	*0-2*
% Ocr: Seat	67.75	*43-85*	42.91	*13-83*

School #1 (Month 2)	No CAM (n= 83)		CAM (n= 47)	
	Mean	*Range*	Mean	*Range*
% Ocr: Noise	58.5	*20-95*	35.36	*5-75*
% Ocr: Aggression	8.0	*0*-35*	4.1	*0*-77*
% Ocr: Seat	60.91	*10-95*	33.81	*0-83*

Initial Findings:
Teacher Labeled Praise and Classroom Behavior

- Significant correlation between teachers use of Labeled Praise during Cam's game and decrease in student aggression and noise.

Means and Standard Deviations of Teacher Labeled Praise and % Occurrence of Student Inappropriate Behavior.

	Cam's Game (n = 344)		TAU (n= 445)	
	M	SD	M	SD
Labeled Praise	0.38	0.225	0.043	0.05
Aggression	0.05	0.071	0.05	0.07
Seat Leaving	0.28	0.21	0.27	0.21
Noise	0.18	0.186	0.37	0.211

Pearson Correlations of Teacher Labeled Praise (LP) and Student Inappropriate Behavior During Cam's Game and During Teaching As Usual (TAU) Conditions.

	LP During Cam's Game	LP During TAU
Aggression	-.112*	-0.021
Seat Leaving	-.032	0.038
Noise	-.149**	0.066

* p< .05, **p<.01

Student Testimonials

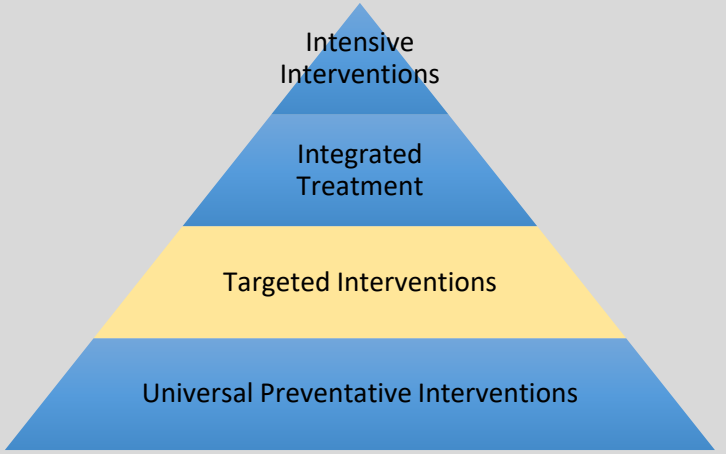
"One thing that I learned about my Cam is that my Cam **always is beside** me when I am sad. Because he has really beautiful colors and I really really like his colors because its like a beautiful rainbow in the sky. And I really like about him is that **he always listens to me** and I really like that **he helps me** – sometimes he helps me **when I am doing my work**."

- Kindergarten dual language student

Student Testimonials

"Hello, my name is ** and this is Cleo Patrick and he **teaches me about his feelings**. And the way he teaches me is because he tells me how he acts with his feelings and **then I understand better so then I know how to act with my feelings**. And I love Cam. Because he is always here to protect me."

- Second Grade Student



Targeted Interventions

Neuropsychological Consultation

Educational Advocacy

Parenting Groups

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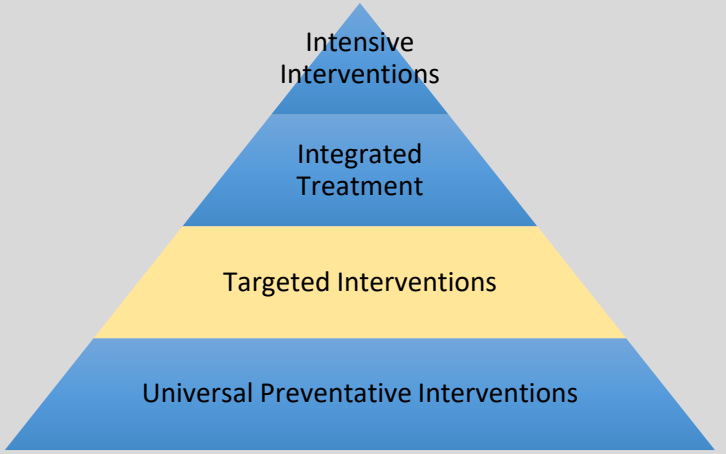
College of Physicians and Surgeons

Division of Child & Adolescent Psychiatry

NewYork-Presbyterian
Morgan Stanley Children's Hospital



Neuropsychological Consultation, Educational Advocacy

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Rationale for Neuropsychological Intervention

- In underserved communities, schools lack resources to…
  - Identify learning disabilities appropriately (and early on)
  - Understand emotional and behavioral dynamics that influence academic functioning
  - Provide appropriate services to address learning needs
  - Support parents with educational advocacy

- Untreated learning disabilities and academic failure associated with poor educational outcomes, school disengagement/dropout, unemployment, involvement in criminal justice system

Program Aim

- Provide community-based, neuropsychologically-informed evaluation, consultation, and advocacy services to promote positive long-term outcomes for at-risk youth
  - Identify at-risk children in need of more intensive support and/or further evaluation
  - Target school compliance with federal education law and educational decision making
  - Provide diagnostic clarity and assist with treatment planning
  - Empower parents and provide support with educational advocacy efforts

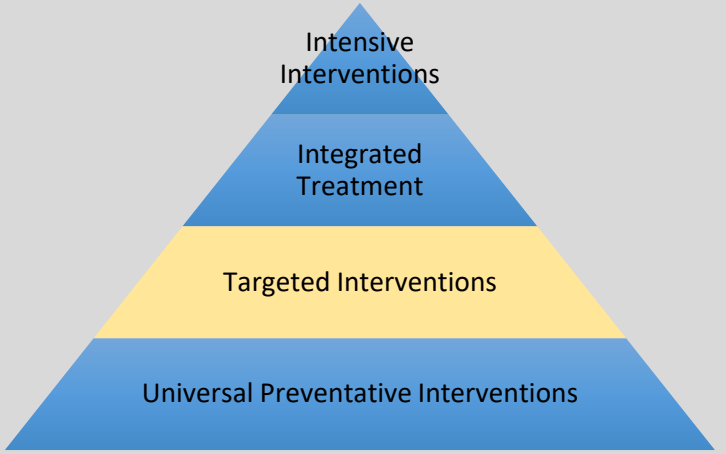
Intervention Components

Neuropsychological Screenings and Evaluations

- Record reviews
- Classroom observations
- Interviews
- Abbreviated measures of intellectual, language, and academic functioning
- Behavior rating scales

Consultation and Advocacy

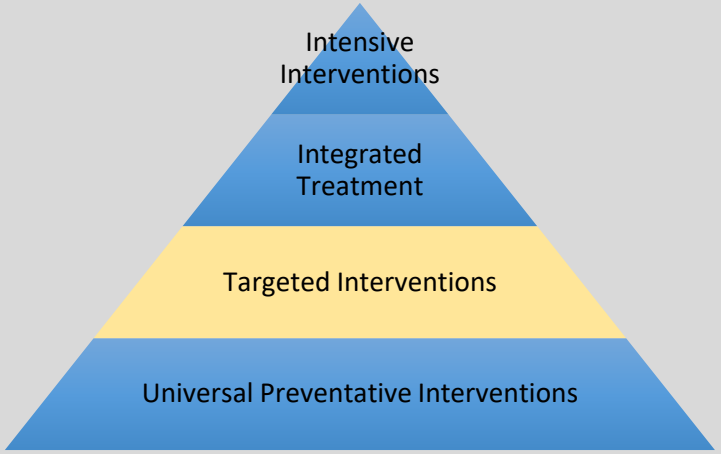
- Participation in school team meetings
- Teacher and school staff consultation
- Participation in special education meetings
- Parent workshops
- Collaboration with Family Youth Development treatment team



Parenting Groups

Parenting Groups

- Informed by Incredible Years and Parent Management Training
- Weekly Group Topics
  - Play and PRIDE Skills
  - Praise, Rewards, & Behavior Charts
  - House Rules and Routines
  - Active Ignoring and Effective Commands
  - Parenting Styles, and Natural and Logical Consequences
  - Self-Care and Problem Solving
  - Discipline Strategies
  - Promoting Self-Esteem and Supporting Your Child's Learning



Initial Findings

Neuropsychological Interventions

Parenting Group

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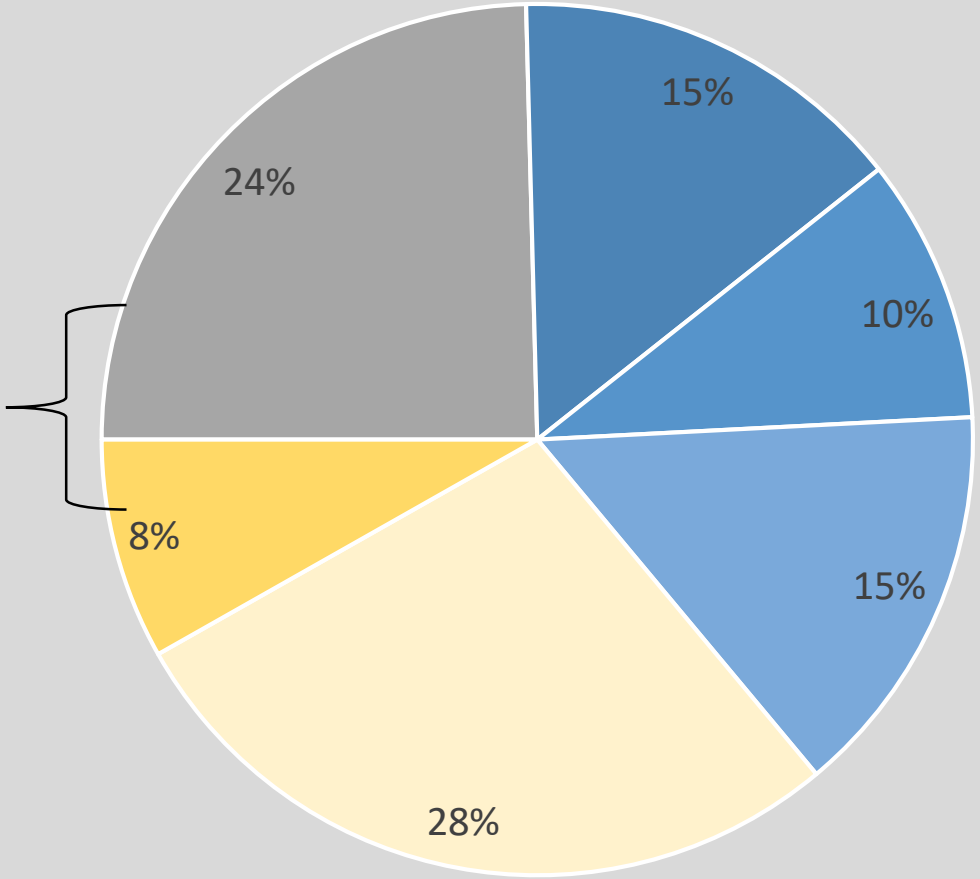
Neuropsychological Outcomes: Children Placed in Appropriate Academic Settings

32% of Screens: No changes required or No IEP required

Remaining 68% of screens required intervention

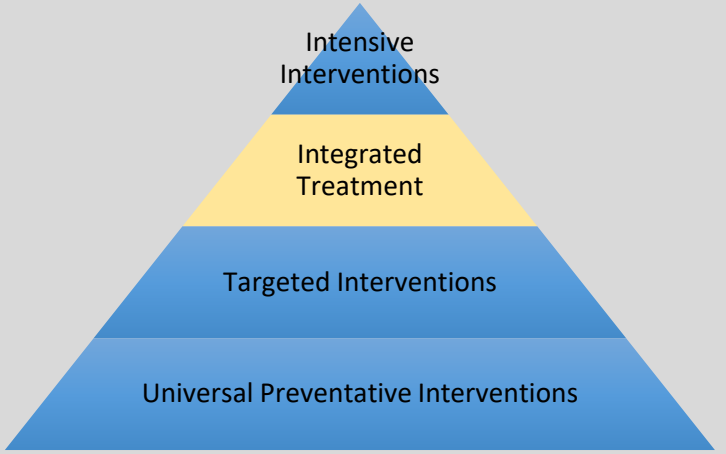


Outcomes

	Referred for Further Evaluation	Diagnostic Clarification Provided	Medication Consult Recommended	Change in Therapy Service Recommended
% of all patients screened	18%	37%	11%	18%

Parenting Group Impact

FYD and SBMH/FYD Enhanced Interventions	Year One Impact	Year Two Impact	Year 3 Impact	
	July 2017-June2018	July 2018-June2019	July 2019-September 2019	October 2019 – June 2020 (Estimate)
Parenting Group (# of parents participating)	23	79	0	40



Integrated Intervention

Evidence Based Psychotherapy and Psychopharmacology

Focus on Trauma Treatment

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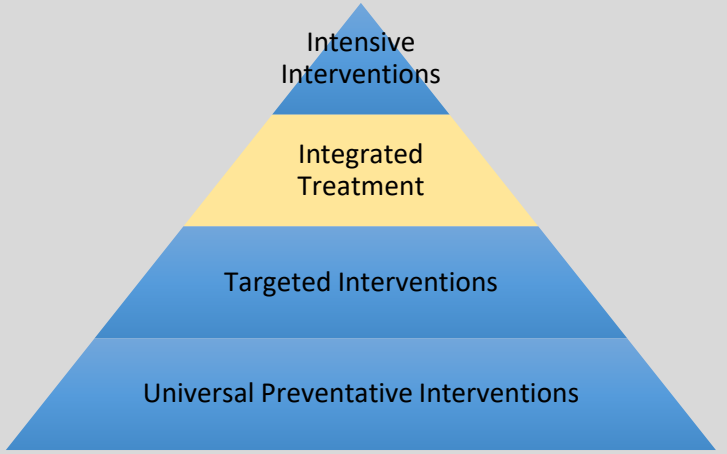

Trauma-Informed Practices in School-Based Mental Health

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Clinical Services

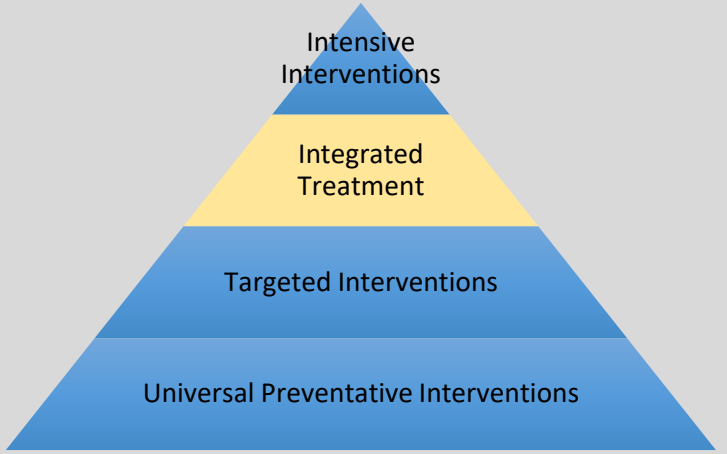
- Clinical Services by on-site clinician and team
  - Individual child psychotherapy
  - Group psychotherapy
  - Parenting guidance and/or family therapy
  - Crisis Intervention
  - Medication evaluation & management
  - Home Based Crisis Intervention
  - Neuropsychologists and Educational Advocates
  - Summer Programming and Educational Support
- Clinical Services in 2018
  - 419 children and their families received integrated outpatient psychiatric care
  - Psychotherapies & Medication Management (number of visits) =10,901

Who are our patients?

- 13 elementary schools in Washington Heights
- Predominantly Latinx, many bilingual
- High rates of exposure to trauma and/or chronic stress
  - 88% report single traumatic event
    - Of that, 26% report five or more discrete traumatic events
- Most Common Diagnoses
  - ADHD
  - PTSD, other trauma-related disorders
  - Anxiety
  - Depression

Trauma Informed Psychotherapy

- CBT
  - Trauma Focused-CBT
  - Alternatives for Families-CBT
  - CBITS/Bounce-Back
  - Coping Cat
- Parent-focused treatment
  - Parent Child Interaction Therapy
  - Parent Management Training
- Psychopharmacology



Initial Findings

Impact

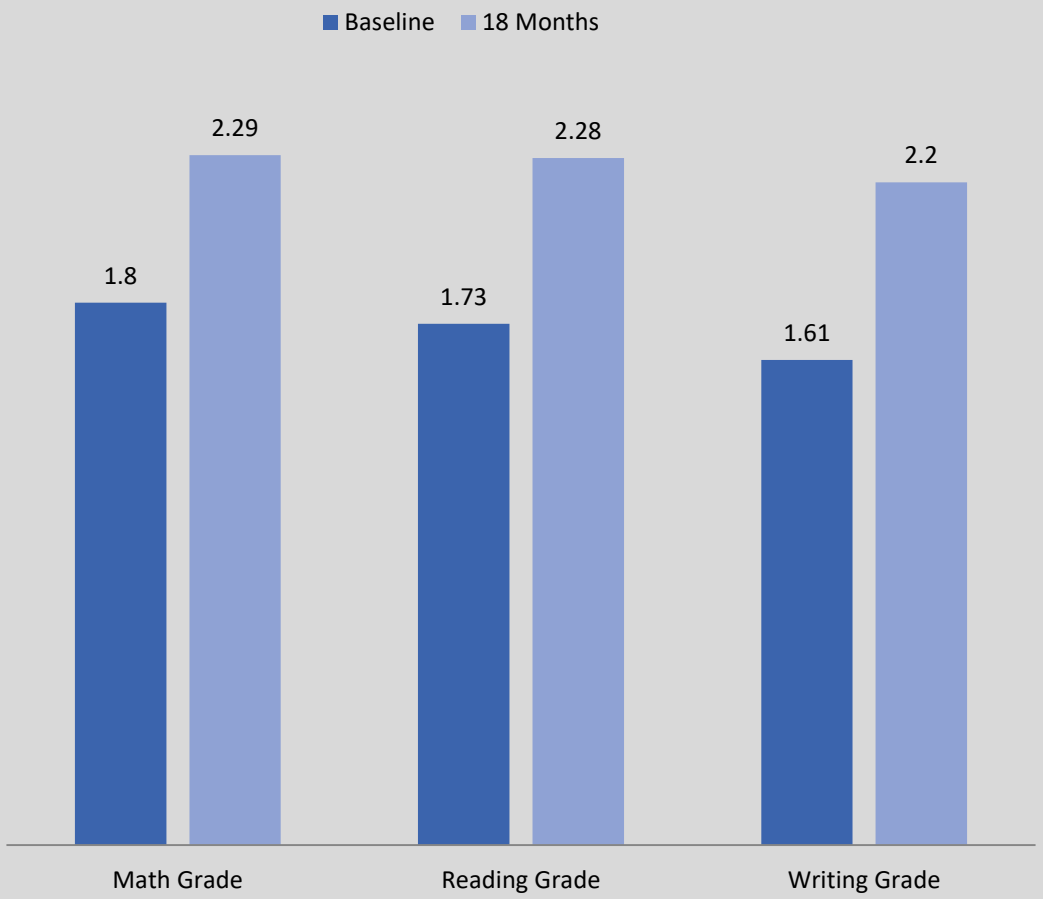
FYD and SBMH/FYD Enhanced Interventions	Year One Impact	Year Two Impact	Year 3 Impact	
	July 2017-June2018	July 2018-June2019	July 2019-September 2019	October 2019 – June 2020 (Estimate)
	2 schools	5 schools	7 schools	
Neuropsychological Interventions (# of evaluations)	30	30	0	30
Trauma Informed Interventions for Psychotherapy and Psychopharmacology (# of children seen)	69	86	33	75

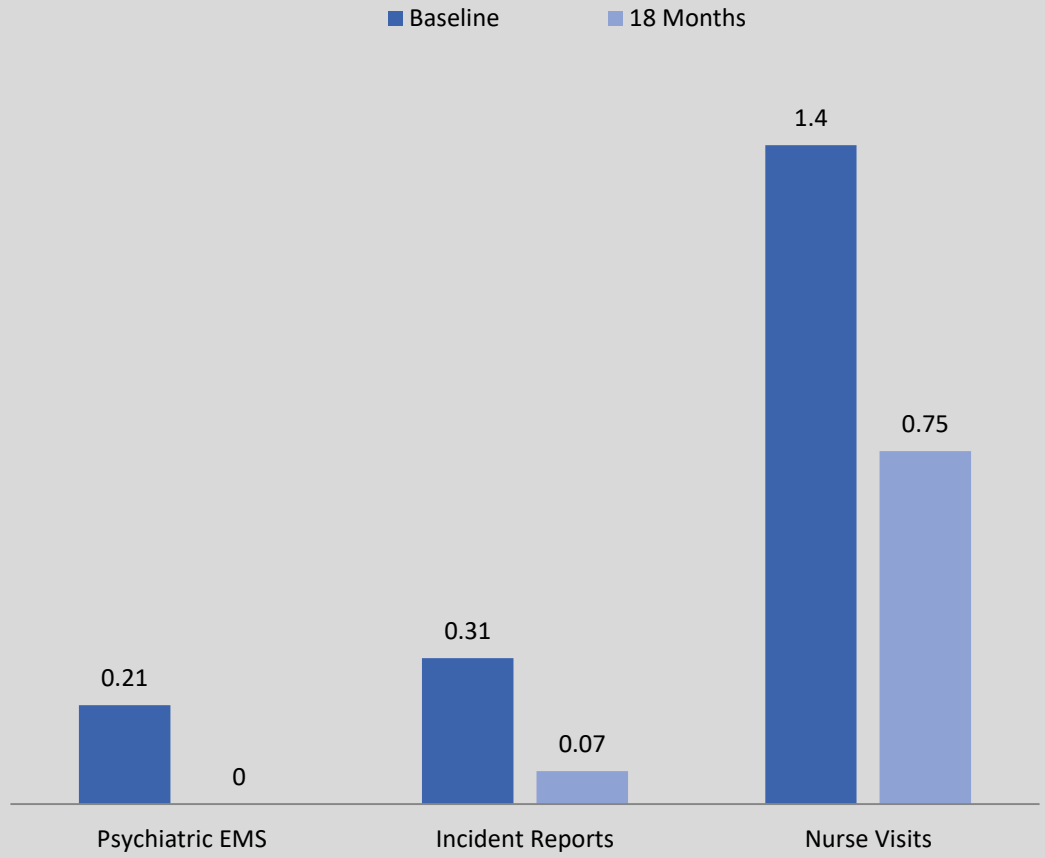
Academic and Behavioral Outcomes

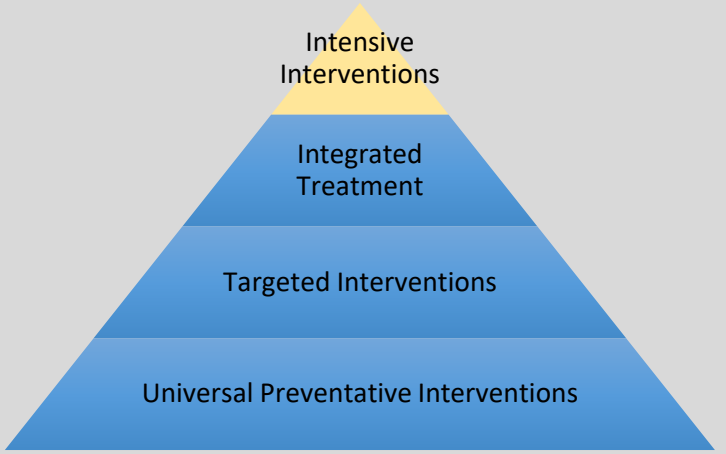
- **Academic Outcomes**
  - Baseline: Half of referred students have reading grades of 1 at baseline
  - Grades: 25% Increase in Reading, Writing, and Math Grades
  - Promotion: 99% of Students advanced to next grade
  - Testing: 3 of 4 students with “1” or “2” on statewide testing improved

- **Behavioral Indicators**
  - Attendance: 5% Increase overall, 80% Of “Poor Attenders” Improved
  - Incidents: Sharp reductions in incident reports, AP, guidance, nurse, and suspensions (65-85%)

Academic and Behavioral Outcomes







Integrating the Best of Two Models

Adapting Home-Based Crisis Interventions into a Three Tiered School-Based Mental Health Program

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Home Based Support and Family Youth Development (FYD) Program

- The Problem:
  - Increased acuity in psychiatric presentation of school aged children leading to growing need for intensive, higher levels of care

- Our Model/Answer:
  - Collaborative, multidisciplinary and culturally humble interventions in school and home

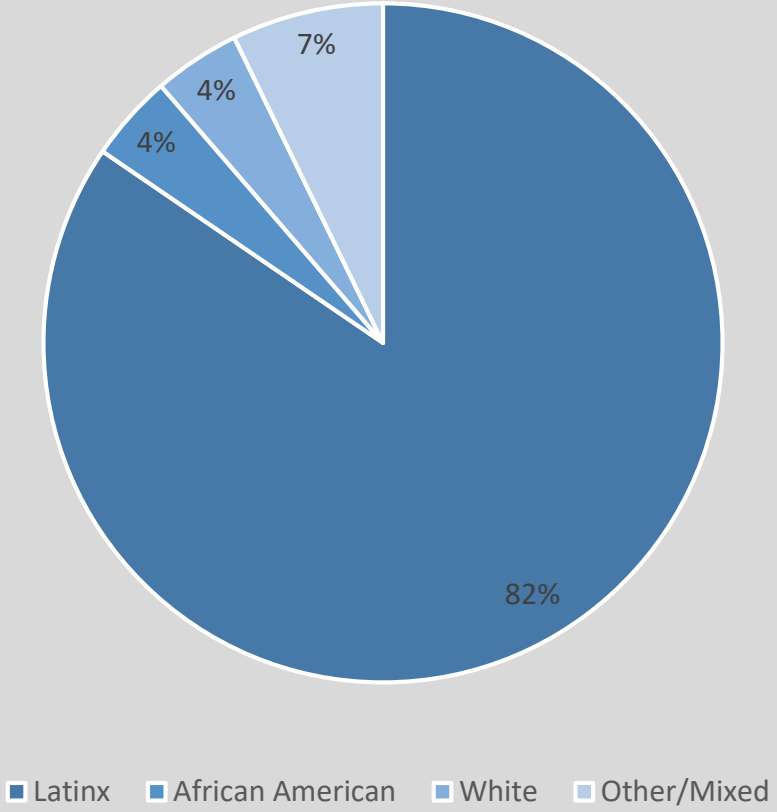
Why Home Based Support?

- Generalization of skills and intervention
- Challenges of artificial settings like clinics, day treatment programs, and/or psychiatric hospitals
- Informed holistic view that captures systemic impact at various levels including home, family, school, community

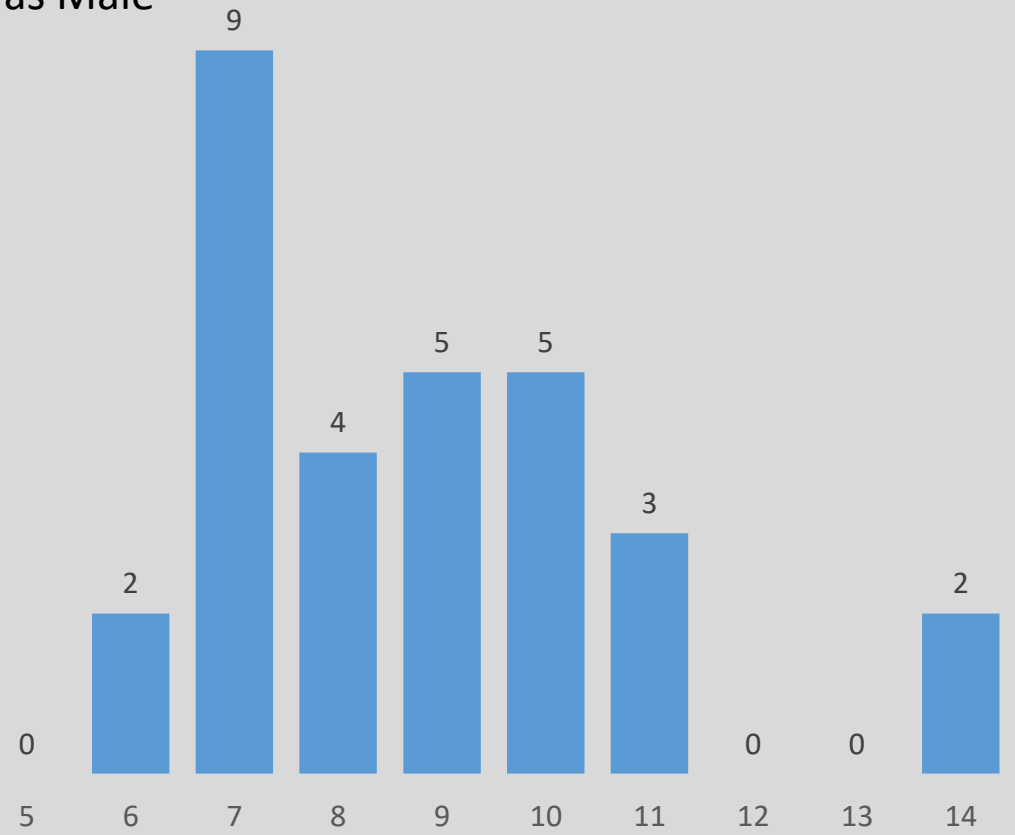
Home Based Support and FYD model

- Fourth tier of FYD intervention
  - Most acute presentation with school based mental health team in place
  - Families identified by a school based mental health provider
  - Integrated into SBMH team with shared treatment goals
  - Consultation and coaching with parents and school staff
- Most Common Referrals
  - ED Diversion
    - School referrals for suicidality
    - Behavior dysregulation in the classroom
  - Acute psychosocial stressors in the home
  - School avoidance

Demographics (n= 30; year 1 and 2)



80% Self Identified as Male

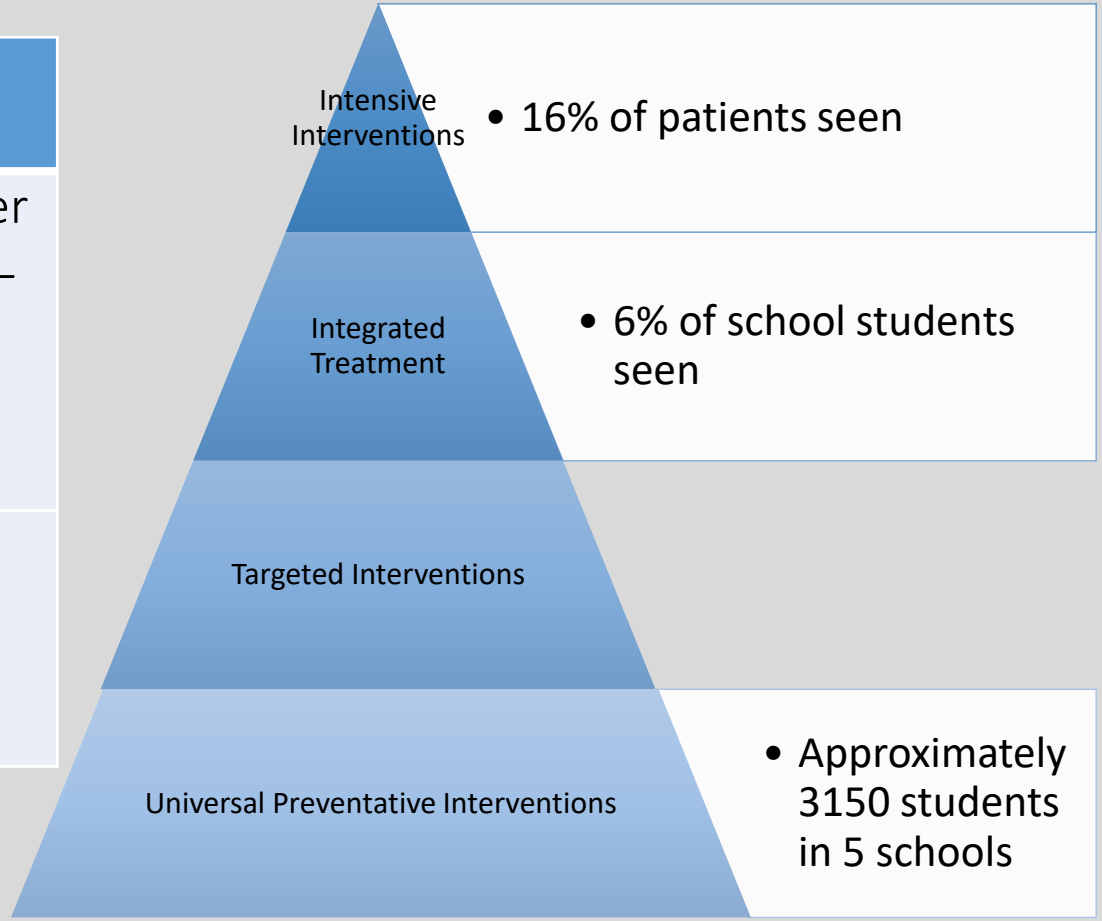


Primary Diagnoses

- ADHD
  - 47%
- Adjustment Disorder with Anxiety
  - 10%
- Separation Anxiety
  - 10%
- ODD
  - 6%
- Panic Disorder
- Unspecified Depression
- Persistent Depressive Disorder
- GAD
- MDD
- PTSD
- Selective Mutism

Impact

FYD and SBMH/FYD Enhanced Interventions	Year One Impact	Year Two Impact	Year 3 Impact	
	July 2017-June2018	July 2018-June2019	July 2019-September 2019	October 2019 – June 2020 (Est.)
Home-Based Crisis Intervention (# of families seen)	17	14	2	19



Outcomes

- Chief compliant for ED visit
  - Elopement
  - Aggression
- Principals report that outside of regular responsibilities the majority of resources are focused on 1-3 students in crisis at any given time.
  - With the assistance of HBCI in schools, principals are able to **re-allocate their resources to academic interventions, IEP adherence, special education evaluations and administrative improvements**.

Patients with ED visits	
During HBCI Treatment	3/30
2 months post discharge	3/30
6 months post discharge	2/30

Combining Home-Based Intervention into School Based Mental Health Care

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Approach to Treatment

Bio

- Biological Vulnerability
- Medical Model

Social Systemic

- How systems affect children
- Social determinants
- Social responsibility and justice
- Power and privilege

Child, Family, School and Community

Psycho

- Dialectical
- Cognitive Behavioral

Cultural

- Acculturation
- Cultural humility

Treatment Outline

Evaluation

- First 3 visits
- Welcome Packet
- Psychoeducation with motivational interviewing/ DBT commitment skills to initiate improve commitment
- Crisis focused, needs assessment
- Measures completed by parents and child:
  - CSSRS (Columbia Suicide Severity Rating Scale)
  - Columbia DISC Depression Scale or PHQ9
  - SCARED (Screen for Anxiety and Related Emotional Disorders)
  - SNAP-IV (teachers and parents)
  - Trauma Checklist (CPSS and Trauma Screen for caregiver and child)
  - Acculturation scale

Evaluation: Welcome Packets

- Includes:
  - Treatment team names and contact information
  - FAQs
  - What to expect sheet
  - Home sanitation handout
  - Middle/young childhood information sheet
  - Sleep diary
  - Calendar
  - Outpatient bill of rights
  - Diagnostic measures

Risk Assessment

- Suicidal behavior, aggressive and impulsive behaviors, non suicidal self injurious behavior?
  - Columbia Suicide Severity Rating Scale (brief version) scale
- Safety plans for all cases, child friendly (Barbara Stanley model)
  - Use plan to address problem behaviors
- Home sanitation- elimination of access to means
  - DBT approach with presenting as treatment necessity, obtaining commitment
  - Psychoeducation: materials explaining process and rationale
  - Patient-centered

Risk Assessment: Safety Plan

Step 1:

How to make my home safe

Step 2:

Triggers

Step 3:

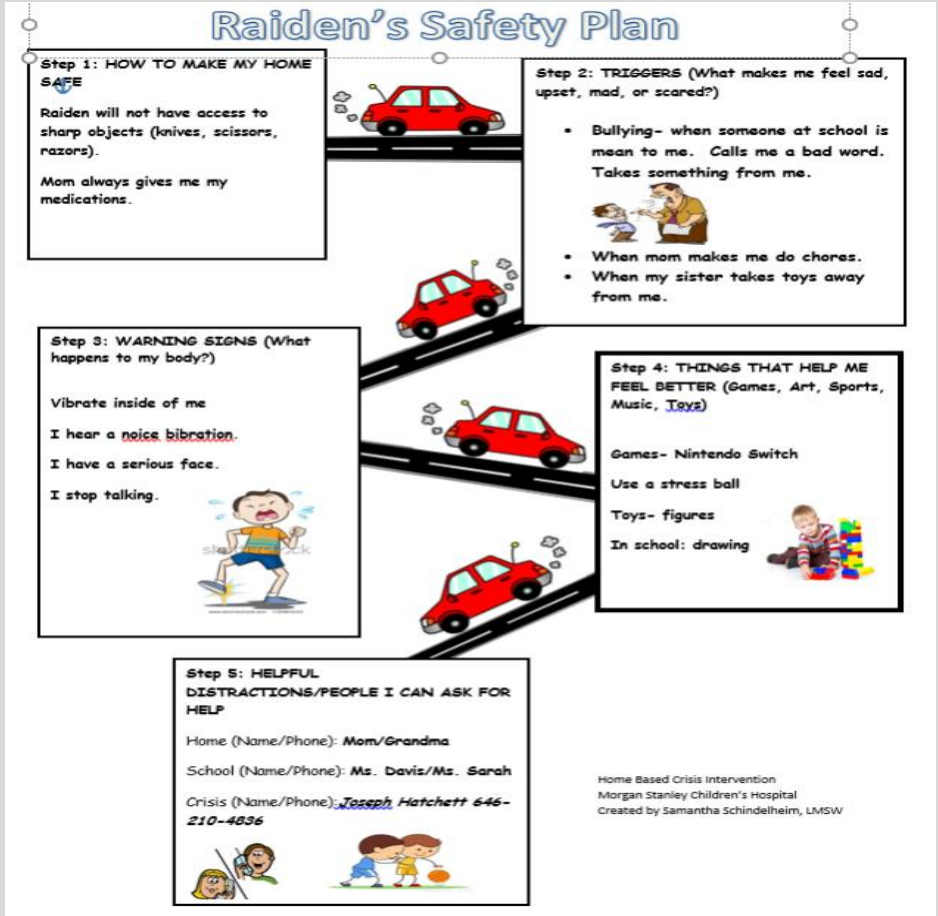
Warning Signs

Step 4:

Things that help me feel better

Step 5:

Helpful distractions and people I can ask for help



Risk Assessment: Home Sanitation for Self-Harm/Suicidality

- For Parents and Child:
  - Handout that describe:
    - What is it?
    - What should I remove these methods?
    - Is the process “effective”?
    - Problem solving
    - Helpful tips
    - Home Sanitation Checklist
    - Spanish version

Morgan Stanley Children's Hospital of NewYork-Presbyterian
Columbia University Medical Center

Home Based Crisis Intervention (HBCI)
Home Sanitation for Self-Harm and Suicidality Assessment

What is home sanitation for self-harm/suicidality? Home sanitation for suicidality is the act of assessing your home environment for safety risks, and disposing and/or locking away objects that could be used by your child to self-harm with or without intent to die. This includes items such as sharps, medication, and firearms. The goal of home sanitation for suicidality is to reduce your child's risk of engaging in suicidal behaviors (i.e. cutting/scratching, burning, overdosing on medication).

During your first evaluation visit with HBCI, clinicians will review the home sanitation assessment to ensure that your child's risk of harming themselves or others is minimized. It is essential that you continuously review these directions throughout their treatment as home environments are always changing. We understand that this process can be very overwhelming so we are more than happy to review this with you and your family whenever needed.

What should I remove from our home or put away?

Cleaning Supplies (Bleach, detergent)

Window screens should be locked

Prescription AND over-the-counter (OTC) medications; we recommend a safety lock box for all medicines kept in your home including:
- Aspirin
- Tylenol
- Vitamins
- Supplements
- Prescription medications

Alcohol (Spirits, Wine, Beer)

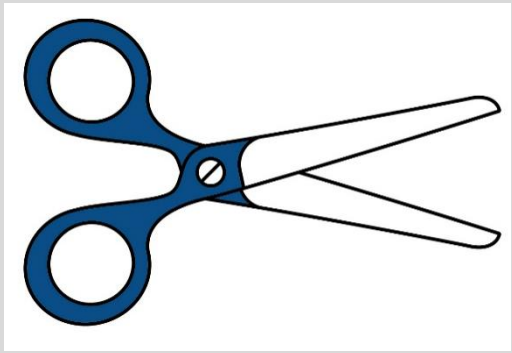
Firearms and/or ammunition (Research shows that owning a gun increases risk of suicide)

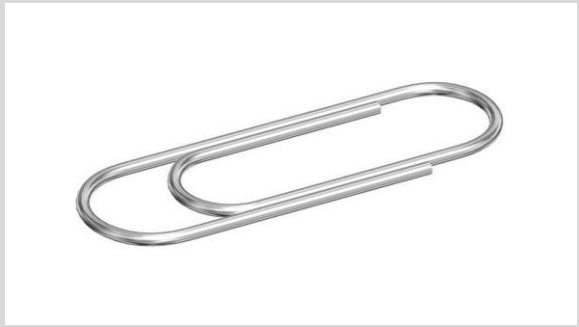
Why Is Home/School Sanitation Important?

- **Restricting access** to methods can disrupt periods of high dysregulation
- Periods of high risk are relatively short and **limiting access may delay an attempt** until the period of high-risk passes
  - Children are impulsive
- **Problem solving abilities deteriorate** during periods of high risk

Home Sanitation

School Sanitation





Crisis Coaching

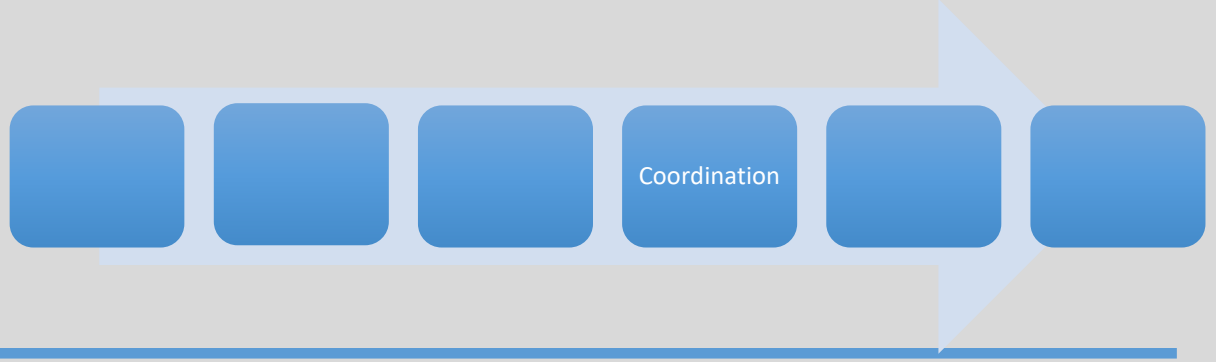
- Two child and parent focused sessions dedicated to use of crisis line
- **Session 1**: Psychoeducation
  - Reasons to call
  - “Feelings thermometer”/ rating scale where patient identifies when they would need to call
- **Session 2**: Exposure
  - Role play
  - Actual call placed to crisis line with imaginary crisis
  - Commitment strategies to commit patient to use crisis line

- Response to crisis calls aim to incorporate model from DBT phone coaching: Assessment, dialectic of acceptance and change, commitment to not engage in undesirable behavior, check in

Crisis Coaching Handout

- Includes:
  - Step by step instructions on how to call
  - Reasons to call
  - Coach-player metaphor

Coordination of Care



- Coordination of care meetings in person or on the phone at beginning, middle, and end of HBCI treatment
  - relevant providers (therapist, psychiatrist, ACS worker, case manager, educational advocate, teachers, school counselors and therapists, paraprofessionals, etc)
- Identify and delegate treatment goals
- Psychoeducation on HBCI referral, presenting crisis, diagnoses, symptoms
- Generalization of skills to community (i.e. phone coaching, sanitation)
- Facilitate communication amongst providers
- In vivo behavior management training for school staff

Treatment

- Diagnosis/presenting problem
  - Impulsive/aggressive behaviors; ADHD, ODD, DBD NOS
- Behavior management/CBT/PCIT
  - More time with parent
  - Commitment and buy-in
  - Parent: crisis calling, psychoeducation (diagnosis, mental health systems, stigma and meds), Parent management training, PCIT, self-care
  - Child: crisis calling, self regulation skills (The Zones of Emotion Regulation), behavior management
  - Systems: Coordination of care meetings, advocacy, case management support to obtain benefits and other community resources

Adapted evidence based treatments

- Language and Culture
  - What are the values and do they match with the treatment delivered?
- In vivo delivery of care
  - Real time and in the actual setting facilitates generalization of skills
- Assessment of barriers
  - In vivo assessment of what might get in the way of treatment
- Examples:
  - PCIT: time out, special time, play and culture
  - Risk assessment and safety planning: in vivo home sanitation
  - Parent training: charts, consequences

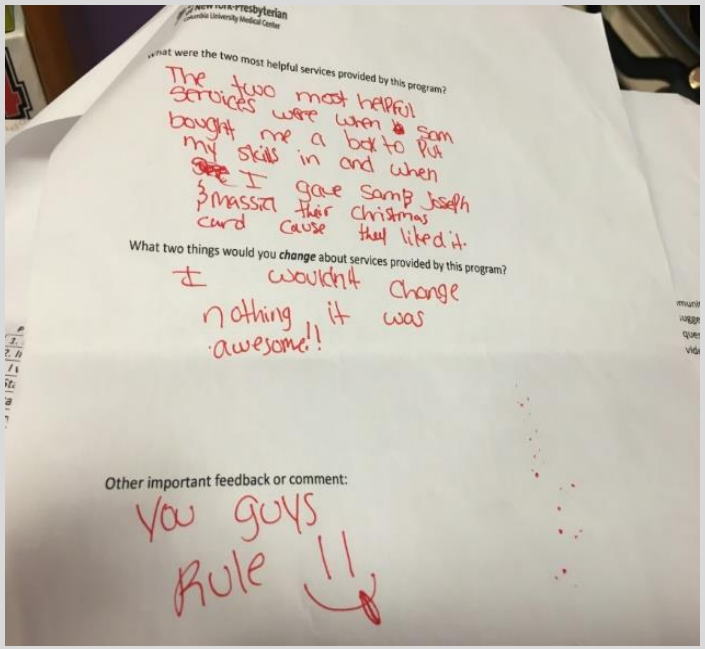
Termination

- Graduation Packets
  - Certificate of Achievement
  - List of Important Contacts
  - Summary of HBCI treatment (w/skills) and long-term recommendations
  - Copies of skills sheets
  - Prize for patient
  - Letter of praise for parent and child
  - Feedback questionnaire

Termination: Feedback Questionnaire

Please indicate agreement or disagreement with each statements:						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
1. I like the services that I received here						
2. If I had other choices, I would still get services from this agency						
3. I would recommend this agency to a friend or family member						
4. Staff were willing to see me as often as I felt it was necessary						
5. Staff returned my call within 24 hours						

11 year old female



Julissa*

Intervention Example

* Identifying information was removed

Julissa

- Background
  - 7 year old Female
  - Bi-racial: Self identified as African American and Latina-Dominican descent
  - English speaking female
  - Domiciled with mother, 4 maternal sisters (ages 14, 5, 4, and 6 mos), and stepfather in a 1 bedroom apartment in Washington Heights. Mother employed half time working night shifts
- Current Treatment
  - Weekly individual psychotherapy (CBT) and Medication Management
  - Monthly parent collateral (25% attendance rate)
  - DSM 5 diagnosis: ADHD, combined type
- Acute presenting crisis:
  - Worsening behavioral dysregulation in home and school- physical aggression with peers and family members, lying, and oppositionality
  - Referred by school-based clinician/ED Diversion

Integrating Intensive (home-based) Treatment

- Treatment approach:
  - **Close collaboration** with SBMH providers who had strong rapport with family and trust established. Interventions delivered in school setting and reinforced by HBCI staff
  - **Cultural humility**: Understanding mother's history and connection to community. Ideas about mental health based on prior experiences. The role of spirituality and understanding of human behavior
  - **24/7 crisis line**: validation and reassurance + guidance
  - **Adapted evidence based**: made for family's individual needs, specific skills
  - **Coordination**: informing SBMH about social context to continue to tailor interventions and SBMH joining home visits for seamless continuity of care
  - **Community resources**: karate classes

Course of Treatment

- Home based treatment
  - 8 week treatment
    - 3 visits/week in home and school
    - Crisis calls (on average 2 per week)
  - Worked with classroom teacher on implementation of Cam's Classroom
  - Coordinated parent and clinician schedule
  - School safety plan
- School based treatment
  - Continued weekly individual psychotherapy
  - Collaboration and coordination with team

Termination

- School-based clinician continued to work on
  - Emotion regulation
  - Medication management
  - Utilization of skills
  - Increased engagement with parent
- Teacher reports ongoing hyperactivity but decreased aggression and risk of elopement
- Follow up calls
  - Mother reported decrease dysregulation in the home and increased coping skills

Strengths, Barriers and Future Directions

Strength: Increased Engagement

- Indicators for Successful Engagement
  - Generally good adherence and compliance when support is added
  - Genuine interest, motivation, and commitment for change
  - Parental availability, involvement and cooperation

Strength: Effective Strategies

- Concrete tools
  - safety plan for school and home
  - multi-environment sanitation
- Coordination/Collaboration
  - know the treatment team
  - Ongoing check-ins with family and staff
- Treatment
  - provide basic, core skills (PRIDE skills, behavior chart, positive and negative reinforcement, emphasize praise)

Treatment Barriers

- Little research on attempts and triggers
- Mental health stigma, particularly for immigrants
- Lack evidence based treatment to address distinct cultural backgrounds
- Intensive (e.g. expensive) intervention
- More parents are working

Future Directions: Addressing Trends

- School refusal/avoidance:
  - Seems chronic and pervasive
  - Many challenges experienced even within home interventions: what supports are available?
  - Does not respond to traditional evidence based approaches. Hypothesis that problem is multifaceted and systemic.
- Referrals outpacing capacity by more than 50%
  - Stress on systems (ED, inpatient, outpatient)
  - Not enough wrap around support other than HBCI- health homes not sufficient for population

Future Directions: Addressing Trends

- Psychosocial barriers:
  - Poverty, rent burden, cost of living in Manhattan, and gentrification
  - Approximately 70% with employed caregivers: decreased caregiver availability, burned out caregivers, employment with little to no flexibility, desires for social mobility
  - Overburdened systems: family
  - Sociopolitical environment: immigration
- Increase in males
  - Majority referrals from schools

Moving Forward: Goals and Projects in Effect

- Program Standardization efforts
  - Stratification of social determinants based on severity
  - Continued modification of crisis calling practice and actual crisis call response with schools
- Program Development
  - HBCI school based intervention model
- Ongoing work around validity and reliability of feedback forms
- Ongoing training in cultural humility and engagement in community, creation of Mental Health Disparities Workgroup
- Training rotation: teaching psychiatry fellows, social work interns, psychology interns

Discussion

What barriers do you predict?

Creative problem solving

Creating a Treatment Plan

Break into groups and create a treatment plan using an integrated model

Vignettes

1. 7-year-old African American male, lives with biological parents
   - School called EMS after he told the school social worker he wanted to jump off the top of his school. Patient was brought to Emergency Department and discharged that day.
   - Past history of threatening to harm self with sharp objects in school with intent to die (sharpeners, pencils, scissors)
2. 10-year-old Dominican American male, lives in two-bedroom apartment with biological parents, paternal grandmother, 17-year-old and 21-year-old brothers.
   - Aggressive behaviors with intent to harm others in moments of increased dysregulation. Often throws glass objects, pots and pans, books at family members during outbursts.
   - School reports that he is “one of the easy ones.”
3. 5-year-old Caucasian female in Kindergarten classroom, lives with single father.
   - No reported behavior problems at home or in PreK. Since entering classroom, school reports that child is running from the room multiple times a day. School has responded with calling father daily to pick her up early. If father is unable school personnel will hold door shut so patient can not leave. Teacher is complaining that other students are fearful and not learning.

Treatment Planning Activity

- Using the case examples, consider the following:
  - Presenting concern
    - What is the most urgent concern?
    - From that concern, what are 2-4 treatment goals? How do you operationally define them?
  - Collaboration
    - Who can you collaborate with in your system/the child's system?
  - Cultural humility
    - What are the cultural factors to think about (both as strengths and barriers)?
  - Community resources
    - What are some resources in their communities?
  - What are concrete interventions (evidence-based):
    - What interventions would you consider to be most beneficial to reach your goals?
    - What are potential barriers to implementing the treatment?

Discussion: Your Own Case

Using this model, return to your group and discuss one of your cases.

Discussion

Discussion

What are your limitations/barriers to implementing this model?

Wrapping Up: What is your take away?

What is your plan for Monday?

Who can you identify as benefiting from this model?

What systems do you want to engage? What modifications to existing treatments are you considering?

Questions?
Thank you!

Samantha: sgs7001@nyp.org

Kimberly: kek9041@nyp.org

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