The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

An In-Home Intervention Program for Children With Mental Health Needs

Treating youths with serious mental health needs without separating them from their families and communities has been a goal for over two decades. However, there is a dearth of innovative and evidence-based interventions that provide long-term, family-based in-home services. Maryland's In-Home Intervention Program for Children (IHIP-C) is a new endeavor that is guided by systems-of-care principles and aims to prevent out-of-home placement for youths with serious mental health needs, including conduct disorders, oppositional defiant disorder, major depression, and bipolar disorder.

The IHIP-C is the result of a confluence of a developing vision of how to better serve youths with serious mental health issues and the opportunity provided by the closing of a regional psychiatric facility, Crownsville Hospital Center in Maryland. Mental health administrators and service providers from five jurisdictions most affected by this closure had noted that children with serious psychiatric disorders served by the public health system were consistently being referred to residential treatment centers. A lack of other community-based alternatives cultivated an overreliance on these treatment centers, resulting in a waiting list for families seeking treatment for their children's mental health needs. State mental health administrators realized that high-cost residential services were consuming a large share of the financial resources for children's mental health care. In addition to the financial inefficiency, concerns were raised about the effectiveness of group placements for youths with mental health needs.

In considering a family-focused, community-based intervention for youths, state mental health administrators and service providers envisioned a program where families could receive in-home services and support that were available 24 hours a day, seven days a week, and that were strengths-based, supportive services in situ as an adjunct to outpatient counseling and psychiatric treatment. The result of this vision was the IHIP-C, launched in January 2005.

The program employs four tenets in serving children and adolescents with mental illnesses and at risk of out-of-home placement: provide intervention services around-the-clock that are evidence based, family focused, multijurisdictional, community based, and in the home; ensure that services are individualized, coordinated, and built on the family's strengths and resilience; either reduce admissions to more costly and more restrictive institutional placements by providing clinical services to families or assist families with reunification after an out-of-home placement; and link children and adolescents to an outpatient therapist throughout their tenure in the program. A mental health clinician is part of each service team and provides direct services. Anne Arundel County Mental Health Agency, Inc., was designated as lead agency for the five-county collaborative project. The IHIP-C is primarily funded through the state-supported psychiatric rehabilitation program.

The target population for the IHIP-C is youths who are deemed high-end users of the public mental health system through institutional care (that is, hospitalization or residential treatment centers) and foster care children, ranging from ages eight to 18. Children and families can be served by the IHIP-C for as long as 15 months—a substantially longer period than comparable alternative community-based intervention programs (such as multisystemic therapy) that target similar risk groups. Families transition from the program as their treatment goals are met—a determination jointly made by IHIP-C clinical staff and the outpatient clinician of record. Program success is defined as improved pre-post assessments of family functioning and when problematic child and adolescent behaviors are contained within the natural ecologies of family and community, thus mitigating the potential that a youth will make contact with a residential treatment center.

Each family is assigned an in-home behavioral interventionist who is primarily responsible for service delivery. This individual conducts an initial assessment and provides weekly clinical services to the child and family (seven to ten hours during the initial 45 days in the program; two to two-and-a-half hours thereafter), in addition to being available to families for crisis intervention as needed. The behavioral interventionist provides short-term family support, parent training and skills enhancement to better manage their child's behavior, and service coordination and empowerment regarding the continued use of outpatient mental health services.

Future research plans include subjecting the IHIP-C to a clinical trial to determine its efficacy as an alternative clinical practice for youths with persistent mental health problems or high-end users of the most intensive services. Results from such a trial might further answer the question of whether this novel practice can prevent more costly and intrusive out-of-home placement.

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Psychiatric Expertise for a Multidisciplinary Huntington's Disease Clinic

In 2005, in response to the development by a private health care provider of a nursing home for patients with Huntington's disease, members of the United Kingdom's National Health Service (NHS) set up a multidisciplinary Huntington's disease clinic. The nursing home was initially set up without consultation with local psychiatric services. Psychiatric presentations by the nursing home residents were leading to some urgent referrals to secondary care and to unilateral discharge from the nursing home. These persons were then admitted to the local psychiatric unit pending placement in a further specialized unit.

Discussions took place concerning the unmet psychiatric needs of the nursing home residents—for example, the lack of implementation of aftercare for patients who had previously been detained (a legal requirement), the absence of an agreed-upon protocol for transferring patients from other services, and the resulting noncompliance with mental health policies. In addition, the relative lack of planning to manage escalations of problematic behavior and the occurrence of potentially destabilizing traumatic and antitherapeutic hospital admissions exemplified the need for such a clinic. These discussions led to a proposal for a community-based clinic, which specified goals, budget, use of resources, and other practical implications for the preexisting local services. Presentations were made to the Social Care Inspectorate by the local psychiatric services on these issues. Several changes were implemented by the private health care provider, including the provision of nursing staff trained in mental health, care assistants, and life-skills coordinators within the nursing home.

A multidisciplinary clinic was also established in response to these difficulties. The clinic was anticipated to affect care in several areas, including admissions to the hospital, appropriate use of health care resources, and management of the progressive deterioration that occurs among patients with Huntington's. The clinic is held on a quarterly basis and comprises a general practitioner, psychiatrist, neurologist, and a regional care advisor (a specialist nurse) from the Huntington's Disease Association, as well as managers and nursing staff from the private nursing home. The progress and management of patients are discussed at the meetings, and detailed quarterly management plans are created. Important components of management include ongoing assessment of the patient's physical and mental health, use of multiple medications, and attempts to balance effective control of movement disorders and psychiatric illnesses for which some of the medications may overlap. Comprehensive summaries of the patients' histories, prepared with psychiatric and general practitioner notes as well as patient interviews, provide supportive documentation to the clinic.

The Huntington's clinic yielded several positive benefits. Local health care resources are used more appropriately and effectively than before, for example. Acute psychiatric disturbances are managed proactively, and hospitalization is rarely required. This has benefited patients who are unable to communicate effectively and who show problematic behaviors in the context of complex concurrent medical pathology. In addition, nursing home staff meet weekly to compile a progress report about the patients, which is faxed to the psychiatric team. The senior psychiatrist advises watchful waiting or a change in treatment. In emergency situations, the psychiatrist arranges prompt domiciliary visits to assess the situation further. This has proved effective in preempting clinical problems. The implementation of the clinic has seen a reduction of admissions, from six admissions of 13 residents from February 2003 to June 2005 to two admissions of 13 residents from June 2005 to October 2007. We believe that the formation of a clinic involving the partnership between a private health care provider and an NHS service has reduced the number of admissions of both nursing home residents and individuals with Huntington's disease living independently. Since the formation of the clinic, patients have not been unilaterally discharged from the nursing home, and all transfers to other units have been by mutual agreement of all relevant professionals involved.

The formation of the Huntington's disease clinic offers a model for other services that need to respond to acute changes in local service needs. The clinic also provides an invaluable training experience. We are looking to expand the clinic by inviting other professionals, including speech and language therapists, dieticians, and physiotherapists. We have collaborated with another Huntington's disease service provider to exchange ideas to further develop the service. The involvement of family members may be particularly useful for patients with diminished capacity. Finally, this model of managing patients who have complex health care needs in a nursing home rather than an inpatient unit can be generalized to other services.

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