BRISC: A Subacute Multidisciplinary Treatment Team to Support Children and Adolescents with ASD in Crisis

The Center for Children with Special Needs
February 10th, 2017
Welcome

• Outline for Today
  o Review of project model
  o Review of child specific clinical services
  o Review of care coordination
  o Executive summary of steps achieved
  o Current reflections
  o Next steps

• Behavior
• Regulation
• Intervention
• Stabilization
• Community
Connecticut Emergency Services

Graphs retrieved from Autism Speaks, www.autismspeak.org
The Current Status

4-9 days
Project Summary

• Intended to divert children or adolescents with ASD from EDs to community based Psychiatric Residential Treatment Facilities (PRTFs)
• Partnership among private and state agencies in the state (PRTF, CCSN, DDS, DSS, and DCF)
• Create sustainable teams within community based organizations (PRTFs, home service organizations) to meet the needs of high-risk children with ASD and their families
• Focus on reducing the likelihood of recidivism
CCSN BRISC Team Members

- Michael D. Powers Psy. D., Director, CCSN
- Mark Palmieri Psy.D. BCBA-D, Assistant Director, CCSN
- Amanda P. Laprime Ph.D., BCBA-D, Program Coordinator
- Marikate Greene M.S., BCBA, Behavior Analyst
- Adrianna Zambrzycka LCSW., BCBA, Care-Coordinator
- Roger Jou, MD, Yale Child Study Center, Psychiatrist
- Kristen M. Powers, M.S., OTR/L, Occupational Therapist
- Stephanie Bendiski, M.S., CCC SLP, BCBA, Speech and Language Pathologist
Model Overview
Service Offered

• Specialized consultative team with expertise in ASD and community supports
• Didactic and on-the-floor staff training in the principles of positive behavior supports and applied behavior analysis (ABA)
  o Function-based assessment and skill programming
• Administrative teaming and collaboration
• Care-coordination for family and community providers

• Family training on-site and in the home
• Educational consultation
• Communication across medical and community providers
• Capacity building for all staff (direct care, clinicians, supervisors)
• Specialized assessment/Consultation:
  o Psychiatric, Speech and language, Occupational Therapy
Meeting the Project Mission

1. Assessing the needs of each PRTF team
2. Working in collaboration with stakeholders, community providers, and the child's family
3. Teaching teams to understand the distinctive ways individuals with ASD think and learn
4. Assessing the issues underlying patients' presenting “tip of the iceberg” crisis behavior
5. Implementing positive/proactive behavior management strategies in the PRTF and community
Program Evaluation Targets

• How do PRTFs rate training and support?
• What is the success of all parties in implementing newly trained strategies?
• Does client behavior improve? To what degree?
• How do this model impact recidivism, maintenance, and generalization?
• How does care coordination impact family quality of life?
• How does care coordination impact general parenting behavior?
• How do caregivers rate individual behavior intervention?
• How does a model like this work for all parties to service the individual needs of children and adolescents with ASD, and their families in the state of Connecticut?
PRTF Capacity Building
Process Map

- Achieving administrative support
- Team learning
- Assessing for barriers
- Capacity building
- Ongoing process of re-assessment and development

**Needs Assessment**
- Define Current State
- Goals
- Motivations

**Planning**
- Define Desired State
- Resources
- Empower change

**Kick Off**
- Training
- Ongoing Support
- Norming

**Sustainability**
- Overcome Barriers
- Move forward
- Build ownership
Preparatory Planning

• Before initiating case support, the BRISC team meets with the administrative team at each site to conduct a systems analysis.

• The systems analysis reviews the following:
  o Training needs for clinical team members and staff
  o Organizational needs (i.e., communication plans, safety response measures, administrative items)
  o Environmental needs for intake (i.e., schedule considerations, location for access to sensory breaks)
  o Barriers to address for intake (i.e., allocating staff resources)
Creating a Shared Vision

• Discuss consultative role of BRISC team
• Cross team information sharing and training (e.g. trauma informed models)
  o Invest time in learning about current systems
  o Discuss worry points
• Problem solve staffing for incoming client
• Establish joint core clinical team within site
• Establish a train-the-trainer model within the PRTF for ongoing support & supervision
• BRISC Teams develop rapport with staff on the floor
  o Spent time with current clientele
  o Join staff meetings and clinical rounds
Team Learning

• Comprised of lectures, case studies, interactive discussions, and practice opportunities

• Content quizzes to evaluate skill acquisition as well as pre and post-tests

• Model of training individualized to each site
  o Site 1: 28 hours across 14 weeks for core staff
  o Site 2: 14 hours across 7 weeks for core staff and school staff
    • Training content updated and consolidated based on feedback and experience from Site 1
Training Topic Areas

- Introduction to Autism Spectrum Disorders
- Principles of Applied Behavior Analysis
- Reinforcement
- Positive Behavioral Strategies
- Operational Definitions of Behavior
- Data Collection
- Functional Assessment of Behavior
- Managing Challenging Behavior

- Differential Reinforcement
- Functional Communication Training
- Antecedent Interventions
- Visual Supports
- Social Skills Instruction
- Ethical Considerations
- Treatment Integrity
Training Outcomes

Site 1 - The Village
• 14 Weeks of Training Completed
• 78% attendees present per training on average
• Make-up days scheduled and successfully completed
• Mean Score= 86% across 14 weeks of training
• Pre-Training Score= 79% average
• Post-Training Score= 88.4% average

Site 2 - The Children’s Center
• 7 Weeks of Training Completed with START Staff and school staff
• Make-up days scheduled
• Mean Score= 83% across 7 weeks of training for START Staff
• Pre-Training Score=72% average
• Post-Training Score= 94% average
On the Floor Teaming

• BRISC Clinician (Board Certified Behavior Analyst) provides on the floor modeling multiple days a week.
• On the floor modeling encompasses skills introduced in lectures up to that point.
• The purpose is for PRTF staff to generalize topics from lectures to real life situations.
• In addition to direct measurement of outcomes, site teams report that training objectives (such as positive behavior supports, solution-oriented problem solving, and being proactive) generalized into conversations within staff meetings and child-staff interactions.
## Feedback and Staff Impressions

<table>
<thead>
<tr>
<th>Category</th>
<th>Site 1</th>
<th>Site 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Training and Intervention</td>
<td>Post Training and Intervention</td>
</tr>
<tr>
<td>Project</td>
<td>3.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Training</td>
<td>3.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Trainers</td>
<td>4.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Acceptability of Behavior Intervention</td>
<td>4.2</td>
<td>4.3</td>
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<tr>
<td>Effectiveness of behavior intervention</td>
<td>4.1</td>
<td>4.3</td>
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</tbody>
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Sustainability: Capacity Building

- Treatment Integrity
- Expanding the trainer of trainers model
- Role designation and overlap
- Identifying needs in the system
  - Collaboration with the PRTF team to discuss system changes that will have universal benefit
- Assessing acceptability of having individualized interventions embedded within the pre-established system
- Working to ensure collaborative model and problem solving
- Addressing barriers to sustaining change
  - Willingness to endure with interventions
- Making changes to both meet the system needs and those of the client
Treatment Integrity Data

- Child 1: Site 1
  o 1st data collection: 65% accuracy on average across 5 staff
  o 2nd data collection: 78% accuracy on average across same 5 staff

- Child 2: Site 1
  o 1st data collection: 63% accuracy on average across 7 staff
  o 2nd data collection: 88% accuracy on average across 3 staff

- Child 3: Site 1
  o 1st data collection: 58% accuracy on average across 3 staff
  o 2nd data collection: In process

- Child 4: Site 2
  o In process
These data continue to guide development and implementation of didactic and real-life booster training across sites.
Administrative and Partnership Reflections

- Administrative staff at Site 1 have commented that without BRISC support they would have either not taken referrals, or would have taken them and struggled significantly.

- Systems implemented through BRISC consultation have expanded to children outside of BRISC consultation (i.e., individualized behavior intervention, reinforcement based procedures, staff interactions).

- Partnership team members have indicated that PRTF teams have reported more comfort when considering intakes who have ASD or other developmental disabilities since training.

- PRTF clinicians have grown in their capacity to implement specific, behaviorally based family training models.
Child Specific Intervention
Children or adolescents with autism spectrum disorder (may have comorbid conditions)

Referred to emergency department for acute crisis

High frequency problem behavior
  - Aggression, property destruction, tantrums, refusal, elopement

May or may not have history of in-home ABA services

Thus far have all had complex family systems requiring intensive care-coordination
Intake Process

- PRTF referral form filled-out and PRTF program director contacted
- PRTF program director and BRISC program coordinator visits child and family in ED to provide in-person assessment
- If child meets criteria, program director invites child and family for tour
- Child intake completed when bed available, per PRTF admission process
- Child intended to be in ED no longer than 48 hours before going to PRTF
- Caregiver agrees to collaboration and participation in training, functional behavior assessment, and community provider communication
Goals of Clinical Treatment

- Complex behavior assessment
  - What are the learning and environmental needs of the individual
- Individualized behavior change strategies
- Skill instruction to teach adaptive skills across caregivers and settings
- Programming for generalization across PRTF, home, and school settings
- Measures of social validity: staff and parents
- Measures of treatment fidelity: staff and parents
Example Functional Analysis

![Graph showing data analysis results](image-url)
BRISC Care Coordination
**Care Coordination Components**

- Participate in treatment development and implementation
- Assure generalization of skills across providers and settings
- Support consistency in proactive supports, skills training, and challenging behavior supports
- Assess the need for additional community services to supplement treatment
- Provide in home parent training
- Train-the-trainer approach for in-home & school providers
- Identify and eliminate barriers to successful discharge
Assessing for Quality of Life Indicators

• **Family Quality of Life Survey**
  o 5-point Likert scale
  o 25 Questions
  o Addresses satisfaction with (1) Family (2) Parenting (3) Emotional well-being (4) Physical or mental well-being (5) Disability related services
  o Utilized to identify areas in need of family support

• **Parenting Behavior Scale-Revised**
  o 5-point Likert scale
  o 20 Questions
  o Addressing general parenting behavior within 2 domains (1) Stimulating the child’s development, and (2) Adapting the child’s environment
  o Intended to identify areas of need for parent training
Family Quality of Life Scales

Intake Scores

- Scale Average
- Family Average
- Parent Average
- Emotional Well Being Average
- Physical or Mental Well Being Average
- Disability Related Service Average

Guardian 1
Guardians 2 & 3

Intake
Pre-Discharge
## Family Assessment

<table>
<thead>
<tr>
<th>Child Specific Items</th>
<th>Family System Items</th>
<th>School &amp; Community Provider Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review intake documents and evaluations</td>
<td>Create list of family needs based on rating scales</td>
<td>Coordinate with BEACON Autism Division regarding in-home family providers</td>
</tr>
<tr>
<td>Assess need for other evaluations (i.e., psychiatric, occupation therapy, speech and language)</td>
<td>Engage family in discharge and intervention planning</td>
<td>Referral made for Intensive Care Coordination (ICC) if needed</td>
</tr>
<tr>
<td></td>
<td>Assess needs for any siblings</td>
<td>Work with peer specialist to collaborate on family system needs</td>
</tr>
<tr>
<td></td>
<td>Work collaboratively to view the entire family system</td>
<td>Participate in PPT and communicate with school district</td>
</tr>
<tr>
<td></td>
<td>Start family therapy</td>
<td>Communicate with any medical or other community based providers</td>
</tr>
<tr>
<td></td>
<td>Make recommendations for post-discharge services</td>
<td></td>
</tr>
<tr>
<td>Child Specific Items</td>
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</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>• Support behavior plan implementation at PRTF</td>
<td>• Establish consistent training schedule within PRTF and at home</td>
<td>• Create service plan with school &amp; in-home providers for training</td>
</tr>
<tr>
<td>• Start training family on individual behavior plan while at PRTF</td>
<td>• Review mastery criteria with family</td>
<td>• Create plan for staff training within PRTF, home, and school</td>
</tr>
<tr>
<td>• Establish data collection systems in home</td>
<td>• Continue to work on family stressors and systemic needs</td>
<td>• Establish models for data collection</td>
</tr>
<tr>
<td>• Assess changes or barriers to in home transfer of systems</td>
<td>• Help family to problem solve changes that need to occur in-home for discharge</td>
<td>• Establish schedule to support home visits</td>
</tr>
<tr>
<td>• Evaluations completed, reviewed by team, and recommendations implemented</td>
<td>• Help prepare for increasing home visits</td>
<td>• Continue communication with school team and plan for training and discharge back to school</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continue communication with medical or community providers around progress and discharge needs</td>
</tr>
</tbody>
</table>
## Discharge Planning

<table>
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<th>Child Specific Items</th>
<th>Family System Items</th>
<th>School &amp; Community Provider Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement contingencies in the home</td>
<td>Support relationship between family and home provider</td>
<td>Transfer oversight of case to in-home BCBA</td>
</tr>
<tr>
<td>Assure current systems appropriate for home and community providers (i.e., school and home)</td>
<td>Problem solve and support continued training needs</td>
<td>Continue to provide problem solving and support to in-home team and BCBA</td>
</tr>
<tr>
<td>Establish emergency protocols</td>
<td>Assess family quality life indicators, satisfaction, and questions</td>
<td>Assure services in place for child post-discharge at appropriate duration</td>
</tr>
<tr>
<td>Assure community services in-place</td>
<td>Assure family has care coordination support post-discharge</td>
<td>Establish data based plan for fading services</td>
</tr>
<tr>
<td></td>
<td>Continue to follow-up on any outstanding items, family system needs, or other needs</td>
<td>Continue to coordinate collaboration among community providers</td>
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<td></td>
<td></td>
<td>Identify and problem solve roles post-discharge</td>
</tr>
</tbody>
</table>
BRISC and Home Team Collaboration

• Work together to look at family needs post discharge and how to modify service levels based on data
  o E.g., Child may need increased amount of BCBA support 1st month home, for training, carryover of work at PRTF, and relationship building
• Identify appropriate family goals and objectives
• Transfer relationship and oversite from BRISC Care Coordinator to In-home and school teams
• Work together to communicate child and family needs to other community providers
Behavior Data - Home Visits

Referral 1: Frequency of Problem Behavior

- Precursor Behavior
- Unsafe Behavior

Referral 1: Adaptive Behaviors at Home
Parent Data-Home Visits

### Positive Statements
- Percentage of Total
- Sessions
- Graph showing decrease in positive statements over sessions for both 'Mom' and 'Dad'.

### Setting Clear Expectations
- Percentage of Total
- Sessions
- Graph showing increase in setting clear expectations over sessions for both 'Mom' and 'Dad'.

### Treatment Integrity
- Percentage of Total
- Sessions
- Graph showing trend in treatment integrity for both 'Mom' and 'Dad'.
Reflections Thus Far
Capacity Building

- Building the skills of PRTF staff, community providers, and families is essential to long term progress
  - This requires ongoing collaboration with transparent and shared effort
- Needs assessment processes must be completed in tandem with all stakeholders in order to build investment and collaboration
- Training resources are required continuously to address ongoing skill development and to respond to staff transitions
- Family planning progresses efficiently when initiated immediately
As the project expands, it is essential that summary and program planning meetings occur that maintain engagement and transparent communication with key stakeholders.

State-level and inter-organization support for overcoming planning and collaboration challenges has been essential.

To effect meaningful growth:
- All stakeholders need to expand our dialogue as the project reaches its mid-point to advocate for sustained change and ongoing opportunities to bring high quality services to individuals with ASD and their families.

Project planning moving onward:
- Proactive meetings with PRTF, state agency, and healthcare providers in order to maintain feedback and support needed program development.
Limitations and Unique Challenges

• It is essential that careful planning be given to engage multidisciplinary planning and integrate different methodologies cohesively
• Emphasizing the importance of individualization of behavior plans while being sensitive to the current PRTF treatment model and resources of the home/community providers
• Staffing constraints and turnover
• Complex client profile
• Discharge delay due to system or unique family circumstances
• Community provider resources for discharge planning, in-home training, and ongoing support needs
Project Enablers

- The Village for Children and Family and Children’s Center of Hamden administrative teams’ collaborative approach and visions for growth
- Working collaboratively within the already established systems of the PRTFs
- Beacon Health communication and collaboration
- Family support, buy-in, and openness to change
  - Family participation in all parts of the intake, assessment, treatment, and discharge process
Barriers

• Access to in-home behavior analytic supervisory supports at the intensity level needed for efficient discharge
  o Secondary impact on individual’s time in the PRTF and on challenging behavior
• Helping families to overcome environmental needs
• Staffing constraints at PRTF and the reasonable capacity of the system to manage more complex cases if staff levels were more consistent with the projected needs
• Staff training to fidelity with positive behavior supports
• Family system needs outside of the BRISC constellation of services
• Intake delays
Next Steps

• Continue to follow timelines for intakes across current PRTFs’
• Expand project to another site in Connecticut
• Transfer certain BRISC team roles to PRTF Staff in effort to expand capacity and build sustainability
• Expand supports available within PRTF communities to support more children
• Expand and train community providers to support more children
• Team with school districts
• Work with ED’s directly to understand project mission and populations served
• Continue to team with community providers
Thank you!

We are very much looking forward to seeing this process move forward and anticipate many positive outcomes for the children, the families, and the treatment facilities

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