IHBT IMPLEMENTATION: CHALLENGES AND OPPORTUNITIES

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CENTER FOR INNOVATIVE PRACTICES
BEGUN CENTER FOR VIOLENCE PREVENTION
2 AGENDA

- Overview of IHBT standards
- Strategies for effective implementation
- Multisystemic Therapy: Evidence-Based Practice
### CENTER FOR INNOVATIVE PRACTICES

**PARTNERSHIPS**

- One of OMHAS’ Coordinating Centers of Excellence
- IHBT Fidelity Reviewer for ODM
- Network Partner for MST
- Developing partnership for dissemination of FFT
- Collaborative partner of SAMHSA’s National Training and Technical Center

**CONTENT EXPERTS**

- Behavioral Health and Juvenile Justice
- Resiliency
- Trauma informed care
- Youth with co-occurring substance use and mental health disorders
- High Fidelity Wraparound
- System of care for youth
- Family engagement
- Emerging adults
- Youth with multiple and complex challenges and their families
RATIONALE FOR IHBT

- Comprehensive treatment modality
- IHBT actively assesses and manages safety issues
- Least restrictive, most normative
- Alternative to custody relinquishment
- Service of access and availability - delivered in the home and community
- Treatment is focused on whole family
- Avoids negative consequences and costs related to placement
- Targets high users of services & resources
IHBT AND BEHAVIORAL HEALTH REDESIGN

- OhioMHAS and ODM have included Intensive Home Based Treatment (IHBT) in the Medicaid Behavioral Health State Plan Services as one of the specialized services.
- Scheduled to begin on July 1, 2017.
- Bh.Medicaid.Ohio.Gov
KEY AIMS

- Ohio Department of Medicaid (ODM) and OMHAS rules promote high quality IHBT service provision.
- Increased adequacy of funding for IHBT
- Increased access and availability of intensive home and community-based treatments statewide
- Treatment delivered per model fidelity not per agency productivity standard
- Practice improvement with a focus on training and supervision
- Emphasis on fidelity and outcomes
ODM RULES FOR IHBT

• New rate for Intensive Home-Based Treatment
• Prior authorization required
• Must have behavioral health license (LSW, LPC, LMFT and above)
• CANS is required to determine service eligibility
• Fidelity review of IHBT team with passing scores required to bill Medicaid
• Service limitations
HISTORY OF HOME-BASED IN OHIO

- Initially rolled out in 1986 via the HOMEBUILDERS model with family therapy component
- Ohio Association for Family-Based Services – 1989
- Multisystemic Therapy – 1995
- ICT developed -- 1999
- CIP CCOE funded to roll out MST- 2000
- IHBT Mental Health rule approved - 2005
- I-FAST @ 2007
- IHBT included in Behavioral Health Redesign
INTENSIVE HOME-BASED TREATMENT

• IHBT is an intensive, time-limited behavioral health treatment for children and adolescents with significant behavioral health challenges and related functional impairments in key life domains.

• IHBT incorporates a comprehensive set of behavioral health services which are delivered in the home, school and community, with the purpose of stabilizing behavioral health and safety concerns, for youth who are at-risk of placement due to his or her behavioral health challenges, being reunified from placement, or require a high intensity of behavioral health interventions to safely remain in the home.
IHBT ELIGIBILITY CRITERIA

• Youth with significant behavioral health impairment that impacts functioning in major life domains
• At risk for out-of-home placement; or
• Returning from out of home placement; or
• Requires a high level of mental health and substance use interventions to stabilize potential safety concerns
• Is under the age of 18; or
• Youth age 18 through 21 who are still living at home and attending high school or under the jurisdiction of another child serving system
<table>
<thead>
<tr>
<th>Intensive Home-Based Service Delivery Model</th>
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<tbody>
<tr>
<td><strong>Location of Service</strong></td>
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</tbody>
</table>
| **Intensity** | Frequency: 2 to 5 sessions per week  
Duration: 4 to 8 hours per week |
| **Crisis response & availability; active safety planning and monitoring** | 24/7 |
| **Active safety planning & monitoring** | Ongoing |
| **Small caseloads** | 4 to 6 families per FTE; 8 to 12 for team of two; no mixed caseloads (e.g. Outpatient and IHBT) |
| **Flexible scheduling** | Convenient to family |
| **Treatment duration** | 3 to 6 months |
| **Systemic engagement and community teaming** | Child and family teaming; skillful advocacy; family partnering; culturally mindful engagement |
| **Active clinical supervision & oversight** | 24/7 availability; field support; individual & group |
| **Program structure and credentials** | Licensed Behavioral Health Professional: MA level preferred. Program size: 2 to 8; .5 to 1 FTE IHBT Supervisor; Individual provider versus teaming approach |
| **Comprehensive service array: integrated and seamless; single point of clinical responsibility** | Crisis stabilization, safety planning, skill building, trauma-focused, family-focused; resiliency & support-building interventions; cognitive interventions |
PROGRAM STRUCTURE AND CREDENTIALS

- 2 to 4 FTE licensed clinical staff LSW, LPC, LMFT, LPCC, LISW, LIMFT, Psychologist
- Core training and quarterly ongoing trainings
- IHBT certified agency
- 24 hour availability of supervisors for each therapist
- Individual provider versus teaming approach
- Independently licensed and experienced supervisor
- Intensive clinical support and field supervision as needed
- Supervisor holds fidelity to the model
- Weekly individual and group supervision/consultation
KEY STRATEGIES THAT SUPPORT IHBT IMPLEMENTATION

• Clear LOS guidelines with procedures for continuing stay
• Flexible schedules
• Rotating coverage for on-call
• Safety policies for workers
• Supervisor dedicated to the program
• Strong supervisor clinical support and team meetings
• Reasonable productivity requirements
• Fidelity and outcome monitoring
• Ongoing training specific to the needs of the team
RISK MANAGEMENT

• IHBT programs require active risk management
• Dedicated supervisor to IHBT team is an insurance policy
• Protected clinical supervision time
• Child and family teaming to share the risk
• Assess for safety and risk with every family
• Active safety planning
• Proactive safety monitoring
• Regular collaboration and communication with system partners
CHARACTERISTICS OF EFFECTIVE IHBT STAFF

- Comfortable in high-risk situations
- Able to think on their feet
- Strong boundaries
- Calm in a crisis
- Comfortable with 24/7 on-call
- Available and accessible to families
- Strength-based and respectful of families
- Strong case conceptualization skills
- Knowledgeable of community resources
- Strong collaborative relationships in the community
- Knowledgeable of youth and family rights
SUPERVISION ISSUES UNIQUE TO HOME AND COMMUNITY-BASED WORK

• Ethical issues are more complex and frequent
• Clinical complexity of family situations
• Management of high risk and safety issues
• Maintaining staff morale and retention
• Staff work independently in unstructured, unpredictable and clinically complex situations
• Training staff with the least experience to do the most complex work
TRAINING AREAS

- Family systems
- Risk assessment and crisis stabilization
- Behavior management for children/adolescents with SED
- Cultural competency
- Intersystem collaboration and coordination
- Trauma-informed care
- Educational and vocational functioning
- Strength-based assessment and treatment planning
- Co-Occurring Disorders
- Behavioral Health and Juvenile Justice
- Ethics in IHBT
- IHBT Supervision
LESSONS LEARNED: IHBT IMPLEMENTATION ISSUES

• Technical assistance is often needed during initial implementation period
• Multiple partners and multiple systems are needed to support implementation
• High level training and ongoing coaching and monitoring of fidelity
• Strong clinical supervision is foundational
• Collect and disseminate outcomes. Stakeholders/funders increasingly relying on data to make financial decisions
IHBT TARGET OUTCOMES

- Reduced symptomatology
- Increased safety and decreased risk
- Reduced/No hospitalizations
- Improved family functioning
- Living at home
- Increased school functioning
- Reduced involvement in the JJ system
- Increased resources and natural supports
FUNDING FOR SUSTAINABILITY

• Medicaid is necessary but not sufficient for implementation and ongoing sustainability.
  • IHBT startup expenses;
  • Coverage of youth who do not qualify for Medicaid benefits;
  • Consultation costs; and
  • Significant program down time due to workforce shortage

• Establish diverse funding sources prior to implementation
• Fund the fidelity (training, consultation, technical assistance)
A Model Program for Treating Adolescents with Significant Behavioral Health Concerns:

Multisystemic Therapy: MST

Maureen Kishna, LISW-S
Center for Innovative Practices (CIP)
Begun Center for Violence Prevention
What is “MST”? 

• Community-based, family-driven treatment for antisocial/delinquent behavior in youth

• Focus is on “Empowering” caregivers (parents) to solve current and future problems

• The MST “client” is the entire ecology of the youth - family, peers, school, and neighborhood
MST Research and Dissemination

Family Services Research Center (FSRC) at the Medical University of South Carolina

Licensed and affiliated organizations:
- MST Network Partner Organizations
- Local MST Provider Organizations
Multisystemic Therapy (MST) Overview

MST Presence Around the World

and

Chile
MST in Ohio

- CIP was created by the state Department of Mental Health in 2000
- A part of a state-wide MH initiative to promote best practices
- Several Centers of Excellences (COE) created
- CIP specifically for MST, initially
- Only COE focused on youth and families
### Standard MST Teams in Ohio

<table>
<thead>
<tr>
<th>Provider</th>
<th>Counties</th>
<th># of Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applewood Center</td>
<td>Cuyahoga and Lorain</td>
<td>1</td>
</tr>
<tr>
<td>Nationwide Children’s Hospital</td>
<td>Franklin</td>
<td>1</td>
</tr>
<tr>
<td>Crisis Center</td>
<td>Stark, Medina, Wayne, Carroll and Holmes</td>
<td>2</td>
</tr>
<tr>
<td>Counseling Center</td>
<td>Columbiana</td>
<td>1</td>
</tr>
<tr>
<td>Buckeye Ranch</td>
<td>Franklin</td>
<td>2</td>
</tr>
<tr>
<td>Zepf Center</td>
<td>Lucas</td>
<td>1</td>
</tr>
<tr>
<td>Cuyahoga County Juvenile Court</td>
<td>Cuyahoga</td>
<td>2</td>
</tr>
<tr>
<td>Dept Child and Family Services-DCFS</td>
<td>Cuyahoga</td>
<td>2</td>
</tr>
<tr>
<td>Homes for Kids</td>
<td>Geauga, Ashtabula, Trumbull and Mahoning</td>
<td>2</td>
</tr>
</tbody>
</table>

| 14 Counties                                   | 14 Teams                                     |            |
MST “Champions” & Advocates
Theoretical Underpinnings

Based on social ecological theory of Uri Bronfenbrenner

- Children and adolescents live in a social ecology of interconnected systems that impact their behaviors in direct and indirect ways.
- These influences act in both directions (they are reciprocal and bi-directional).
Social Ecological Model

- Community
- Provider Agency
- School
- Neighborhood
- Peers
- Extended Family
- Caregiver
- Family Members
  - CHILD
  - Siblings
Causal Models of Delinquency and Drug Use: Common Findings of 50+ Years of Research

Family

School

Delinquent Peers

Prior Delinquent Behavior

Delinquent Behavior

Neighborhood/Community Context
Common findings of 50+ years of research: delinquency and drug use are determined by multiple risk factors:

- Family (low monitoring, high conflict, etc.)
- Peer group (law-breaking peers, etc.)
- School (dropout, low achievement, etc.)
- Community (↓ supports, ↑ transiency, etc.)
- Individual (low verbal and social skills, etc.)
MST Assumptions

- Children’s behavior is strongly influenced by their families, friends, and communities (and vice versa)
- Families and communities are central and essential partners and collaborators in MST treatment
- Caregivers/parents want the best for their children and want them to grow to become productive adults
MST Assumptions (Cont.)

- Families can live successfully without formal, mandated services
- Professional treatment providers should be accountable for achieving outcomes
- Science/research provides valuable guidance
- And...

**Change can occur quickly**
MST Theory of Change

MST

Improved Family Functioning

Peers

School

Community

Reduced Antisocial Behavior and Improved Functioning
How is MST Implemented?

Intervention strategies: MST draws from research-based treatment techniques

• Behavior therapy
• Parent management training
• Cognitive behavior therapy
• Pragmatic family therapies
  - Structural Family Therapy
  - Strategic Family Therapy
• Pharmacological interventions (e.g., for ADHD)
How is MST Implemented? (Cont.)

- Single therapist working intensively with 4 to 6 families at a time
- 3 to 5 months is the typical treatment time (4 months on average across cases)
- Work is done in the community, home, school, and neighborhood: removes barriers to service access
- Team of 2 to 4 therapists plus a supervisor
- 24 hr./ 7 day week team availability: on-call system
How is MST Implemented? (Cont.)

- MST staff deliver all treatment - typically no or few services are brokered/referred outside the MST team
- MST staff must be able to have a “lead” clinical role, ensuring services are individualized to strengths and needs of each youth/family
- Strong focus on engagement and alignment with primary caregiver/s & other key stakeholders (e.g. probation, courts, children and family services, etc.)
- MST has strong track record of client retention and satisfaction
35+ Years of Science

55 Published Outcome, Benchmarking, and Implementation Studies

Including 25 randomized trials and 28 independent evaluations (yielding >100 peer-reviewed journal articles)

- 16 with serious juvenile offenders
  - 7 independent studies

- 11 with adolescents with serious conduct problems
  - 10 independent studies
55 Published Outcome, Benchmarking, and Implementation Studies (cont’d)

- 2 with substance abusing or dependent juvenile offenders (MST-Substance Abuse)
- 3 with juvenile sexual offenders (MST-Problem Sexual Behavior)
- 3 with youths presenting serious emotional disturbance (MST-Psychiatric)
- 3 with maltreating families (MST-Child Abuse and Neglect)
- 6 with adolescents with chronic health care conditions (MST-Health Care) Diabetes, obesity, HIV, asthma
- 13 implementation studies

Complete list of MST outcome studies: www.mstservices.com/files/outcomestudies.pdf
Long-term Outcomes

- 54% Fewer Arrests
- 59% Fewer Violent Arrests
- 57% Fewer Days In Adult Confinement
- 43% Fewer Days On Adult Probation

14 year post treatment
(n= 165, 94% tracking success)
Very Long-Term Outcomes

- 36% Fewer Arrests
- 75% Fewer Violent Arrests
- 33% Fewer Days in Adult Confinement
- 38% Fewer Issues With Family Instability (divorce, paternity, child support suits)
- 3% Fewer Financial Problems (credit, contact, rent, suits)

22 year post treatment
(n= 148, 84% tracking success)
Consistent Outcomes

In Comparison with Control Groups, MST:

- Led to higher consumer satisfaction
- Decreased long-term rates of re-arrest 25% to 70%
- 47% to 64% decreases in long-term rates of days in out-of-home placements
- Improved family relations and functioning
- Increased mainstream school attendance and performance
- Decreased adolescent psychiatric symptoms
- Decreased adolescent substance use

But, none of this happens without adherence to MST
Quality Assurance and Continuous Quality Improvement in MST

Goal of MST Implementation:
• Obtain positive outcomes for MST youth and their families

QA/QI Process:
• Training and ongoing support (orientation training, boosters, weekly expert consultation, and weekly supervision)
• Organizational support for MST programs
• Implementation monitoring (measure adherence and outcomes, and work sample reviews)
• Improve MST implementation as needed, using feedback from training, ongoing support, and measurement
MST Quality Assurance System

Research-based adherence measures:

- **TAM** - youth criminal charges 36% lower for families with maximum adherence score (1) than for families with minimum adherence score (0)
- **SAM** - youth criminal charges 53% lower for families with maximum SAMSP score (1) than for families with minimum SAMSP score (0)
- **CAM** - consultant/MST expert adherence predicts improved therapist adherence and improved youth outcomes
Washington State Institute for Public Policy (2011)
- Evaluating “evidence-based” options to reduce the future need for prison beds, save money, and lower crime rates.
- Estimated net taxpayers benefits for using MST in lieu of placement: $29,302/youth
- Benefits of $4.07 for every $1.00 invested in MST implementation
**Standard MST Referral Criteria (ages 12-17)**

**Inclusionary Criteria**
- Youth at risk for placement due to anti-social or delinquent behaviors, including substance abuse
- Youth involved with the juvenile justice system
- Youth who have committed sexual offenses in conjunction with other anti-social behavior

**Exclusionary Criteria**
- Youth living independently
- Sex offending in the absence of other anti-social behavior
- Youth with moderate to severe autism (difficulties with social communication, social interaction, and repetitive behaviors)
- Actively homicidal, suicidal or psychotic
- Youth whose psychiatric problems are primary reason leading to referral, or have severe and serious psychiatric problems
### MST Ultimate Outcomes

#### 2015 MSTI Data Report

<table>
<thead>
<tr>
<th>Location</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AT HOME</strong></td>
<td>90%</td>
</tr>
<tr>
<td><strong>IN SCHOOL/ WORKING</strong></td>
<td>85.6%</td>
</tr>
<tr>
<td><strong>NO ARRESTS</strong></td>
<td>86.2%</td>
</tr>
</tbody>
</table>

These results are based on a comprehensive review of the 11,958 cases* (85.4% of 13,995 cases referred for treatment) that were closed for clinical reasons (i.e., completed treatment, low engagement, or placed).
How is MST Similar to Other Treatments?

- **Common Characteristics of Family Preservation Services:**
  - Services are provided to the family and individuals
  - Target children at risk of out-of-home placement
  - Time-limited, flexibly-scheduled
  - Tailored to the needs of family members
  - Services are provided in the context of the family’s values, beliefs, and culture.
  - Low caseloads (2-6), 24hr/7day availability

Fraser. 1998
How is MST Different?

- In general, MST differs from other treatments for antisocial behavior in these areas:
  - Research: Proven long-term effectiveness through rigorous scientific evaluations
  - Treatment theory: A clearly defined and empirically grounded treatment theory
  - Implementation: A focus on provider accountability and adherence to the model
  - Focus on long-term outcomes: Empowerment of caregivers to manage future difficulties
Questions?

Thank you for your time and attention!

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MST Expert and Program Developer

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FOR MORE INFORMATION ON IHBT

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