# Program and Practice Standards for Intensive In-Home Behavioral Health Treatment (IIBHT)

National Association of State Mental Health Program Directors (NASMHPD)

Children, Youth, and Families Division

October 15, 2019

SAMHSA
Substance Abuse and Mental Health Services Administration

1

This webinar is hosted *by the National TA Network for Children's Behavioral Health, operated by and coordinated through the University of Maryland.*

*This presentation was prepared with partial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS280201500007C with SAMHSA, U.S. Department of Health and Human Services (HHS). The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.*

2

SAMHSA
Substance Abuse and Mental Health Services Administration

2

# Acknowledgements

Special Thanks to the Original Informants:
Lucy Berliner, University of Washington
Leslie Schwalbe, Optum Health
Kelly English, Mass DMH Children's Health Knwl. Center
Christopher Bellonci, Harvard University
Liz Manley, University of Maryland
Dan Edwards, Evidence-Based Associates
Tim Marshall, CT Depart. of Children and Families
Jack Simons, Mass Behavioral Health Partnership
Joe Woolston, Yale University
Bob Franks, Harvard University
Keller Strother, MST Services
Zoe Barnard , Montana DMH
Jim Spink, Beacon Health Options
Bruce Kamradt, Wraparound Milwaukee

Expert Task-Force:
Kelly English
Susan Maciolek
Richard Shepler
Eric Bruns
Philip Benjamin
Joe Woolston



SAMHSA
Substance Abuse and Mental Health Services Administration



# Presenters

**Philip H. Benjamin, M.A, Marianne Kellogg, B.A. & Eric J. Bruns, Ph.D.**
Department of Psychiatry, University of Washington

**Richard Shepler, Ph.D.**
Case Western Reserve University



SAMHSA
Substance Abuse and Mental Health Services Administration

## Intensive In-Home Behavioral Health Treatment (IIBHT)

- IIBHT services occupy a critical place in the children's behavioral health continuum of care.
- They exist in some form in most states.
- The IIBHT workforce consists mainly of entry level, Master's level clinicians who are asked to serve the most complex and highest risk youth and families.



SAMHSA
Substance Abuse and Mental Health Services Administration



## Intensive In-Home Behavioral Health Treatment (IIBHT)

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Intensive home-based programs for youth with serious emotional disturbances: A comprehensive review of experimental findings

Samantha Moffett[a,b,*], Line Brotnow[a,c], Anisha Patel[d], Jean Adnopoz[a], Joseph Woolston[a]

[a] Yale University School of Medicine, United States
[b] University of Delaware, United States
[c] Akershus University Hospital, Oslo, Norway
[d] Long Island University-Post, United States

ARTICLE INFO

*Keywords:*
Intensive home-based treatment
Multi-systemic
Community-based treatment
Serious emotional disturbance (SED)

ABSTRACT

Intensive home-based programs for youth with serious emotional disturbances operate in nearly every state and occupy a critical position in the continuum of care: the threshold between community retention and institutional placement. Despite their ubiquity and in contrast to research on home-based interventions for other populations, there is a relative dearth of empirical findings describing the efficacy of such interventions with youth with serious emotional disturbances and their families. The present paper offers a comprehensive review of experimental and quasi-experimental studies in this field. Taken together, the results of these studies suggest that intensive home-based interventions can effectively improve children's emotional and behavioral impairment, particularly from caregivers' perspectives. Involving state partners in large-scale, multi-outcome studies may further elucidate mechanisms of change and establish benchmarks that allow for more conclusive comparisons between treatment alternatives.



SAMHSA
Substance Abuse and Mental Health Services Administration

## Why Focus on IIBHT?

- Substantial state-level variation in IBHT definition, operationalization, and presence of implementation and practice standards
- Evidence-based practices (EBPs) such as Multisystemic Therapy (MST) require adherence and outcome data, but do not represent the majority of IBHT services provided.
- "IBHT generally lacks the data generation, data collection, data analysis and data feedback capability that would allow for basic quality assurance and improvement"
  (Moffett et al., 2016, p. 3).



SAMHSA
Substance Abuse and Mental Health Services Administration



## Overall Goal for the Project

Review, compile, and synthesize existing literature and information in order to define evidence-based standards for Intensive In-Home Behavioral Health Treatment (IIBHT) at the practitioner, organizational, and system levels:

- *Produce materials* (e.g., informational briefs, quality frameworks, recommended standards and indicators) to guide the field
- *Inform future quality improvement efforts* (e.g., learning or quality collaboratives, state/MCO contracting, workforce development models, national interest or trade groups)
- *Support future research* on IIBHT implementation and outcomes



SAMHSA
Substance Abuse and Mental Health Services Administration

## The Project: Phases of Effort

**Literature Review**

**Expert Interviews (N=16)**

**Initial standards developed (49 practice, 30 program)**

**IIBHT Decision Delphi Learning Community (LC) – Ratings of:**

- Importance to include
- Language / wording



SAMHSA
Substance Abuse and Mental Health Services Administration



## Literature Review

- Relevant manualized EBPs and promising practices (13 models)
- Peer reviewed literature (24 articles and 18 book chapters/monographs/manuals)
- Program (n=14) and Practice (n=27) elements from:
  - Lee et al. (2014) literature review on prevention of out-of-home placement
  - 2 IHBT models (OH IHBT; and Connecticut IICAPS)
- Materials from 35 states (AL, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IL, IN, LA, ME, MA, MD, MI, MO, MN, MS, MT, NE, NC, NM, NJ, NY, OH, PA, RI, SC, TN, TX, VA, WA, WI, more now being solicited)



SAMHSA
Substance Abuse and Mental Health Services Administration

# Relevant Manualized IBHT Models

| | |
|---|---|
| MST | Multisystemic Therapy and MST Adaptations |
| HOMEBUILDERS-IFPS | HOMEBUILDERS- Intensive Family Preservation Services |
| IICAPS | Intensive In-Home Child & Adolescent Psychiatric Services (CT) |
| ESFT | Eco-structural Family Therapy (PA) |
| FCT | Family Centered Treatment |
| ICT | Integrated Co-Occurring Treatment |
| IHBT | Intensive Home Based Treatment (OH) |



SAMHSA Substance Abuse and Mental Health Services Administration

11

# Manualized Family Therapies: Delivered in Multiple Settings or Modalities with Varying Intensity

| | |
|---|---|
| MDFT | Multidimensional Family Therapy |
| I-FAST | Integrative Family and Systems Treatment |
| SFBT | Solution-Focused Brief Therapy |
| FFT | Functional Family Therapy |
| TST | Trauma Systems Therapy |
| BSFT | Brief Strategic Family Therapy |



SAMHSA Substance Abuse and Mental Health Services Administration

12

## Main Practice Focus Areas (from Literature and Model Review)

1. Culturally mindful partnerships (youth and family)
2. Youth and family supports
3. Crisis stabilization and safety planning
4. Skill building (youth, parent, family)
5. Cognitive and trauma-focused interventions
6. Systemic and relational interventions (family and ecological)
7. Resiliency promotion
8. Cross-system collaboration and coordination



SAMHSA
Substance Abuse and Mental Health Services Administration



## Main Practice Focus Areas, Cont.

- **Caregiver-Focused**
  - Natural consequences
  - Praise
  - Response cost
  - Rewards
  - Support network
  - Goal setting
  - Problem solving
  - Supervision and monitoring
  - Safety planning
- **Youth-Focused**
  - **Skill Building**: Anger management; emotional regulation; problem solving; communication, conflict resolution, social and relational skills, etc.
  - Crisis management
  - Exposure
  - Functional analysis
  - Cognitive interventions: (CBT; DBT; TF-CBT, etc.)
  - Rapport
  - Youth support
  - Goal setting
  - Pro-social peers and activities



SAMHSA
Substance Abuse and Mental Health Services Administration

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Program Elements

| Category | Definitional Criteria |
|---|---|
| **Location of Service Delivery** | Average % of time service delivered in the: 1) home; 2) school; 3) community; 4) office |
| **Intensity** | Frequency: sessions per week<br>Duration: hours per session |
| **Crisis response & availability** | On-call availability: 24/7; 24/5; agency business hours; Type of response: phone vs. on-site; Who provides the response: IBHT team vs on-call system (Agency; community) |
| **Safety planning & monitoring** | Requirements for safety planning; |
| **Caseload Size** | Caseload size limits per FTE/team |
| **Flexibility of scheduling** | Appointment times that are convenient to family: including evenings and weekends |
| **Treatment duration** | Length of stay criteria; time-limits; treatment brevity |
| **Staffing and Provider Credentials** | Individual vs Team model<br>Level of credentials required to provide service: Paraprofessionals, Peer Support; BA QMHP; MA Licensed Behavioral Health Professional |
| **Supervisory support** | Intensity and availability: 24/7 availability; field support; weekly team meetings; hours of supervision per week |

15

15

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Program Elements

| Category | N states w/req'mt | Preliminary Results |
|---|---|---|
| **Location of Service Delivery** | **24 State Rules**<br>**11 MST EBP** | 24/35 states require services delivered in the home, school; and community; range >60 to >90%.<br>(MST provided in 11 states without supporting state rule evidence.) |
| **Intensity** | **15 State Rules**<br>**9 MST EBP** | Range: 2 to 5 sessions; 2 to 20 hours per week<br>Average: 3 sessions per week; 4 to 6 hours per week.<br>(MST provided in 9 states without supporting state rule evidence.) |
| **Crisis response & availability** | **17 States**<br>**12 MST** | 24/7 on-call availability required for 17 states. Three others require the provider to have a plan unique to each youth/family served. |
| **Safety planning & monitoring** | **10 states** | While included in most models, only required in 1/3 of the state rules |
| **Caseload Size** | **14 States**<br>**11 MST** | 2 to 15 for one person teams (average 4 to 6):<br>8 to 12 for two person teams; 16 for three person team. |
| **Flexibility of scheduling** | **12 States** | Appointment times that are convenient to family: including evenings and weekends are part of most models, but referenced in minority of states |
| **Treatment duration** | **13 States**<br>**12 MST** | 13 states have specified time duration.<br>Typical Range: 3 months to 7 months; Several states have no time limit. |
| **Staffing and Provider Credentials** | **21 States**<br>**12 MST** | Individual vs Team model; Wide range of credentials: Paraprofessionals, Peer Support; BA QMHP; MA Licensed Behavioral Health Professional. |
| **Supervisory support** | **17 States** | Intensity and availability: 24/7 availability; weekly team meetings<br>Wide range of hours of supervision per week |

16

16

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Practice Principles and Elements

| Category | Definitional Criteria |
|---|---|
| **Comprehensive service array:** | Services included in model:<br>• Crisis stabilization,<br>• Safety planning,<br>• Resiliency & support-building interventions,<br>• Family/system therapy<br>• Behavior management/parenting<br>• Cognitive interventions: (CBT/DBT)<br>• Skill building: (problem solving, emotional regulation, etc.)<br>• Cross-system teaming<br>• Substance use treatment; integrated treatment<br>• Trauma-focused interventions:<br>• Social services for basic needs |
| **Systemic engagement and community teaming** | Child and family teaming; Wraparound; care coordination<br>System level advocacy; |
| **Evidence-based practice (EBP) or integration of EBP into the IBHT model** | Use of EBP (s);<br>level of evidence of the program |
| **Family partnerships** | Youth and family engagement and culturally mindful partnerships<br>Person-centered planning |

17

17

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Practice Principles and Elements

| Category | N states w/req'mt | Preliminary Results |
|---|---|---|
| **Service array** | **24** **(+11 more follow expectations as per 1 or more specific EBPs*)** | Most states/programs required a comprehensive set of behavioral health services including many of the following:<br>• Individual and Family Therapy<br>• Crisis stabilization and safety planning,<br>• Resource & support-building interventions,<br>• Behavior management/parenting<br>• Skill building: (problem solving, emotional regulation, etc.)<br>• Trauma-focused interventions:<br>• Social services for basic needs<br>• Cross-system coordination<br><br>Some programs/states address substance use treatment provision (MST; FFT; MDFT; ICT; NC; ME; DC; OH) |
| **Systemic engagement and community teaming** | **10** | Cross-system collaboration and coordination included in most models;<br>Care coordination and/or Child and Family Teaming specifically referenced in 29% of the state rules |
| **Evidence-based practice (EBP)/Evidence-Informed or integration of EBP into the IBHT model** | **34** | 31 states utilize MST<br>Other EBP and Promising Practices also utilized: FFT; ICT; MDFT; DBT; MI; Homebuilders; IICAPS: Family Centered Treatment; I-FAST<br>EBP's and promising practices have manualized treatment protocols; |
| **Family partnerships** | **10** | Youth and family engagement and culturally mindful partnerships in most models; referenced in 29% of state rules |

18

18

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Quality and Outcomes

| Category | Definitional Criteria |
|---|---|
| **Training Requirements** | Core training requirement:<br>Booster trainings required/offered:<br>Length of trainings: (i.e. 3 day; 5 day core training)<br>Trainings offered:<br>• Family/system therapy<br>• Crisis Intervention and safety planning<br>• Behavior management/parenting<br>• IBHT Ethics<br>• IBHT Supervision<br>• Cognitive interventions: (CBT/DBT)<br>• Skill building: (problem solving, emotional regulation, etc.)<br>• Resiliency promotion<br>• System of care principles<br>• Cultural Competency<br>• Cross-system partnerships<br>• Youth and family engagement and partnerships<br>• Youth with co-occurring disorders (SU; DD; Health)<br>• Trauma-focused interventions: |
| **Fidelity** | Fidelity tool developed<br>Frequency of fidelity/adherence reviews<br>Independent review |

19

19

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Quality and Outcomes

| Category | N states w/req'mt | Preliminary Results |
|---|---|---|
| **Training Requirements** | **12 state rules**; All EBP's require training | • Some states require the provider to have certification and training in an EBP.<br>• Others require training/competencies in a combination of the following:<br>Family/system therapy<br>Crisis Intervention and safety planning<br>Behavior management/parenting<br>IBHT Ethics<br>IBHT Supervision<br>EBPS': e.g., (CBT;DBT; MI; etc.)<br>Skill building: (problem solving, emotional regulation, etc.)<br>Resiliency promotion<br>System of care principles<br>Cultural Competency<br>Child and Family Teaming<br>Youth and family engagement and partnerships<br>Youth with co-occurring disorders (SU; DD; Health)<br>Trauma-focused interventions |
| **Fidelity** | | All EBP's require fidelity or adherence reviews<br>Minority of states with "home grown" IBHT (e.g., CT, DC, GA, MT, PA, OH) require fidelity reviews to their state models |

20

20

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Quality and Outcomes

| Outcomes | |
|---|---|
| **Outcome Tools (vary by state)** | CANS; CAFAS; CBCL, Ohio Scales; trauma scales |
| **Outcomes measured (vary by state and by EBP)** | • Psychiatric Hospitalizations/ED visits: # of admissions, # of days<br>• School functioning; Truancy: Expulsions, Attendance, Passing<br>• Juvenile justice involvement: new misdemeanor, felony, PV<br>• Child welfare involvement: DV; abuse and neglect<br>• Successful treatment completion<br>• Decreased symptomatology<br>• Youth and family statement and rating of the problem<br>• Increase in social supports<br>• Decrease in frequency and intensity of crises<br>• Improved family functioning<br>• Satisfaction with services<br>• Placement prevention; successful reunification<br>• Employment<br>• Decreased substance use<br>• Decreased risk<br>• Increased safety |
| Measurement timeframe: Pre-post; every 3 months; post discharge | • Pre-and-post-treatment administration and scoring of standardized assessment tools<br>• Quarterly to Yearly evaluation of adherence to model<br>• One state requires one year post treatment placement data; school functioning, juvenile justice and child welfare involvement, and need for involvement with IBHT service. |

21

21

## State Scan of Intensive In-Home Behavioral Treatment
## Coding Categories: Funding and State Standards

| Category | Preliminary Results |
|---|---|
| **State Rules and Standards** | Rule or standard in statute: **30 states** have an identifiable standard or rule on Intensive In Home Treatment or MST |
| **Funding mechanisms** | • Medicaid 1915i; 1915C; Rehabilitation Option;<br>• State funding:<br>• Grants:<br>• Federal funding<br>• Regional and County Boards<br>• Private insurance<br>• Child Welfare<br>• Juvenile Justice: Example- Ohio's RECLAIM and BHJJ initiatives |
| **Coverage** | • HCPC: H2033 (MST); H2015; H2022; H2019; H0036; S5145 HE; H0040; H0039; H0004; H2014; Psychotherapy; Family therapy |
| **Reimbursement rates and methodology** | • Hourly and Day rates<br>• Range: $64 per hour to $207.84 (psychotherapy/MST/IHBT); Mean hourly rate: $127.90<br>• Non-licensed staff rates range: $40 to $88 with average $66.04 |
| **Typical Service Limitations** | • Individual Counseling; Group Counseling; and Family Counseling<br>• Day Treatment; Group Therapy<br>• Certified Peer Services<br>• Psychiatric inpatient or residential treatment<br>• Psychosocial rehabilitation; Therapeutic Behavioral Service |
| **Prior Authorization** | Most states require prior authorization with hourly limits and time frames |

22

22

Translating the Literature into Guidance

## Initial Standards and Review by Learning Community



SAMHSA
Substance Abuse and Mental Health Services Administration



## Example From Program Standards

**Intensive In-Home Behavioral Health Treatment (IIIBHT)**
**Program Standards**

| Clinical Program Categories | Description |
|---|---|
| ***To achieve the most positive outcomes possible for youth with serious emotional and behavioral needs and their families, an effective IIBHT Program must:*** | |
| **1) Competent staff** | **1.1** *Role clarity:* Regardless of composition of teams (i.e., solo practitioners; two or three-person teams), there are clear roles and responsibilities for the IIBHT practitioners, including detailed job descriptions for each role [e.g., therapists, other qualified mental health professionals (QMHPs), peer support workers, supervisors].<br>**1.2** *Practitioner credentials:* All members of IIBHT teams (i.e., therapists, QMHPs, peer support workers, supervisors) have a clear set of credentials (i.e., relevant degree and training) appropriate to their role. Moreover, regardless of composition of teams (i.e., solo practitioners; two or three-person teams), IIBHT teams as a whole have credentials that allow them to provide the complete array of services included in IIBHT (i.e., if the program utilizes a single practitioner model, staff need to have the necessary credentials to provide the full continuum of IIBHT services).<br>**1.3** *Qualified personnel:* Practitioners have prior experience and training working with youth with intensive needs and their families, demonstrate the ability to engage and build relationships with youth and families, and demonstrate skills appropriate to their role (e.g., therapists, QMHPs, peer support workers, supervisors).<br>**1.4** *Stable workforce:* Turnover among staff is maintained at a level that does not detrimentally affect the performance of the IIBHT program (e.g., below 25% per year) and average tenure of practitioners is at a level that ensures effective provision of IIBHT by the program or organization (e.g., greater than two years).<br>**1.5** *Rigorous hiring processes:* The IIBHT provider organization has written interviewing and hiring protocols for each of the relevant positions. Interview and selection protocols are rigorous, and include, for example, behavioral questions, direct observation of skills, and/or written exercises (e.g., progress notes, treatment plan).<br>**1.6** *Effective training:* IIBHT staff and supervisors are required to participate in initial and booster trainings relevant to their roles and responsibilities. There are written training protocols that include behavioral rehearsal and direct observation of skills-based practice as well as knowledge tests. |



Philip H. Benjamin & Eric J. Bruns, Wraparound Evaluation and Research Team, University of Washington | pbenja87@uw.edu | ebruns@uw.edu

SAMHSA
Substance Abuse and Mental Health Services Administration

# Example From Practice Standards

**Intensive In-Home Behavioral Health Treatment (IIBHT)**
**Practice Standards**

| Clinical Practice Categories | Description |
|---|---|
| **Engagement**<br>***To achieve the most positive outcomes possible for youth and families, an effective IIBHT Practitioner (or team) must:*** | |
| **1) Engagement** | **1.1** Describes the process of IIBHT treatment for youth and families, detailing roles, boundaries, and limitations, particularly as they differ from other treatment settings and modalities.<br>**1.2** Explains confidentiality (and limitations of confidentiality) specific to the IIBHT model, including how and why information may be shared with individuals within the team and outside the team (e.g., for supervision).<br>**1.3** Engages the youth/family utilizing evidence-based techniques. These include:<br>A. Promotes youth/family voice and choice in decision-making.<br>B. Identifies potential future barriers to attending treatment and actively brainstorms solutions.<br>C. Reframes or clarifies youth/family perspectives in a way that avoids criticism or judgement.<br>D. Utilizes strengths-based language.<br>**1.4** Implements motivational interviewing strategies based on the youth and family's change readiness. |
| **2) Cultural competence** | **2.1** Actively seeks to understand and demonstrate respect for the unique and diverse roles, values, beliefs, race, ethnicity, culture and gender of the youth, family, and their community.<br>**2.2** Avoids using expert or medically-based jargon |
| **Risk Identification, Safety Planning, & Crises Response**<br>***To achieve the most positive outcomes possible for youth and families, an effective IIBHT Practitioner (or team) must:*** | |
| **3) Risk identification** | **3.1** Identifies risk and safety concerns and situations across life domains that may lead to dangerous or potentially harmful consequences. |
| **4) Safety planning** | **4.1** Completes a safety plan, when clinically indicated, that includes identification of safety concerns, potential crises, triggers, actionable stabilization steps, means reduction steps, de-escalation and coping strategies, and family identified supports.<br>**4.2** Regularly monitors and updates safety plan as needed. |
| **5) Crisis response and stabilization** | **5.1** Serves as the lead crisis responder, responds to calls immediately, and is available for on-site stabilization as necessary.<br>**5.2** Uses crisis de-escalation skills and demonstrates ability to effectively stabilize crisis situations. |

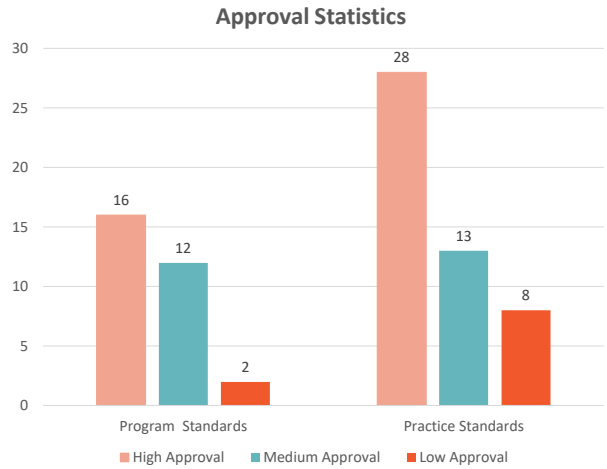
Philip H. Benjamin & Eric J. Bruns, Wraparound Evaluation and Research Team, University of Washington | pbenja87@uw.edu | ebruns@uw.edu



SAMHSA Substance Abuse and Mental Health Services Administration



# Results Summary From LC Round 1




157 people invited to participate:

- 58 people fully completed program standards (39% response rate)
- 74 people fully completed practice standards (48% response rate)



SAMHSA Substance Abuse and Mental Health Services Administration

# LC Results Round 1 Program Standards: High Approval

15. Commitment to flexibility and accessibility: IIBHT sessions are delivered at times and in places that are flexible, accessible, and convenient to the ~~family~~ youth and caregivers, including evening and weekend appointment times, and sessions at the location of the youth~~'s/family's~~ and caregivers' choice.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments |
|---|---|---|---|---|
| 0.100<br><br>Inadvisable: 0%<br>Optional: 0%<br>Essential: 100% | 0.91<br><br>Unacceptable: 0%<br>Minor Revisions: 9%<br>Acceptable: 91% | None | | |

Revised Standard:
15. Commitment to flexibility and accessibility: IIBHT sessions are delivered at times and in places that are flexible, accessible, and convenient to the youth and caregivers, including evening and weekend appointment times, and sessions at the location of the youth and caregivers' choice.



SAMHSA Substance Abuse and Mental Health Services Administration



# LC Results Round 1 Program Standards: Medium Approval

25. Review of ~~care~~ treatment plans: Each youth ~~/family's~~ and caregiver's initial treatment plan ~~of care~~ is reviewed by an expert (i.e., supervisor or EBP consultant) in the IIBHT practice model ~~(ideally external to the supervisor or coach)~~. Updated plans of care should also be regularly reviewed ~~no less than bi-monthly~~.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments |
|---|---|---|---|---|
| 0.78<br><br>Inadvisable: 0%<br>Optional: 22%<br>Essential: 78% | 0.51<br><br>Unacceptable: 13%<br>Minor Revisions: 24%<br>Acceptable: 64% | Impractical: (7 comments)<br>-Undue burden<br>-May not have access to someone who can do this and may not be funds available | Supervisor should fill this role: (6 comments)<br>-They are the ones that review plans already | Define bi-monthly: (4 comments)<br>-Twice a month or every two months? |

Revised standard:
**25. Review of care plans: Each youth and caregiver's initial plan of care is reviewed by an expert in the IIBHT practice model. Updated plans of care should also be regularly reviewed.**



SAMHSA Substance Abuse and Mental Health Services Administration

# LC Results Round 1 Program Standards: Low Approval

4. Stable workforce: The organization or team will make every effort to ensure that turnover among staff is maintained at a level that does not detrimentally affect the performance of the IIBHT program (ideally, <25%) ~~and average tenure of practitioners is at a level that ensures effective provision of IIBHT by the program or organization (e.g., greater than two years)~~.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments |
|---|---|---|---|---|
| 0.57<br><br>Inadvisable: 3%<br>Optional: 36%<br>Essential: 60% | 0.55<br><br>Unacceptable: 9%<br>Minor Revisions: 27%<br>Acceptable: 64% | Not practical or enforceable due to high turnover rates<br>(12 comments) | Turnover rates are not under the program's control<br>(6 comments) | Remove timeframe:<br>(3 comments) |

Revised standard:
**4. Stable workforce: The organization or team will make every effort to ensure that turnover among staff is maintained at a level that does not detrimentally affect the performance of the IIBHT program (ideally, <25%).**

29

SAMHSA Substance Abuse and Mental Health Services Administration

29

# LC Results Round 1 Practice Standards: High Approval

2. Explains confidentiality (and its limitations ~~of confidentiality~~) specific to the IIBHT model, including how and why information may be shared with individuals within the team (e.g. caregivers) and outside the team (e.g., for supervision).

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments |
|---|---|---|---|---|
| 0.99<br><br>Inadvisable: 0%<br>Optional: 1%<br>Essential: 99% | 0.88<br><br>Unacceptable: 0%<br>Minor Revisions: 12%<br>Acceptable: 88% | Mention confidentiality with respect to youth and caregivers<br>(2 comments) | | |

Revised standard:
**2. Explains confidentiality (and its limitations) specific to the IIBHT model, including how and why information may be shared with individuals within the team (e.g., caregivers) and outside the team (e.g., for supervision).**

30

SAMHSA Substance Abuse and Mental Health Services Administration

30

# LC Results Round 1 Practice Standards: Medium Approval

8. Works with the youth and caregivers to complete~~s~~ an individualized safety plan (if not completed by another provider, such as a care coordinator). ~~, when clinically indicated, that~~ Safety plans should include~~s~~ the identification of safety concerns, potential crises, triggers, ~~actionable stabilization steps, means reduction steps~~, de-escalation and coping strategies, actionable stabilization steps, prevention measures, and ~~family~~ youth- and caregiver-identified supports.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments |
|---|---|---|---|---|
| 0.96<br><br>Inadvisable: 0%<br>Optional: 4%<br>Essential: 96% | 0.50<br><br>Unacceptable: 1%<br>Minor Revisions: 47%<br>Acceptable: 52% | Safety plans should not be optional (9 comments)<br>-Remove "when clinically indicated" | Family empowerment: (5 comments)<br>-Families should be involved in this process | Jargon: Means-reduction steps? (2 comments) |

Revised standard:

**8. Works with the youth and caregivers to complete an individualized safety plan (if not completed by another provider, such as a care coordinator). Safety plans should include the identification of safety concerns, potential crises, triggers, de-escalation and coping strategies, actionable stabilization steps, prevention measures, and youth- and caregiver-identified supports.**

31

SAMHSA Substance Abuse and Mental Health Services Administration

31

# LC Results Round 1 Practice Standards: Low Approval

6. ~~Avoids using expert or medically-based jargon.~~ Uses language that is accessible to the youth and caregivers and, where necessary, translates clinical terminology (e.g., diagnoses and acronyms) used by professionals into content that is understandable.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments |
|---|---|---|---|---|
| 0.55<br><br>Inadvisable: 8%<br>Optional: 28%<br>Essential: 64% | 0.53<br><br>Unacceptable: 10%<br>Minor Revisions: 28%<br>Acceptable: 62% | Sometimes, medical jargon is necessary (10 Comments)<br>-Does not need to be avoided as long as explained. | Give examples of what you mean by jargon (3 comments) | |

Revised standard:

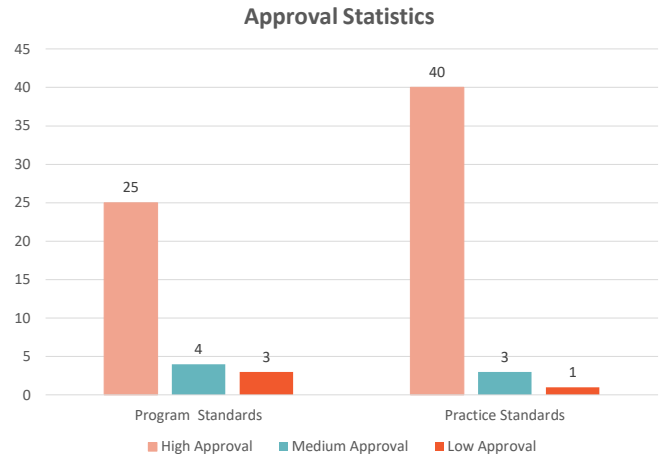
**6. Uses language that is accessible to the youth and caregivers and, where necessary, translates clinical terminology (e.g., diagnoses and acronyms) used by professionals into content that is understandable.**

32

SAMHSA Substance Abuse and Mental Health Services Administration

32

## Results Summary From LC Round 2




74 people (all round 1):

- 38 people fully completed program standards (51% response rate).
- 38 people fully completed practice standards (51% response rate).

33

SAMHSA Substance Abuse and Mental Health Services Administration

33

## Utilization of Standards

We hope that the IIBHT standards will be utilized by:

- States, jurisdictions, and managed care entities
  - to inform contracting, financing strategies, investments in workforce development, and accountability efforts
- Provider organizations
  - to inform training, coaching, supervision, and continuous quality improvement (including fidelity) efforts
- Practitioners
  - to inform their work with youth and families, enhance practice, and aid in matching protocols and practices appropriately to youth and families' needs and populations that may benefit from receipt of IIBHT

34

SAMHSA Substance Abuse and Mental Health Services Administration

34

## Next Steps for the Project

- Translate the "practice standards" into **"clinical guidelines"**
- Develop and validate **measures** for assessing IIBHT quality/ standards adherence
- Convene a **state learning community** interested in using the standards to support their IIBHT agenda
- Convene and run a **quality collaborative** of states and/or IIBHT provider organizations that use the measures of IIBHT quality/adherence as the basis for quality improvement
- Submit a federal (NIMH? AHRQ?) grant to evaluate impact of using a state/local QC with these standards/clinical guidelines to improve quality and outcomes



SAMHSA Substance Abuse and Mental Health Services Administration



## Questions for State Children's MH Directors!

- What states currently have (or might have in the near future) an agenda for IIBHT specification, implementation support, or quality improvement in the next 1-2 years?
- What does/will your IIBHT agenda consist of?
- Would materials such as this be supportive to your agenda? How?
- **Would your state be interested in joining (immediately) a state IIBHT learning community**
- **Might your state join a quality collaborative (6-12 months) that emphasizes measurement of standards/guideline adherence?**
  - **How about a randomized study?**
- **What else can we do with these materials to help improve quality and outcomes?**



SAMHSA Substance Abuse and Mental Health Services Administration

# THANK YOU!

Contact us:
Philip H. Benjamin: pbenja87@uw.edu
Eric J. Bruns: ebruns@uw.edu
Marianne Kellogg: mkello@uw.edu
Rick Shepler: Richard.shepler@case.edu



SAMHSA
Substance Abuse and Mental Health Services Administration

37