Indiana Statewide Implementation of Multisystemic Therapy Frequently Asked Questions

Financial Questions

Which costs are Indiana FSSA-DMHA covering as part of the statewide implementation?

Indiana FSSA-DMHA is paying for MST program development and start-up services for the first 2 years. This encompasses a needs assessment session to discuss the need for MST and the feasibility of building a sustainable program; critical issues review sessions to discuss the key elements of a successful MST program; on-site readiness review meeting to provide an overview of MST to the community, and to meet with key stakeholders to refine the final implementation plan; staff recruitment assistance; a blended orientation training for each new program for up to 5 staff per team, which involves online modules to be completed within 30 days and 2 days of training in person; weekly MST phone consultation for MST clinical team (one hour per week for up to 45 weeks per year); up to 4 booster trainings per year; and all required training materials and manuals.

FSSA-DMHA funds are also available to support organizations in covering costs related to administrative time spent participating in the MST program development process, administrative time providing supervision towards licensure for unlicensed therapists, hiring and recruitment support services, hiring and retention bonuses for MST team members, cell phone plans for MST team members, and flex funds to support families participating in MST.

Will providers be responsible for support after the second year?

After the second year, the annual program support and training services will be the responsibility of the provider agency in addition to training for replacement staff.

Which funding streams are available for this model?

MST services can be funded through Medicaid reimbursement using therapy CPT codes and funding via Indiana Department of Child Services (DCS) can be utilized for cases that meet eligibility requirements. Specifically, providers can receive per-diem based reimbursement for providing MST to youth who are eligible for Family Preservation Services. MST Services will work with provider agencies to work through funding and referral models to ensure sustainability.

MST Clinician and Team Questions

What is an MST team?

An MST team is comprised of 1 doctoral or masters-level supervisor, at least half-time, and 2-4 full-time masters-level therapists. Bachelors-level therapists may be included on a case-by-case basis, to be determined by *MST Services* staff as well as funding stream requirements.

In Indiana, do the therapists and supervisors have to be licensed in order to provide MST?

It depends on the funding stream/plan for reimbursement. For example, if an agency plans to fund an MST team through per-diem reimbursement for providing MST to youth who are eligible for Family Preservation Services (which now includes DCS and juvenile probation), the DCS Family Preservation Service Standard applies. This standard requires the supervisor to be master's level or above and licensed. Remaining staff must be credentialed according to the service model used (i.e. MST), but DCS does not set specific state licensure requirements.

What types of community organizations are most successful in providing MST?

All types of youth-serving agencies have been successful in providing MST, including behavioral health agencies, non-profits, government departments, etc. Please contact us at indmst@iu.edu to request a call to discuss the fit of MST within your agency.

Can team members provide services other than MST while serving on 5 MST cases? For example, if the member is an LCSW or LPC, can they continue to provide outpatient therapy?

MST therapists need to be full-time and dedicated to just MST services. The MST supervisor needs to have at least 50% full-time equivalent dedicated to MST.

How many hours of treatment are provided to each family each week?

MST treatment is highly individualized to each youth and their family, and therefore specifically-set family contacts or treatment time is not prescribed by the MST model. It is typical for therapists to have direct contact with families several times a week with more intensive contact in the early weeks of a case. In many states, Medicaid systems rates have been established based on the framework that 60 or more hours of service to family members and/or case collateral contacts (e.g. DCS, probation, school, and extended family) is typical.

What is the typical caseload per clinician?

An average caseload is 5 per therapist. Caseloads typically range from 4 to 6 cases per therapist over time. The average length of service is 3-5 months per family. When projecting costs, agencies may consider approximately 12 families for each therapist per year.

If you have multiple teams, can one team member "sub" for another in another area if there is a personnel need?

This is a question that will need to be addressed on a provider-specific basis. MST teams (1 supervisor for 2-4 therapist staff) review all of the cases and case plans in an ongoing way with the MST expert. Team structure and support is important because it supports service delivery to youth and their families, but also supports on-call responsibilities. This kind of "sub" arrangement would be highly unusual but can be explored.

MST Service Questions

Can other clinical services, such as in-home services, still occur when MST is in place?

Yes, other services such as a caregiver's individual therapy can still occur, as long as the family and primary caregiver voluntarily desire to have these services in place. MST staff will be accountable for the coordination of services while MST is in place.

If the youth is not in school or has legal charges pending, is that a rule-out?

No, these are not 'rule-out' criteria for MST.

Has MST been tested with different minority groups?

Yes, and MST has consistently been proven to work well with all minority populations served in those study groups. For the most recent update in this area of research across all treatment models please see the following study: Pina, A.A., Polo, A.J. & Huey, S.J. (2019) Evidence-Based Psychosocial Interventions for Ethnic Minority Youth: The 10-Year Update, Journal of Clinical Child & Adolescent Psychology, 48:2, 179-202. The link to this article: https://doi.org/10.1080/15374416.2019.1567350

What happens if it emerges during treatment that the child has a primary mental health diagnosis?

MST services are not an alternative to inpatient psychiatric services. If a youth is in a mental health crisis (suicidal or homicidal), youth should be stabilized before receiving MST services. There are not exclusionary mental health diagnoses, but youth need to be stable before receiving outpatient MST services. In many communities, the primary referral stream is mental health agencies, while other typical referral sources are DJJ and Social Services agencies. Mental health diagnoses are relevant and add to the understanding of the complexity of challenges for the long-term success of the youth.

What are the estimated costs associated with the collection and reporting of required metrics?

The cost that is not embedded in program administration is the Therapist Adherence Measure. This data is collected by a call-center and costs $6,000 per year. This support will be covered by Indiana FSSA-DMHA funds for the first two years.

What is the anticipated overlap with MST's inclusionary/exclusionary criteria?

While systems use different terminology and focus on different elements of a youth's behavior, it is not unusual to identify MST-appropriate youth in all child-serving systems: DJJ, DCS, Foster Care, Mental Health, Substance Abuse, and so on. The view of "same youth, different door" is a very appropriate way to think of an MST-appropriate referral population. We will work with agencies and their local community stakeholders to find the best language to characterize your MST program's referral criteria and target population descriptions. Exclusionary criteria tend to be limited and our 'standard' language most often meets the needs of communities implementing MST.

Training Questions

What is the MST training process and how long does it take?

MST program support and training is ongoing. The staff support QA/QI (Quality Assurance and Quality Improvement) and professional development activities that make up the MST on-the-job-training structure are as follows: MST Blended Orientation Training, which involves online modules to be completed within 30 days and 2 days of training in person; Quarterly Booster Training (on-site 1 ½ days each quarter); and weekly case plan review and phone-based consultation calls with the full MST team to provide feedback on the prior week's progress and current case plans. Additional weekly support and development calls with the on-site MST Supervisor are a part of this support model. Annual MST Program Support and Training costs are $37,200 for single teams per year, or $28,500 per team per year for organizations with 2-3 teams. plus additional fees for agency and team licensing, adherence monitoring calls to families (i.e. TAM data collection) and trainer travel expenses. These costs are covered by Indiana FSSA-DMHA funds for the first 2 years.

What are the estimated costs for the re-training that will come with employee attrition?

Indiana FSSA-DMHA funds cover the initial MST Blended Orientation training for organizations, which includes registration costs, materials, and travel for the MST trainer. In the case of employee replacement within the first 2 years, Indiana FSSA-DMHA funds will cover the registration costs but organizations will be responsible for travel costs for employees to Atlanta for the 2-day portion of the training. After the first 2 years, the registration costs are approximately $950 per employee and travel expenses as needed.

Miscellaneous Questions

Will MST replace intensive in-home services in the state of Indiana?

MST is an in-home services model that is evidence-based, from clinical research. Indiana FSSA-DMHA encourages local departments of social services to utilize trauma-informed and evidence-based services, when appropriate, for a family.

If you have sites in multiple regions, can they all have teams? What is the limit?

This opportunity will fund the development of MST teams in up to 12 provider agencies. There is interest in ensuring representation across the state. This funding does not exclude one program from receiving training for multiple sites. If an agency has multiple sites delivering MST services, each team will have to receive the training.