Meadows Mental Health Policy Institute

Monica Thyssen – Testimony on Senate Bill 1177, April 9, 2019

Evidence-Based Practices for Children and Youth in Medicaid

Intensive mental health services for children and youth are critical. Through our statewide work supporting the needs of children, youth, and their families, as well as our in-depth assessments of the children's system of care in the North Texas Region, Harris County,[1] Bexar County,[2] Midland, the Panhandle, and the Rio Grande Valley,[3] we have identified substantial gaps in the availability of intensive home and community-based mental health services for children and youth with the most serious mental health challenges.

We have also found that most of the intensive, evidence-based practices (EBPs) that are known to have good outcomes for children and youth with the highest mental health needs (and their families) are not covered by the state under Medicaid – despite the fact that these services can be cost effective, especially when compared to inpatient hospitalization or residential care. Today, the primary evidence-based intensive intervention available to children and youth with intensive needs is Wraparound Service Coordination (Wraparound).

Wraparound is a facilitated *planning* and coordination *process* guided by activities intended to wrap services and supports around a child/youth and their family in an effort to reduce the risk of inpatient hospitalization or residential placement after community-based treatment options have been exhausted. Wraparound is not necessary for all individuals; it is only needed when all other options are exhausted. In the current system, there are few community-based treatment options accessible for children and youth with intensive needs.

Recommended Evidence-Based Practices (EBPs)

In order to address gaps in the availability of intensive community-based services, we recommend that the following EBPs be added as allowable services in Medicaid for children and youth with intensive mental health needs:

- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)

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[1] Our report, "Harris County Mental Health Assessment for Children, Youth and Families: 2017 System Assessment," can be accessed through this link: https://www.houstonendowment.org/resources/reports/.
[2] Our report, "Bexar County Mental Health Systems Assessment," can be accessed through this link: http://www.mhm.org/library/policy-publications/bexar-county-mental-health-systems-assessment.
[3] Our report, "Valley Baptist Legacy Foundation Rio Grande Valley Behavioral Health Systems Assessment," can be accessed through this link: http://texasstateofmind.org/wp-content/uploads/2015/11/MMHPI-VBLF-System-Assessment-Report_for-Public-Release_FINAL_2017.10.24.pdf.

- Multidimensional Family Therapy (MDFT)
- Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
- Treatment Foster Care
- Dialectical Behavioral Therapy (DBT)

Please refer to Addendum A for a description of these EBPs.

Adding "in lieu of" language to Medicaid Managed Care contracts

Many states have implemented intensive EBPs through their Medicaid managed care authority, which allows managed care organizations (MCOs) to provide other services that may not be in the state plan. For example, Florida added EBPs into its managed care contracts without having to add new services to their state plan; Florida did so by updating language in their managed care contracts to allow the use of EBPs in lieu of other services. **"In lieu of" services are alternative services or services provided in alternative settings that are delivered in lieu of covered services or settings.** Providing "in lieu of" services are optional for MCOs and must be cost effective as defined in the federal regulations. Arizona, Louisiana, South Carolina, and Pennsylvania have all added EBPs through various Medicaid authorities under managed care similar to the "in lieu of" approach utilized by Florida.

SB 1177 (Menéndez) would make EBPs available in all of its Medicaid managed care programs by updating the managed care contracts to include EBPs "in lieu of" other services. Similar language already exists in the current managed care contracts, which allows MCOs to provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital "in lieu of" an acute care inpatient hospital setting for individuals between the ages of 21 and 64.

"In Lieu of" Services Currently Provided in Medicaid Managed Care

"In lieu of" services are allowed in the managed care regulations at 42 CFR 438.3(e)(2). There are four criteria under these regulations for "in lieu of" services under a managed care contract:

- The state must determine that the alternative service or setting is a **medically-appropriate** and **cost-effective** substitute for the covered service or setting under the state plan. This determination must be made under the contract, rather than on an enrollee-specific basis.
- The enrollee **cannot be required** by the MCO to use the alternative service or setting.
- The approved services must be authorized and identified in the MCO contract and **offered at the MCO's discretion**.
- The **utilization** and **cost** of "in lieu of" services are taken into account in developing the component of the capitation rates that represents the covered state plan services.

Addendum A: Evidenced-Based Practices Glossary

Functional Family Therapy (FFT) is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at-risk youth and their families, targeting youth between the ages of 11 and 18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.[4] FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on both risk and protective factors. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.[5]

Multisystemic Therapy (MST) is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.[6] In addition, the developers are currently working to form specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive, home-based service model provided to families in their natural environment at times convenient to the family. MST has low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context and was developed to address major limitations in serving juvenile offenders, focusing on changing the determinants of youth anti-social behavior.[7] At its core, MST assumes that problems are multi-determined and that, to be

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[4] Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for violence prevention series, book three: Functional family therapy (FFT).* Boulder, CO: Center for the Study and Prevention of Violence.

[5] Rowland, M., Johnson-Erickson, C., Sexton, T., & Phelps, D. (2001). A statewide evidence based system of care. Paper presented at the 19th Annual System of Care Meeting. Research and Training Center for Children's Mental Health.

[6] Huey, S. J. Jr., Henggeler, S. W., Brondino, M. J., &, Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. J*ournal of Consulting and Clinical Psychology*, 68 (3), 451–467.
Schoenwald S. K., Henggeler S. W., Pickrel S. G., & Cunningham, P. B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), *Model programs in child and family mental health*, (pp. 317–332). Mahwah, NJ: Lawrence.

[7] Henggeler S. W., Weiss, J., Rowland M. D., Halliday-Boykins, C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry,* 42(5), 543–551.

effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and a reduction in association with "deviant" peers, primarily through parental mediation.[8] **MST-Psychiatric (MST-P)** is an approach similar to MST but adapted for teens with serious emotional disorders.

Multidimensional Family Therapy (MDFT) is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African-American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban, and rural settings.[9] Treatment usually lasts between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including adolescent and parents individually, family as an interacting system, and individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent's development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.

The Intensive In-Home and Child and Adolescent Psychiatric Services (IICAPS) model was developed by Yale University to provide a home-based alternative to inpatient treatment for children and youth returning from out-of-home care or at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team that includes a master's-level clinician and a bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child and adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provide 24-hour/seven-days-a-week emergency crisis response.

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[8] Huey, S. J. Jr., Henggeler, S. W., Rowland, M. D, Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(2):183–190.

[9] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

Hogue, A. T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young youth: Immediate outcomes. *Journal of Community Psychology*, 30(1), 1–22.

Liddle H. A., Dakof, G. A., Parker K., Diamond G. S., Barrett K., Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, 27, 651–687.

Treatment Foster Care is another promising area, particularly Treatment Foster Care Oregon (TFCO). TFCO, formerly Multidimensional Treatment Foster Care, is the most well-known and well-researched intensive foster care model. TFCO has demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. TFCO is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African-American, and American-Indian youth and families.[10] There is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically lasts about six months. Aftercare services remain in place for as long as the parents want, but typically last about one year.

Dialectical Behavior Therapy (DBT) Approaches for Youth is well supported for adults, but also has moderate support for helping youth to develop new skills to deal with emotional reaction and to use what they learn in their daily lives.[11] DBT for youth often includes parents or other caregivers in the skills-training group. This inclusion allows parents and caregivers to both coach youth in skills and improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week. There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions: help consumers develop new skills, address motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment: group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

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[10] Chamberlain P, Reid J. B. (1991). Using a specialized foster care community treatment model for children and youth leaving the state mental hospital. *Journal of Community Psychology*, 19, 266–276.
Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.
Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). *Evidence-based psychotherapies for children and youth*. New York: Guilford Press.
Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337–363.

[11] Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal youth receiving DBT. *Cognitive & Behavioral Practice*, 7, 183–187.
Rathus, J.H. & Miller, A.L. (2002). Dialectical Behavior Therapy adapted for suicidal youth. *Suicide and Life-Threatening Behavior*, 32, 146-157.
Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health,* 7(3), 121–127.