

Use of Best Treatment Protocols in Managed Care Environments



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Use of Treatment Protocols in Managed Care Environments

During the last decade the Medicaid program has become an increasingly important element of the mental health system in Florida. Consistent with this growth the Agency for Health Care Administration (AHCA) has introduced a number of initiatives that are designed to improve the efficiency and effectiveness of the Medicaid program. To evaluate the Medicaid Prepaid Mental Health Program (PMHP) that was initiated in AHCA Area 6 under the authority of a 1915(b) waiver from the Federal Health Care Financing Administration, AHCA contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida. One key component of the PMHP evaluation is quality of care.

This study represents one aspect of the evaluation's examination of the quality of services provided. The specific **purpose of this study is to examine the use of treatment guidelines/protocols for children's mental health services in managed care environments.** The purpose of this descriptive study is to determine whether treatment protocols are being used by Managed Care Organizations (MCOs), Community Mental Health Centers (CMHCs), and clinicians in private practice. A second purpose was to determine whether existing treatment protocols meet national best practice standards for children's mental health services. Area 6 (Hillsborough, Manatee, Hardee, Highlands and Polk Counties), the site of Florida's PMHP was the focus of this study. Area 4 was originally selected as a comparison site for Area 6. After completing the telephone interview component of this study, Area 4 was dropped because it proved not to be a comparable site in terms of this particular study.

Organization of this Report

This report is organized into six sections: (1) **Methods:** details the different approaches used to gain a deeper understanding of the impact of treatment protocols in the delivery of mental health services for children and adolescents; (2) **Literature Review:** identifies best practices for specific child mental health diagnoses; (3) **Analysis of Treatment Protocols:** identifies similarities and differences found in the protocols reviewed; (4) **Analysis of Administrative Data Sets:** examines the treatment history of children and adolescents with certain diagnoses; (5) **Telephone Interviews:** present the perspectives of administrators from MCOs and CMHCs about treatment protocols; and (6) **Focus Groups:** present the perspectives of direct service providers (therapists and case managers) about treatment protocols.



Section 1: Methods

Literature Review: A review of the literature was completed to identify best practices for children and adolescents with various psychiatric diagnoses such as depression, oppositional defiant disorder/aggression, attention deficit hyperactivity disorder (ADHD), conduct disorder, anxiety/fears/phobias, schizophrenia, and eating disorders. The literature review served as a point of reference for quality standards when conducting the protocol review component of this study.

Analysis of Treatment Protocols: A national environmental scan was conducted to collect best practice treatment guidelines/protocols for children's mental health services that have been endorsed by accrediting bodies and/or standard setting organizations, such as the American Psychiatric Association, and the American Academy of Child Psychology. Treatment guidelines/protocols were also collected from the MCOs and Behavioral Health Organizations (BHOs) servicing Area 6. An analysis of the protocols was conducted to determine to what extent they reflect national best practices and to establish differences between various treatment guidelines/protocols.

Analysis of Administrative Data Sets: This aspect of the study was not included in the original evaluation design. However, based on a similar study being conducted by FMHI in the area of adult mental health, the evaluation team decided to incorporate this component into the study. This analysis represents an exploratory analysis of Medicaid administrative data sets to determine the types of services (i.e., evaluation, treatment, medication, etc.) offered to children and adolescents with a specific diagnosis.

Telephone Interviews: Telephone interviews were conducted with the medical directors of the MCOs, BHOs, and CMHCs in Area 6 and with the medical directors of children's mental health agencies in Area 4 to determine their awareness and use of treatment guidelines/protocols. The interview addressed issues related to compliance, quality control, and the directors' perceptions about the impact that integrating treatment protocols has at the agency as well as at the client-therapist levels.

Focus Groups: Focus groups with clinicians, therapists, and case managers from the CMHCs in Area 6 and with a group of private providers were conducted to determine compliance with best practices at the individual treatment level. In addition, the focus groups gathered information about the providers' perspectives on how treatment guidelines/protocol utilization impacts practice and the benefits and disadvantages related to their use.

Synthesis of Relevant Findings: Provides a summary of the findings from the different data collection methodologies used in this study.

Policy Implications: Highlights those findings that may be of concern to policy-makers, legislators, and administrators from MCOs, BHOs, insurance companies, and mental health agencies.



Section 2: Literature review of efficacious treatments for children and adolescents with emotional and behavioral disorders

There is much we do not know about the treatment of children and adolescents with emotional and behavior disorders. There are many treatments currently in widespread use for various childhood problems, which have not been empirically tested. In some cases, treatments are provided on the basis of their theoretical strength. In other cases, treatments have been shown to be anecdotally effective, or effectiveness has been shown but in the absence of a control group. Some types of psychotherapies lend themselves much better to the classic design of control group comparison with a standardized treatment received by an experimental group. These types of psychotherapies, predominantly cognitive, behavioral, or a combination, have been more widely studied due to the greater ease of defining, operationalizing, and quantifying the components of treatment. More recently, there have been trials of some types of interpersonal therapies. Family therapy interventions and psychodynamic treatments such as play therapy have not been studied with nearly the same precision as these other types of therapies. To further complicate matters, different therapies with different theoretical underpinnings may have differences in expected outcomes. Following a medical model, some therapies (i.e., Cognitive Behavioral Therapy) may look for reduction in frequency and severity of the symptoms that comprise a certain diagnostic category. Other therapies (i.e., psychodynamic treatment) may have goals of strengthening attachment or ego-strength with the belief that this will lead to improved functioning and a reduction in symptoms.

The purpose of this section is to provide a brief overview of the psychological interventions that, to date, have been shown to be effective or efficacious (empirically validated) in the traditional types of controlled studies. Effectiveness, in these studies, is generally measured following the medical model, by a reduction in the number and severity of symptoms comprising certain diagnostic categories. The clinical issues involved in the treatment of complex co-morbid disorders, or for children along the more severe spectrum of SED, such as those in residential or inpatient treatment are not discussed. Additionally, this section does not address the developmental disability spectrum or the substance abuse treatment literature. It is also important to note that there is often a gap between results from the laboratory or university settings where the randomized controlled trials showing efficacious treatments of children and adolescents are often conducted, and the results of similar treatments in real-world clinical settings (Weisz, 2000). Furthermore, the adult literature shows that client characteristics such as functional impairment, subjective distress, resistance to treatment, and coping style are all important factors in matching treatment to a client (Beutler, 2000; Norcorss & Beutler, 1997). While such issues have yet to be investigated as they pertain to children, they are important factors to consider when choosing treatments that rely upon parental involvement.



Outpatient therapy

Outpatient therapy is considered the least restrictive component along the continuum of care, and is usually the first and most frequent type of treatment provided to children and families (Tuma, 1989). It can vary in theoretical approach from psychodynamic to behavioral to systems to cognitive-behavioral, or a combination. Psychotherapy has been defined by Kazdin (1991) as “an intervention designed to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and prosocial functioning” (p.785). Outpatient psychotherapy takes place in a variety of settings which include schools, community mental health centers, outpatient psychiatry departments of hospitals, private offices and clinics. Counselors, social workers, psychologists and psychiatrists most often provide it.

A positive therapeutic alliance and perceived empathy of the clinician by the clients have been shown to be related to positive treatment outcomes across different types of therapeutic interventions. Psychoeducation about one’s illness, diagnosis or disorder is thought to be an important part of any treatment for a child or adolescent, to assist them and their families in feeling involved in treatment (Bermaher & Brent, 1998).

Effectiveness

Meta-analyses indicate that for a variety of psychological problems, outpatient psychotherapy has been shown to be effective, with behavioral interventions showing greater effectiveness than non-behavioral interventions (e.g. Kazdin & Weisz, 1998; Weisz, Weiss, Alicke & Klotz, 1987). For example, one meta-analysis of 150 child and adolescent psychotherapy outcome studies found the effect of outpatient therapy to be positive and highly significant, with behavioral interventions showing greater effectiveness than non-behavioral interventions (Weisz, Weiss, Han & Granger, 1995). While outpatient psychotherapy has been shown to be effective in the treatment of a number of childhood psychological problems when examined in randomized, controlled clinical trials, it has not been shown to be as effective in clinical practice as it has been in laboratory outcome studies (Weisz, Donenberg, Han & Kauneckis, 1995; Weisz, Donenberg, Han & Weiss, 1995). Beneficial therapy effects are found to be associated with factors such as the use of behavioral and cognitive-behavioral methods, reliance on specific focused therapy methods rather than mixed and eclectic approaches, and provision of structure through methods such as treatment manuals and monitoring to foster adherence to treatment plans (Weisz, Donenberg, Han & Kauneckis, 1995).

Effectiveness for specific diagnoses

• Depression

Commonalties of empirically validated treatment programs for depression in children include identifying and modifying depressogenic schema and attributional biases, social skills training, social problem solving, progressive relaxation training, and structured experience in mood-enhancing activities (Kazdin & Weisz, 1998). This package, known as “coping skills training” or CST, has shown beneficial effects in a number of studies, with the strongest effects in adolescents (e.g. Lewinsohn, Clarke, Rohde, Hops & Seeley, 1996; Stark, Swearer, Kurowski, Sommer & Bowen, 1996; Weisz, Rudolph, Granger & Sweeney, 1992).



Another treatment shown to be effective in treating adolescents with nonpsychotic, non-bipolar depression is interpersonal psychotherapy for depressed adolescents (IPT-A). To improve the client's overall social networks, the 12 week IPT-A program involves the affected teenager as well as his or her parents. The treatment focuses on the problem areas of grief, interpersonal role disputes, role transitions, interpersonal deficits, and single-parent families (Mufson & Moreau, 1998; Mufson, Moreau, Weissman & Klerman, 1993).

For helpful reviews and treatment manuals/protocols of empirically validated treatments for depression in children and adolescents, also see Van Hasselt and Hersen's (1998) "Handbook of psychological treatment protocols for children and adolescents", and Hibbs and Jensen's (1996) "Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice."

• **Post-traumatic Stress Disorder (PTSD)**

There is not currently a set manualized treatment that has been piloted with children or adolescents for the treatment of PTSD. Reviews of treatment for PTSD for children conclude that there are essential components of treatment. These include direct exploration of the trauma, stress management (i.e., relaxation skills, breathing retraining), exploration and correction of faulty cognitions related to the trauma, and inclusion of parents in treatment (e.g., Berliner, 1997; Freidrich, 1996).

• **Oppositional Defiant Disorder/Aggression**

For younger children, parent management training (PMT), where parents are trained to alter their children's behavior, is the most well established treatment. PMT is based upon the general premise that conduct problems are inadvertently developed and sustained by maladaptive parent-child interactions such as attending to the disruptive behavior, failing to attend to appropriate behavior, and frequently using ineffective commands and harsh punishment (e.g., Patterson, 1982). Parents are trained to identify, define and observe problem behaviors in new ways, with careful attention to delivery of clear and consistent rewards and consequences for promoting desired behaviors and discouraging undesirable behaviors.

There is a tremendous amount of literature on PMT, and many effective established programs that have been shown to have long-term treatment effects. Examples of such programs include Barkley's (1987) "Defiant Child", Patterson's (1987) "Parents and adolescents living together", Webster-Stratton's (1994; 1996) videotape interventions for use with parents.

Problem solving skills training (PSST) is a type of treatment, which has been successfully applied in helping aggressive youngsters generating alternative solutions to interpersonal problems. The focus of PSST is to engage the child in a step-by-step process of interpersonal problem solving including prosocial behaviors that are reinforced through modeling and reinforcement, and treatment uses structured tasks involving games, academic activities and stories. Finally, therapists take a very active role in treatment, modeling verbal self-statements and delivering feedback (Kazdin & Weisz, 1998). For reviews of outcome studies of these programs, see Kazdin (1993) and Kendall, Reber, McLeer, Epps and Ronan (1990).



• Attention Deficit Hyperactivity Disorder (ADHD)

Research indicates that the inattentiveness associated with ADHD is most effectively treated with stimulant medications (e.g., Ritalin, Dexedrine). For difficulties with aggression, misbehavior, or impulsivity associated with ADHD, the programs described above (PMT & PSST) are useful. The National Institute on Mental Health (NIMH) is currently sponsoring a large, randomized, controlled study comparing different treatments for children with ADHD. Preliminary results show both stimulant medications and behavioral treatment to be effective in treating the symptoms associated with ADHD, but overall the combination of medication and behavioral treatment yields better outcomes. Additionally, children receiving combination treatment are prescribed lower dosages of stimulant medication to get the same effects as children receiving medication in the absence of behavioral treatment. As ADHD is a chronic disorder, initial treatment is likely to require follow-up “booster” sessions for families (Pelham, 2000).

• Conduct Disorder

For the treatment of conduct disorder, individual psychodynamic treatment in the absence of other interventions has been shown to be ineffective, as have “tough love” or scare-tactic approaches such as boot camps or mock incarcerations. Single-session and short-term treatments are similarly ineffective. Multi-modal treatments in a continuum of care are the most helpful for treatment of conduct disorder.

For adolescents who have conduct problems, violent behavior, and/or substance use problems, Multisystemic Therapy (MST) has been demonstrated in numerous randomized clinical trials to facilitate long term reductions in criminal activity, drug-related arrests, violent offenses and incarceration. The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders. Outcomes have been similar across the adolescent age range (12-17), for males and females, and for African-American and White youth and families (e.g., Henggeler, 1999; Henggeler, 1994; Henggeler, Cunningham, Pickrel, Schoenwald & Brondino, 1996; Henggeler, Melton, Smith, Schoenwald & Hanley, 1993).

While MST can be considered an outpatient therapy, it is closer to intensive home-based services than to traditional outpatient treatment. Services typically involve several hours of home-based behavioral family therapy per week over the course of about four months. Therapists are available on an on-call basis 24 hours a day, 7 days a week to the family. Efforts are also made to link the child and family up with other formal and informal supports and services that can be helpful to them in building a healthy environment (Henggeler, Schoenwald, Pickrel, Brondino, Borduin & Hall, 1994).

• Anxiety/Fears/Phobias

Cognitive-behavioral techniques have been present in all empirically validated treatments for childhood anxiety disorders (Kazdin & Weisz, 1998). Educational components involve teaching the child about the biological arousal associated with anxious feelings. Children are also taught techniques to manage anxious feelings, such as relaxation and self-talk. Exposure to anxiety through techniques such as role-plays and imaginal exercises is the final component present in all effective anxiety treatments for children (see Kendall, et al., 1992 for examples).



Randomized, controlled clinical trials have shown beneficial effects immediately upon post-treatment and at one-year follow-up (Barrett, Dadds & Rapee, 1996; Kendall, 1994; Kendall, et al., 1997) and at three-year follow-up (Kendall & Southam-Gerow, 1996). Barrett, et al. (1996) have also demonstrated that the addition of a family management training component to the treatment has especially positive outcomes.

• Schizophrenia

The prevalence of childhood-onset schizophrenia is so infrequent that it is not addressed here. A study of the national register in Denmark, for example, tracked all children and adolescents who had psychiatric admissions over a 23 year period. They found that only 4 (1.2%) children under the age of 13 years and 28 (4.8%) children under the age of 15 years had received such a diagnosis. The study showed that a number of adolescents who were diagnosed with schizophrenia at their first admission were not given the same diagnosis at later admissions in adulthood. The most common diagnoses in this group of apparently misdiagnosed cases were personality disorders, primarily borderline and antisocial personality disorder (Thomsen, 1996).

• Eating Disorders

Bulimia Nervosa: It has been well established in the literature, in treatment studies, reviews and meta-analyses, that group and individual cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) are significantly more effective than wait-list controls for the treatment of bulimia nervosa (e.g., Fairburn, Norman, Welch, O'Connor, Doll & Peveler, 1995; Leitenberg, 1995; Hartmann, Herzog & Drinkman, 1992; Mitchell, 1991; Fettes & Peters, 1990). Indeed, Hartmann et al. stated, "Low effect sizes for control groups support the thesis that there is no spontaneous remission of clinically relevant bulimia nervosa. It no longer seems ethical to withhold therapy for scientific reasons (control groups)." (p.165). The most common indicator of the effectiveness of treatment for bulimia is the absence, or significant reduction, of binge and purge behavior. Indicators where both individual and group CBT have also shown to be significantly more effective than wait list controls and group behavior therapy include a reduction in psychopathological symptoms and a reduction in preoccupation with dieting (Wolf & Crowther, 1992). Family environment factors have been found to be stronger predictors of outcome when the client is exposed to in-group cognitive behavioral therapy than any other factors, including depression (Blouin, et al., 1993).

CBT versus IPT: CBT works through systematically altering harmful behaviors and replacing them with healthy ones, while at the same time challenging and restructuring incorrect thoughts and beliefs that work to maintain the bulimia. IPT assumes that mastery of current social roles and adaptation to interpersonal situations are sufficient for treatment effectiveness because of the relationship among negative mood, low self esteem, interpersonal function, and eating behavior (Fairburn, et al., 1991).

While CBT and IPT address bulimia from very different angles, available evidence does not show group CBT to be more effective than group IPT both post-treatment and at follow-up (Wilfley, Agras & Telch, 1993) for the treatment of non-purging bulimia, with binge



eating as the indicator. No study to date has directly compared group CBT to group IPT for purging bulimia. Available evidence also does not show individual CBT to be more effective than IPT both post-treatment and at follow-up (Fairburn, et al., 1995).

Anorexia Nervosa: There is no one specific treatment that has been shown to be effective for treatment of anorexia nervosa. Rather, prudent guidelines for treatment include a variety of treatments across modalities. Comprehensive medical, psychological and family treatment are all part of a typical treatment plan. Since the initial aim of treatment should be to restore weight to the point of resumption of normal menses, inpatient care is required if the client fails to improve in outpatient treatment. A good nursing staff is the key to effective management, to provide the client with encouragement and support in her efforts to combat ambivalence and compulsions. The program should include a few powerful behavioral contingencies, for example, requiring bed rest until a weight gain pattern is evident, providing the client with feedback about calories taken and weight gained, and gradually returning control of eating to the client.

Individual psychotherapy should be used when the client is sufficiently motivated, cognitively intact, and able to participate meaningfully. Family psychotherapy is indicated for virtually all younger clients and should be conducted to reduce hostile blaming, improve direct communications regarding major family conflicts, and prepare the family to deal effectively with the client on her return home. Family therapy should not be used in cases where one or more family members are viewed as rigidly destructive (adapted from Yager, 1994)

• **Pharmacotherapy for Mood and Anxiety Disorders in children and adolescents**

With the exception of ADHD, there are no behavior disorders of childhood or adolescence, which are shown to be treated more effectively with medication than with a combination of medication and psychotherapy (where medication has been shown to be effective at all). While frequently prescribed, there have been relatively few double blind studies in the use of antidepressants in children and adolescents, and they do not consistently demonstrate a difference between medication and placebo (Steingard, De Maso, Goldman, Shorrock & Bucci, 1995) with tricyclic antidepressants. Only one study to date (Emslie, Walkup, Pliszka & Ernst, 1999) has shown a positive effect of fluoxetine (56% showed improvement as evidenced by CDRS-R scores) vs. placebo (33% showed improvement) for the treatment of children meeting criteria for major depressive disorder.

This study which is part of a 1999 review of published articles and of scientific meetings published in the Journal of the American Academy of Child and Adolescent Psychiatry found that obsessive-compulsive disorder is the only psychiatric diagnosis for which pediatric use of selective serotonin reuptake inhibitors (SSRIs) has been approved. Other clinical trials of non-tricyclic antidepressants in depressed adolescents are in progress.

No studies to date have examined pharmacotherapy for social anxiety in children or adolescents. One double blind, placebo-controlled study, examined the efficacy of alprazolam (Xanax) for childhood and adolescent overanxious or avoidant disorders. On a clinical global rating, there was no significant difference between alprazolam and placebo (Simeon, et al., 1992).



Section 3: Analysis of Treatment Protocols

Treatment guidelines/protocols from several organizations were gathered to establish differences among them and to compare them with empirically validated treatment modalities. Treatment guidelines/protocols published by the following organizations were reviewed:

- Florida Health Partnership, Options Health Care, Inc.
- Horizon Behavioral Services
- United Behavioral Health
- Behavioral Health Management Services, Inc. (Florida First)
- Journal of the American Academy of Child and Adolescent Psychiatry Practice Parameters (October 1997).

The first step of this analysis consisted in developing a matrix of the different treatment modalities and characteristics derived from empirically validated treatment modalities. Then information from the various treatment guidelines/protocols was classified following this pattern. Each matrix also presents empirically validated treatment recommendations based on the literature review. The matrix was sorted by diagnoses in order to facilitate the analysis process and to present the information in a clear and concise manner.

Treatment guidelines/protocols typically include specific directions for assessment. Many also include guidelines regarding psychotropic medications, some with a great deal of specificity. The use of psychotropic medications was outside the scope of the current analysis, which focused on non-medication based therapy interventions for disorders occurring in childhood and adolescence.

It should be noted that with the exception of the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the treatment guidelines/protocols are not child/adolescent specific. For example, if medications are effective for the treatment of depression in adults, the guidelines state that medications should be used in its treatment, even if there is no data to suggest that medications are effective with children. Also, information from the JAACAP is not included in the tables because it was extremely extensive and not well suited to be analyzed in this format.



Table 1
Attention Deficit Disorder with Hyperactivity (ADHD)

	Treatment Modality	Ind/Group Therapy	Family Therapy	Number of Sessions	Follow-up
Horizon Behavioral	<ul style="list-style-type: none">• Psychosocial• Pharmacological	Individual & group	Yes	6 prior to psychological evaluation	Continuing clinical evaluation
Behavioral Health Management	<ul style="list-style-type: none">• Refer to psychiatrist• Medication• Community-school	Individual & group	Yes	12	As clinically indicated
United Behavioral Health	<ul style="list-style-type: none">• Pharmacotherapy• Psychotherapy	Individual & group	Yes	Not stated	Not stated
Florida Health Partnership	<ul style="list-style-type: none">• Medication• Therapy• School involvement• Parent education	Individual	Not stated	Not stated	Not stated
Empirically validated treatment	<ul style="list-style-type: none">• Medication• Parent Management Training (PMT)	Individual & group	Yes (behavioral focus)	Not stated	Not stated



**Table 2
Depression**

	Treatment Modality	Ind/Group Therapy	Family Therapy	Number of Sessions	Follow-up
Horizon Behavioral	<ul style="list-style-type: none"> • Psychotherapy • Somatic Combination 	Individual	Not stated	3 prior to psychological evaluation	Not stated
Behavioral Health Management	<ul style="list-style-type: none"> • Based on 3 phases: acute, stabilization, and maintenance • Pharmacotherapy, education, and therapy 	Individual	Yes	Not stated	Yearly visit
United Behavioral Health	<ul style="list-style-type: none"> • Pharmacotherapy • Psychotherapy • Electroconvulsive therapy 	Individual & group	Yes	Not stated	Maintenace therapy
Florida Health Partnership	<ul style="list-style-type: none"> • Based on 3 phases: acute, stabilization, and maintenance • Pharmacotherapy, education, and therapy 	Individual	Not stated	Not stated	Yearly
Empirically validated treatment	<ul style="list-style-type: none"> • Coping skills training (CST) • Psychotherapy • Cognitive behavioral tx • Psychodynamic • Interpersonal 	Individual & group	Yes	12+ (varies)	Not stated



Table 3
Post-traumatic Stress (PTSD)

	Treatment Modality	Ind/Group Therapy	Family Therapy	Number of Sessions	Follow-up
Horizon Behavioral	<ul style="list-style-type: none">• No protocol				
Behavioral Health Management	<ul style="list-style-type: none">• Therapy• Medication• Community supports	Individual & group	Yes	Not stated	Not stated
United Behavioral Health	<ul style="list-style-type: none">• Psychotherapy (CBT-CISD)• Pharmacotherapy	Not stated	Yes	Not stated	Not stated
Florida Health Partnership	<ul style="list-style-type: none">• Therapy• Medication evaluation• Community supports	Individual & group	Yes	Not stated	Not stated
Empirically validated treatment	<ul style="list-style-type: none">• No validated treatment for children	Individual	Yes	Not stated	Not stated



**Table 4
Conduct Disorder**

	Treatment Modality	Ind/Group Therapy	Family Therapy	Number of Sessions	Follow-up
Horizon Behavioral	<ul style="list-style-type: none">• No protocol				
Behavioral Health Management	<ul style="list-style-type: none">• Medication (maybe)• Community focus	Individual & group	Yes	10	As clinically indicated
United Behavioral Health	<ul style="list-style-type: none">• Psychotherapy• Pharmacotherapy	Individual & group	Yes	Not stated	Not stated
Florida Health Partnership	<ul style="list-style-type: none">• Medication• Therapy	Individual & group	Yes	Not stated	Not stated
Empirically validated treatment	<ul style="list-style-type: none">• Multi-model treatments, multisystemic therapy (MST)	Individual	Yes	Not stated	Not stated



Table 5
Eating Disorders

	Treatment Modality	Ind/Group Therapy	Family Therapy	Number of Sessions	Follow-up
Horizon Behavioral	<ul style="list-style-type: none">• No protocol				
Behavioral Health Management	<ul style="list-style-type: none">• No protocol				
United Behavioral Health	<ul style="list-style-type: none">• Psychotherapy• Pharmacotherapy• Weight restoration		Yes	Not stated	Not stated
Florida Health Partnership	<ul style="list-style-type: none">• No protocol				
Empirically validated treatment	<ul style="list-style-type: none">• Bulimia: CBT and interpersonal therapy (IPT)* Anorexia: multi-modal, medical component		Yes	Not stated	Not stated



**Table 6
Anxiety/Fears/Phobias**

	Treatment Modality	Ind/Group Therapy	Family Therapy	Number of Sessions	Follow-up
Horizon Behavioral	<ul style="list-style-type: none"> • No protocol 				
Behavioral Health Management	<ul style="list-style-type: none"> • Individual therapy • Medical evaluation • Community support 	Individual & group	Yes	Not stated	Not stated
United Behavioral Health	<ul style="list-style-type: none"> • Psychotherapy • Pharmacotherapy, (CBT) 	Individual & group	Yes	Not stated	Not stated
Florida Health Partnership	<ul style="list-style-type: none"> • Individual therapy • Medical evaluation • Community support 	Individual & group	Yes	Not stated	Not stated
Empirically validated treatment	<ul style="list-style-type: none"> • Cognitive-behavioral techniques 	Individual & group	Yes	Depending on program (16–20)	Not stated

Review of the treatment guidelines/protocols showed that, in general, there is not much difference among the recommended treatment modalities. However, the range of specificity among them varies. For example, Horizon Behavioral only has treatment guidelines/protocols for their most common disorders (ADHD, depression, substance abuse, and schizophrenia). United Behavioral Health has the greatest specificity; their guidelines not only list types of treatment and techniques, but also provide comprehensive definitions of terms and techniques. The other guidelines reviewed do not offer this level of specificity. Most of the treatment guidelines allow for a fair amount of flexibility on the part of the clinician.

When comparing the guidelines with best practices, one guideline was exemplary in how it reflected current empirical data on the treatment of psychological problems, while another one was at the other end of the spectrum. The latter one is primarily intended as a “level of care” tool that only covers the four most prevalent diagnoses emphasizing psychopharmacology and de-emphasizing behavioral treatment to a degree that does not reflect the empirical literature. The other two guidelines fall somewhere in between in their compliance with best standards.



Section 4: Analysis of Administrative Data

This study component was added based on a similar exploratory analysis being conducted at FMHI. This analysis emerged as a result of reviewing adult treatment guidelines/protocols such as the American Psychiatric Association Guidelines and the Florida Health Partnership Guidelines. These guidelines recommend a combination of talk/psychosocial treatment and medication for the treatment of disorders such as major depression, bipolar disorder, and schizophrenia. Since the treatment guidelines/protocols for children and adolescents recommend a similar approach for the treatment of several diagnoses the evaluation team decided to conduct an analysis of administrative data focusing on three diagnoses: conduct disorder, depression and ADHD.

An exploratory analysis of AHCA's administrative data sets from March 1998 to February 1999 for Area 6 was conducted to examine the treatment histories of children and adolescents enrolled in a managed care plan with a diagnosis of conduct disorder, depression, or ADHD. The analysis for each diagnosis consisted of: (1) determining the percentage of children who received an assessment at some point in the year prior to receiving services to treat the disorder and (2) categorizing the children who received treatment according to whether they received mental health services, other medical services, received a psychotropic medication appropriate for children and adolescents, although not diagnosis specific, and/or a combination of services.

The results of the analysis showed the following:

Table 7		
Conduct Disorder (N=256)		
Services received	Number of Children	Percentage of Children
Evaluation before Tx	176	68.75%
Evaluation only	3	1.17%
Evaluation and medications	5	1.95%
Mental health Tx	21	8.20%
Other services/Tx	34	13.28%
Combination mental health and Other service/treatment	61	23.83%
Mental health and medications	43	16.80%
Other services/Tx and medications	35	13.67%
Combination mental health and Other Tx and medications	54	21.09%



According to the data, 31% of this population did not have an assessment completed before treatment and 17% were prescribed psychotropic medications, although the literature review indicated that medication is not recommended for the treatment of conduct disorder. This level of analysis does not indicate whether the mental health intervention was a multi-modal treatment.

Services received	Number of Children	Percentage of Children
Evaluation before Tx	822	72.49%
Evaluation only	10	.88%
Evaluation and medications	21	1.85%
Mental health Tx	63	5.56%
Other services/Tx	114	10.05%
Mental health and other Tx	228	20.11%
Mental health Tx and medications	164	14.46%
Other Tx and drugs	102	8.99%
Mental health and other Tx and medications	432	38.10%

According to the data, 28% of this population did not have an assessment completed before treatment, and 14% were prescribed psychotropic medications, although medication is not recommended for the treatment of depression in children/adolescents. This level of analysis does not indicate whether the mental health intervention included “coping skills training” (CST) and/or interpersonal psychotherapy.



Table 9
Attention Deficit Hyperactivity Disorder (ADHD) (N=1866)

Services received	Number of Children	Percentage of Children
Evaluation before Tx	1140	61.09%
Evaluation only	6	.32%
Evaluation and medications	20	1.07%
Mental health Tx	77	4.13%
Other services/Tx	69	3.70%
Mental health and other Tx	88	4.72%
Mental health Tx and medications	686	36.76%
Other Tx and medications	77	4.13%
Mental health and other Tx and medications	843	45.18%

According to the data, 39% of this population did not have an assessment completed before treatment, and 63% were prescribed psychotropic medications, which is a central component of the most effective treatment for this diagnosis. This level of analysis does not indicate whether the mental health intervention combined medications with behavioral treatment as indicated in the literature review.

Section 5: Telephone Interviews

Brief telephone interviews were conducted with the medical directors of the CMHCs, and MCOs in Area 6 and with medical directors of children's mental health service providers in Area 4 to determine their awareness and use of treatment guidelines/protocols in the field of children and adolescent's mental health. For this purpose a total of 15 administrators were identified and targeted in these areas and a total of 12 interviews were completed. Out of the 12 interviews completed, 9 were in Area 6 and 3 in Area 4.

Data Analysis

The interviews were divided into three groups: (1) Administrators of MCOs in Area 6, (2) Administrators of CMHCs in Area 6, and (3) Administrators of children's mental health agencies in Area 4. The data collected from the telephone interviews were classified into two broad categories: (1) Utilization of treatment guidelines/protocols, which includes the reasons for their utilization, the identification of guidelines used, and how their use is monitored; and (2) Practice effects, benefits and disadvantages of treatment guidelines/protocol utilization. Once the data were classified they were analyzed according to the frequency of the responses provided by the respondents under each classification.



The responses from the MCO and CMHC's administrators in Area 6 are presented side by side in an effort to compare and contrast their perceptions and to show the extent to which there is congruency between them. Findings from the interviews with the CMHC administrators in Area 4 are presented separately because they reported that only treatment guidelines/protocols these agencies are required to use are Medicaid guidelines which are geared to eligibility issues rather than treatment modalities and their internal guidelines. Given this information, Area 4 is not considered to be comparable with Area 6 for this particular study. For this reason, Area 4 was not included in the remainder of the study.

Utilization of Treatment Guidelines/Protocols

The areas addressed are the use of treatment guidelines/protocols, how and when the adoption of treatment guidelines/protocols took place, how use is monitored, and benefits and disadvantages associated with their utilization.

Exhibit 1: Comparison of Utilization of Treatment Guidelines/Protocols

• MCOs (N=5)	• CMHCs (N=4)
<p>Three of the five administrators interviewed responded that their companies require the utilization of treatment guidelines/protocols, one said their use is strongly encouraged, and one said it is up to the provider. When asked about the reasons for adopting treatment guidelines/protocols, two respondents said that protocols were used for consistency in decision making, one said to keep treatment on track, and one said for quality services.</p> <p>The interviewee from the company that leaves use up to the provider reported that professionals are the best ones to establish guidelines, and pointed out that corporate approval of guidelines is a costly and difficult process, with much disagreement about which ones are best to use. The three MCOs using treatment guidelines mentioned that they had developed their own. The protocols are diagnosis specific and have been developed based upon reviews of best practice guidelines, and/or those of other insurance companies. They also reported that they have had protocols in use between 1 and 5 years. The respondents were not clear about the process of adopting treatment guidelines/</p>	<p>All four of the CMHCs administrators interviewed reported that the utilization of treatment protocols is required by their agencies. The reasons for adopting treatment protocols differ somewhat among the respondents. Three mentioned that the managed care companies that underwrite their services require their use. Two of the respondents also mentioned that they adopted the guidelines out of their interest in best practices and in providing quality services. One respondent stated that their agency had helped developed the treatment protocols they were using and felt these were needed.</p> <p>The treatment guidelines/protocols developed by the Florida Health Partnership (FHP) are used by three of the CMHCs while one uses its own treatment guidelines. The CMHCs reported that FHP guidelines are general and inclusive; only minor modifications are needed to comply with the guidelines of other MCOs. For the CMHC that participated in the development of the FHP treatment guidelines/protocols adopting them at the practice level was easy since their staff had the opportunity to offer their</p>



Exhibit 1: Comparison of Utilization of Treatment Guidelines/Protocols (Continued)

• MCOs (N=5)

protocols, which may be related to their length of time working for these companies. However, one respondent mentioned that his/her company had convened a national advisory committee to develop the treatment guidelines/protocols with annual update meetings.

In regards to the training offered staff on the utilization of treatment guidelines/protocols, two of the respondents stated that clinicians receive copies of the materials and that they participate in monthly meetings and in orientations twice per year. One respondent noted an education training program while another mentioned that his/her agency offers clinician orientations twice per year. This question was not applicable to the agency that does not require the use of treatment guidelines/protocols.

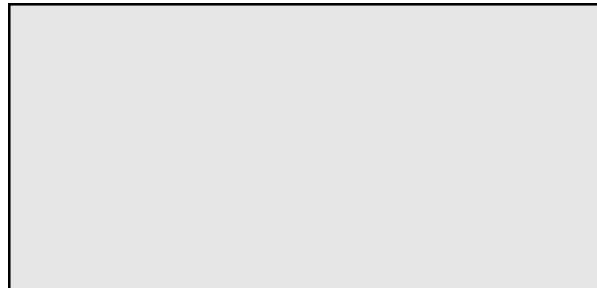
The utilization of treatment guidelines/protocols is monitored by three of the agencies interviewed through the outpatient treatment plans the providers send in for service authorization. One agency monitors their use through their annual inter-rater reliability review and their case reviews. This question was not applicable to the agency that does not require the utilization of treatment guidelines/protocols.

• CMHCs (N=4)

input in the development process. For the remaining three CMHCs, the adoption of treatment protocols was easy because their agencies had always used some type of treatment guidelines.

Regarding the issue of training, the responses ranged from specific to vague. Two of the respondents mentioned in-house training and orientations. One stated that in his/her agency there is a “unified effort to provide training”, and one mentioned the agency’s role in helping to develop the treatment guidelines/protocols as the extent of the training provided to clinicians.

Two of the CMHCs monitor the utilization of treatment guidelines/protocols through their internal utilization management. The other two CMHCs use peer reviews, record reviews, and planning meetings to monitor their utilization.





Practice Effects, Benefits and Disadvantages

The areas covered under practice effects are how the utilization of treatment guidelines/protocol affects practice, what are the benefits and disadvantages that the MCOs and CMHCs identified as a result of their use, and how has their adoption impacted the client-provider therapeutic relationship.

Exhibit 2: Comparison of Practice Effects, Benefits and Disadvantages

• MCOs (N=5)	• CMHCs (N=4)
<p>There was little consensus among the five MCOs regarding the effect of protocol utilization. One respondent mentioned that using treatment guidelines results in better care and that this care can be measured across providers. Another stated that following treatment guidelines results in more timely and consistent decisions. Another respondent noted that treatment guidelines force providers to look into their own practice and promote effectiveness and solution focused therapy. Similarly, another respondent said that treatment guidelines provide MCOs the opportunity to clarify their philosophy to providers and offered as an example that his/her agency believes in “psychiatry and medication evaluations” and as such they want those clients with moderate to severe depression to be placed on medication. This issue was not applicable to the agency that does not require the utilization of treatment guidelines/protocols.</p> <p>Regarding the benefits of using treatment guidelines/protocols, once again there was little consensus among the respondents. One respondent mentioned that using treatment guidelines/protocols results in a higher quality of service. Another mentioned that decisions are made in a more timely manner and the care is more consistent. Another stated that clients receive better care because services are closely monitored. For one respondent the benefit is on the short-term approach that is solution-focused. For the</p>	<p>All respondents felt very positive about the effects that treatment protocols have on practice. One respondent commented that “We are a more enlightened profession by reviewing research and summarizing it into best practices.” Another one mentioned that by using treatment guidelines, clinicians are “covering themselves”. The remaining two respondents stated that clinicians are able to provide a more standardized and appropriate treatment and as a result the length of stay and the level of care have improved.</p> <p>Regarding the benefits of using treatment protocols one respondent mentioned that treatment guidelines help clinicians focus on the client rather than on the training orientation of the provider. The remaining three respondents talked about how treatment guidelines help providers cover all the bases, meet the requirements of the insurance companies, and at the same time add a certain level of accountability to their practice.</p> <p>When asked about the disadvantages associated with the utilization of treatment guidelines/protocols, two of the respondents stated that there were none. One respondent mentioned that providers needed to overcome the stigma of “cook book” treatment associated with treatment guidelines because in reality they do not limit the therapists’ ability to individualize the treatment. One respondent mentioned that because Medicaid and the various</p>



Exhibit 2: Comparison of Practice Effects, Benefits and Disadvantages (Continued)

• MCOs (N=5)

MCO that does not require the utilization of treatment protocols, the potential benefit of their utilization is that they help in reassuring that the care provided is not taking an unorthodox turn.

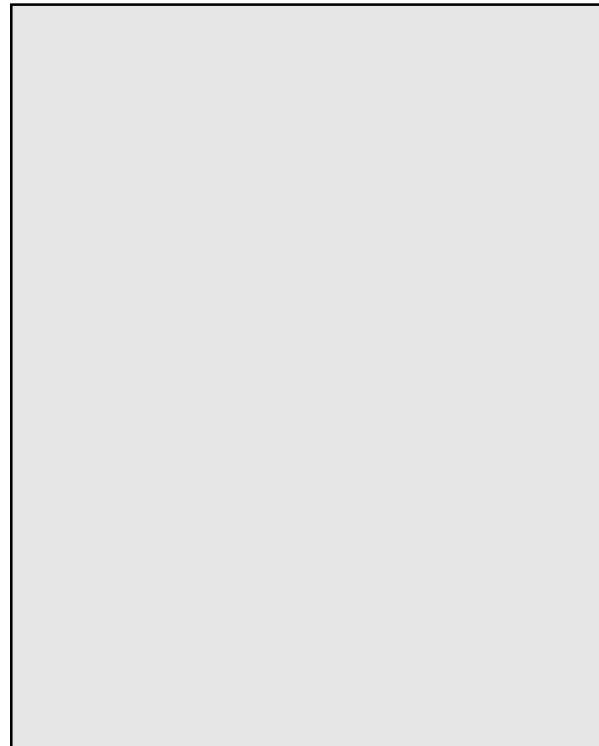
In terms of **disadvantages** three respondents mentioned that they personally did not see any. One these respondents added, that some clinicians could feel like they are being told how to practice. Another respondent stated that using treatment guidelines/protocols limits the flexibility of the clinician. The respondent from the MCO that does not require the utilization of treatment guidelines/protocols mentioned that often these guidelines rely on expensive treatments and that what is missing is practice that is “best [and] efficient” considering the economic factor.

The respondents could only speculate about the impact that the adoption of treatment guidelines/protocols has in the therapeutic relationship between clinician and client since they do not have direct knowledge of this. However, they offered some comments about how they thought treatment guidelines impact the client-provider relationship. Two stated that providers might be more open and direct about treatment goals. Two mentioned that they have a closer relationship with providers, which allows for the provision of individualized feedback to help providers achieve their goals. One mentioned that if he/she were the parent of a child receiving services and was aware of best practices, his/her confidence in the provider would increase by knowing that a protocol is being followed. All of these effects were thought to be positive.

• CMHCs (N=4)

HMOs are handled by managed behavioral organizations that use “commercial protocols” designed for the “walking well” (clients with minor problems), it is difficult to use treatment guidelines/protocols with the severe and persistent mentally ill clients because they need much more than what is called for in the guidelines.

When asked to comment about the impact of treatment guidelines/protocols in the client-provider relationship, one respondent said there were no changes. Two mentioned that the treatment is more focused and directive and one mentioned that there is more client involvement in the treatment, that clients are better educated, and that there is increased accountability on the part of the provider.





Area 4

The administrators from three children's mental health agencies in Area 4 were interviewed about their agency's use of treatment protocols. The results of these interviews showed that providers in this Area are not working with MCOs that require them to use specific treatment guidelines/protocols. With the exception of one agency that works strictly with Medicaid and is required to follow its guidelines, the other two providers reported that they have their own internal treatment guidelines and manuals, which are used for the training of clinicians and as reference. They also have quality control mechanisms to monitor services such as peer reviews, record reviews, and group supervision.

The information provided by these agencies showed that they were not operating under the same or similar parameters guiding the operations of the CMHCs in Area 6 and as such it was not possible for the evaluation team to compare the two areas.

Section 6: Focus Groups

The five Community Mental Health Centers (CMHC) located in AHCA Area 6 were contacted for participation in the focus groups. Three of the CMHCs responded positively and focus groups were arranged at their facilities. In addition, a group of private clinicians was contacted for participation in a focus group conducted at FMHI.

Participant selection and description

Participants for the focus groups self-selected. All the clinicians/therapists from the CMHCs that agreed to participate were invited to the focus groups. Focus groups with case managers were conducted at two sites and the same process of self-selection was followed. A total of 31 private clinicians received invitations for participation and they self-selected.

A total of 22 therapists from three different community mental health centers participated in focus groups. Sixteen (73%) were female and six (27%) were male. Twenty (91%) have Master's degrees and two (9%) have Doctorate degrees in Clinical Psychology. On average, the therapists have caseloads of 73% children and adolescents and 17% adults; about a third of the therapists have caseloads exclusively comprised of children and adolescents. They were on an average of 2.2 insurance panels (range 0 - 6). However, it should be noted that therapists were not always sure exactly which insurance panels they were on, as the administrative offices in the agencies typically took care of billing and insurance issues.

A total of 9 therapists in private practice participated in focus groups, of whom 5 are female (56%) and 4 are male (44%). Five have Master's degrees and four have Doctorate degrees. On average, the private practitioners' caseloads are 33% children and adolescents. None of the private practitioners had caseloads that are exclusively comprised of children and adolescents. The private practitioners were on an average of 3 insurance panels (range 1 - 8), which was not significantly different from agency-based therapists.

There were a total of 10 case managers in the focus groups, 8 of whom were female. Eight of the 10 had Bachelor's degrees, one had an Associate's degree, and one had a Master's degree. On average, the group had a caseload of 89% children and adolescents.



Data analysis

As part of the focus group process a summary of the data collected was presented to each group for confirmation and consensus building. The data were transcribed and organized according to the sections of the question guide used in the focus groups (see table 1). Once the data were organized they were coded to establish the main emerging themes and the secondary themes. Main themes represent data found in at least two of the three focus groups conducted. Secondary themes represent data that may have only appeared in one focus group but that provide relevant or additional information to the study. Two independent coders coded the data to increase reliability. The coders also debriefed to discuss any discrepancy in the coding and reach consensus.

Table 10 Focus Group Questions
Treatment Protocols <ol style="list-style-type: none">1. Have you seen the treatment protocols?2. What do you think of the treatment protocols?3. How do you use the treatment protocols?4. What training have you received regarding the use of treatment protocols? Have you received any direct training from the insurance companies? Any written materials?
Service Provision <ol style="list-style-type: none">5. How has service provision changed as a result of insurance company demands? As a result of the treatment protocols?6. Have you had services denied because you were not following the treatment protocols?
Treatment <ol style="list-style-type: none">7. What is your procedure for diagnosis and assessment? Does this differ by the insurance provider? By the treatment protocol?8. How do you determine a service plan? Does this differ by insurance provider? By the treatment protocol?9. How do you decide what therapeutic techniques to employ? (such as cognitive-behavioral, play therapy, interpersonal therapy). Does this differ by the insurance provider? By the treatment protocol?10. How do you decide who to involve in treatment (individual vs. family therapy? Group therapy?) Does this differ by the insurance provider? By the treatment protocol?11. How do you decide to make a referral for a medication evaluation? Does this differ by insurance provider?12. What would you do differently if a client came in who could pay for services out of pocket and insurance was not involved in the therapy?



Focus Groups with Clinicians/Therapists

The data collected from the focus groups are organized into three sections, which represent the main issues discussed with the participants. They are (1) Treatment Protocols, (2) Service Provision, and (3) Treatment Plans. The sections are further divided into main themes (mentioned by at least two of the groups) and secondary themes (mentioned by only one group).

Treatment Protocols

In this section of the focus groups the participants discussed their awareness and knowledge about treatment protocols, their opinions about their utilization, and the training received in order to integrate them at the practice level.

• *Main Themes:*

- Treatment protocols are part of the agencies' training manuals/policies and procedures. The level of awareness regarding the protocols varied in that not all participants had seen, reviewed, or use them.
- Clinicians/therapist feel that considering their training and their understanding of their work they do not need to rely on treatment protocols to do their job. They trust that their decisions are in line with best practices. Protocols may be used as a reference if they run into an unusual situation. However, any unusual situation is discussed with their supervisor and treatment team.
- The purpose of treatment protocols is to guide practice and to reduce costs. Therefore, when insurance companies write these protocols for clinicians, the clients' needs are not their only priority.
- Clinicians/therapists have not received any training focused specifically on the utilization of treatment protocols. They have participated in different types of training such as solution focused therapy.
- Insurance companies have not provided any formal training. Some insurance companies send newsletters addressing specific diagnosis and treatment approaches.

• *Secondary Theme:*

- The participants from one of the groups provided two distinctive perspectives regarding the benefits and disadvantages of using treatment protocols. The advantages were having access to a reference source whenever in need and knowing that these protocols are based on research, which most clinicians do not have the time to conduct. The disadvantages were the treatment specificity laid out in the protocols and knowing that for any research findings advocating a certain practice, there is another body of research stating the opposite.



Service Provision

In this section of the focus groups the participants shared their opinions regarding the ways in which service provision has changed as a result of insurance company's demands and the introduction of treatment protocols. Service denials based on lack of adherence to treatment protocols were also discussed.

• **Main Themes:**

- Clinicians/therapists are doing more “Band-Aid therapy” due to the reduced number of sessions. They are treating the symptoms rather than the “deep issues”. As a result clients either keep coming back for additional services or never return because they think services were not helpful.
- The number of sessions is limited unless the client has a severe condition. The sessions approved may not match the treatment recommended by the therapist. Length of stays (inpatient services) has also been reduced. In some cases this does not represent a problem if the client is able to continue receiving outpatient services.
- Clients tend to worry about the reduced lengths of treatment they are entitled to receive. Clinicians are spending more time explaining the treatment limitations to their clients. Clinicians are doing less therapy and have more clients and more paperwork.
- Insurance companies focus on “how sick client is” and on the improvements achieved, which at times is difficult for therapists to establish. Mild client improvements result in denial of additional services clients may need. “As soon as clients reach an O.K. stage they are discharged.”
- Clinicians have not been denied services for not following specific treatment guidelines. The insurance companies are not directing the clients’ treatment. However, the agencies’ financial office may review the clients’ progress notes and suggest treatment changes to fit the guidelines of the insurance companies.
- Insurance companies are becoming more intrusive by requiring a lot of personal information about the clients. This information may be used to label clients and to deny certain services. Clients are selling their confidentiality when they sign up with insurance companies.
- The quantity and quality of the paperwork required from the clinicians/therapists has increased. This takes a lot of time and effort that the clinicians could use working with their clients.

• **Secondary Themes:**

- The development of the Waiver served to shift the structure of the service menu offered by one agency. The Waiver's capitation rate also offers more freedom to clinicians in service delivery.
- Clinicians and doctors spend a lot of time on the phone obtaining authorizations from insurance companies.
- Changes in insurance coverage, contracts, and panels impact the treatment process of some clients. Treatments may be reduced or discontinued depending on the insurance guidelines.



- The demands placed on clinicians/therapists leave them with no time to research issues, to exchange opinions with other professionals, and to have any collateral contacts.
- Clinicians/therapists are seeing a difference between the training they receive in school, the published research, and the insurance companies' demands.

Treatment

In this section of the focus groups the participants shared their opinions regarding the processes they follow in order to assess and diagnose their clients, to develop treatment plans, to determine the therapeutic approaches they utilize, and to decide if their clients require medication evaluations. Participants also shared their views about the approach they would take when working with clients who are able to pay for services out of pocket.

• Main Themes:

- Treatment plans are developed following an established process, which includes goal and objective setting, determining the types of interventions, and stating target dates for completion. The clinicians and the clients are involved in this process.
- Treatment modalities and therapeutic techniques are established based on the clients' needs. The therapists solicit input from their supervisors and treatment teams in making these decisions.
- Medication evaluations are completed whenever the therapist and the treatment team deem it necessary. These referrals are based on the clients' diagnosis, severity of symptoms, and behaviors.
- Clients paying out of pocket would follow the same process. However, their treatment plans would be guided by the clients' needs only and as such would allow clinicians to be more creative.

• Secondary Themes:

- In developing treatment plans some clinicians are focusing solely on the clients' needs regardless of their insurance limitations while others review the insurance limitations first and then develop a plan accordingly.
- Insurance companies are becoming more aggressive in prompting clients to seek medication evaluations.

Focus Group with Private Clinicians/Therapists

A focus group with private clinicians was conducted for comparison purposes. The clinicians in this focus group served on panels of both Medicaid MCOs and private insurers. Their responses to the questions were based on their experiences with both public and private MCOs. The data collected from this focus group does not show any significant difference between this group and the other two groups. Some of the private clinicians were more aware of the treatment protocols than others. Their utilization of treatment protocols is maintained at an administrative level in that protocols are used to write acceptable treatment plans and ensure payment, to find ways to obtain more sessions for their clients, and as a reference.



Just as the participants in the other groups, not all private clinicians had received specific training on treatment protocols from insurance companies. They confirmed reports of insurance companies sending newsletters suggesting questionnaires to use in certain diagnosis.

Regarding the impact that insurance companies and treatment protocols are having on service provision, this group's participants reported having similar experiences to those described by the other participants. One distinction found between this group and the other two is that commercial insurance companies hold private clinicians responsible for the paperwork the clients must submit. Consequently, payment of claims may be withheld until the client submits the appropriate paperwork. Also, insurance companies may deny services if clinicians are not using the appropriate treatment modality, type of service, or service location (e.g., office vs. home).

The treatment process followed by private clinicians is similar to the process followed by the participants in the other two groups. Private clinicians noted that not everything that is documented in the treatment plans is necessarily what is being done. They also mentioned the increased promotion of medication evaluations by insurance companies by facilitating the psychiatric referral process and by not requiring clients to see a therapist before obtaining medications. The participants expressed concern about this trend because in their views many medications are being prescribed without having a solid research base.

Finally, private clinicians mentioned the limitations placed by insurance companies on "growth issues". As a result of this limitation they are no longer able to promote wellness.

Focus Groups with Case Managers

Two focus groups were conducted with case managers to determine the impact of treatment protocols in their work. The intention of the evaluation team was to compare and contrast the findings from these focus groups with the information gathered from the therapists' focus groups. Unfortunately this comparison was not possible because the information gathered from the two case managers' focus groups showed that case managers are not impacted by treatment protocols. Although case managers are aware of the existence of treatment protocols, they do not define the nature of the services they provide.

The duties of the case managers are not clinical in nature. Case managers are members of treatment teams and the clinician on the team determines what services each child and family receives. Case managers are responsible for linking clients with services authorized by the treatment plan.

Synthesis of Relevant Findings

- There is much we do not know about the treatment of children and adolescents with behavior disorders. Many of the treatments currently in use for various childhood problems have not been empirically tested.
- Various types and approaches of outpatient therapy have been proven to have positive effects in the treatment of emotional and behavioral disorders.
- With the exception of ADHD, there are no behavior disorders of childhood or adolescence which are shown to be treated more effectively with medication alone, rather than with a combination of medication and psychotherapy.



- There is not much difference among the various treatment guidelines/protocols developed by the MCOs regarding recommended treatment modalities. However, the range of specificity among them varies.
- Administrators of MCOs and CMHCs view the utilization of treatment guidelines/protocols as a vehicle to standardize practice, to provide quality care, and to raise the providers' awareness about their own accountability.
- Private clinicians use treatment guidelines/protocols to help them comply with the requirements of the MCOs.
- Some clinicians from CMHCs are more impacted by managed care than others. The difference rests in whether they are responsible for obtaining service approvals, which can take time away from clients, and on their agencies' resources. For example, some agencies are able to cover services not approved by the MCOs. In addition, capitation allows some MHCs to provide a wider array of services without being constrained by insurance companies as long as services do not exceed a pre-determined amount.
- While many clinicians are not very familiar with the treatment protocols/guidelines, most clinicians are operating within the guidelines most of the time due to the range of therapeutic techniques included in most guidelines. Treatment guidelines may serve best as a reference treatment for unusual diagnoses.

Policy Implications

Findings from the current study which should be of concern to policymakers, legislators, administrators from insurance companies, and administrators from agencies and organizations that provide mental and behavioral health services are highlighted.

- **Protocols vary tremendously** in breadth, depth, quality, and intended use.

Implication: Consequently, protocols vary in clinical utility. If a carpenter needs a set of allen wrenches of varying sizes to complete a sound cabinet, having just a hammer available won't do. Good tools are vital to good work. Clinical practice guidelines, if they are to have sound clinical utility, will reference established scientific and professional guidelines (such as those by the American Academy of Child and Adolescent Psychiatry), which have summarized the known clinical research by teams of experts. They will be updated with regularity. They will include all known effective and efficacious treatments for disorders. Terminology needs to be clearly defined; "cognitive therapy" may mean different things to different clinicians. In order for clinical practice guidelines to have maximum clinical utility, they will need to take into account the influence of such moderating factors as client variables (i.e. functional impairment, subjective distress), ethnic background of the client, and co-morbidity.

- **There are many barriers** to use of guidelines on the practice level. Barriers identified in this study included: 1) Lack of exposure to the protocols, 2) Clinician resentment that protocols call into question their clinical judgment, training and expertise, 3) Concern that the protocols are so comprehensive that there is no way an individual will be able to be completely in compliance, and 4) Protocols that do not reflect the relevant research.

Implications: Barriers 1, 2 and 3 are likely to be reduced substantially with education and training in the content and expected clinical utility of the treatment



guidelines in practice. In addition to education about the guidelines, discussion groups or meetings with clinicians and administrative staff together (in agency settings) may also be a way that concerns about treatment guidelines can be addressed. The fourth barrier can be ameliorated by the creation of scientifically sound protocols, which draw from current scientific clinical practice guidelines (see <http://www.guidelines.gov> for examples). Administrators should be aware of ways in which their clinical practice guidelines may fall short and not reflect the current clinical knowledge base (for example, if they are due to be updated every 2 years, and it has been 22 months since the last iteration).

- **Protocols are not all-encompassing.** It is unlikely that any set of treatment protocols for mental and behavioral disorders of children and adolescents can be completely comprehensive. There is often a gap between results from the laboratory or university settings where the randomized controlled trials showing efficacious treatments or children and adolescents are often conducted, and the results of similar treatments in real-world clinical settings. It requires time, money and training to provide efficacious treatments.

Implications: Ongoing training and support for clinicians to understand and put into practice efficacious treatments that are outlined in good treatment guidelines will be needed. It is also important to note that this money spent on training and support for efficacious treatments can lead to reduced costs by preventing expensive services such as inpatient hospitalization or incarceration. When good care is provided, investment of resources can lead to better clinical outcomes for children and adolescents as well as reduced costs. Funding and evaluating the following types of demonstration projects would help to provide additional information about the utility of guidelines at the practice level, and the utility of particular treatments in the community: a) Test the application of MCO treatment protocols in community settings b) Test the application of specific empirically validated treatments for particular disorders or presenting problems in community settings, c) Provide specific training to clinicians in guideline usage, d) Provide specific training to clinicians at community-serving agencies in particular efficacious treatments (such as MST).

- **Protocols have been widely adopted** by MCOs and CMHCs. Administrators at MCOs report requiring use of clinical practice guidelines primarily for quality and consistency in service provision. Administrators at CMHCs use protocols primarily because funders and accreditors require them, and secondarily to aid in provision of quality services.
- **Protocols are rarely used** by clinicians to guide clinical services.

Implication: It is vitally important to examine how much clinicians may already be doing what is recommended in the protocols, and what differences compliance with protocols may make at the level of practice. Until we know the impact of protocols on outcomes, it is not sound policy to mandate their use.



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