Behavioral Health and Rehabilitation Services Brief Treatment Report

2004 - 2009

Allegheny HealthChoices, Inc.
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Introduction

As recovery and resiliency oriented care models have taken hold in the behavioral health care system, there has been continued interest in developing family systems based treatment strategies. Family systems based treatment strategies empower children and adolescents with mental health needs, and their families, to become the agents of positive change in their lives. (See box below.) The increased adoption of this philosophy has resulted in the development and refinement of many different child- and adolescent-specific models of care; two such examples are Behavioral Health and Rehabilitation Services (BHRS), and the Brief Treatment model of BHRS, which are both built around the family systems approach to behavioral health care.

BHRS are the second most commonly used behavioral health services for children and adolescents in the HealthChoices program, and make up nearly one-third of total expenditures on behavioral health services for this age group. Since becoming available in Allegheny County in 2004, the Brief Treatment adaptation of BHRS has been adopted by an increasing number of providers, children and their families. This report uses information gathered from claims data, provider feedback, and consultation with Community Care Behavioral Health[1] to analyze and discuss how Brief Treatment has changed since its introduction and reasons for why changes have occurred. This report also examines how Brief Treatment has been successful in meeting goals that were established for this level of care when it was created.

A Family Systems Approach to Treatment

One component of Family Systems Theory is that the family system acts from within as the creator of rules and expectations for family members. Under this theory, meaningful, lasting behavior change must be internally generated by the family, and cannot be imposed by external forces. Traditional and Brief Treatment forms of BHRS therefore focus on teaching families the skills they need to become the locus of change within their own family system.

Overview of Brief Treatment

Brief Treatment is a specialized form of BHRS, which provides mobile therapy and behavioral interventions to children[2] with emotional or behavioral disorders. Community Care Behavioral Health worked collaboratively with BHRS providers to develop this model of care, which became an approved, Medical Assistance covered service in July, 2004. The primary goal of implementing Brief Treatment was to facilitate expedited access to master's level clinical services for children who did not require the intensiveness of traditional BHRS. Brief Treatment services are intended for children and families whose treatment needs do not include high levels of behavior modification and practice with support staff; these individuals would likely be better served by traditional BHRS.

[1] Community Care is the behavioral health managed care organization in Allegheny County for the HealthChoices program.

[2] "Children" in this document refers to both children and adolescents under the age of 21 years.

In addition to providing more timely access to services, Brief Treatment was also introduced to allow for continuity of care for children stepping down from traditional BHRS, to facilitate rapid access to mobile therapy for children leaving inpatient settings, and to make "booster" therapy sessions available (up to 3 non-consecutive, 2-week sessions of Brief Treatment services in the year following discharge from Brief Treatment). Brief Treatment has also shown promise as a way to provide services to children and families new to behavioral health whose treatment needs are not yet comprehensively understood.

Brief Treatment services are provided by either a master's or doctoral level mobile therapist (MT) or behavioral specialist consultant (BSC) in the home or other community settings for up to six hours per week. Mobile Therapists have traditionally provided child-centered, family focused individual and family therapy. One goal of implementing Brief Treatment was to expand the role of the MT by allowing therapists with experience in behavior modification to develop, implement, and assess behavior plans. Behavioral Specialist Consultants focus on modifying problematic behaviors through the development of behavior management plans. The BSC primarily interacts with the child and family, and school to develop plans and supervise implementation; BSCs do not provide mobile therapy. Brief Treatment does not include therapeutic staff support[3] (TSS) services.

Although traditional BHRS and Brief Treatment both utilize the same types of master's level clinicians to deliver treatment, there are significant differences in how the two types of services are accessed and delivered. A detailed outline of the differences between Brief Treatment and traditional BHRS can be found in Table 1 on the next page.

One difference between traditional BHRS and Brief Treatment is how medical necessity criteria (MNC) is established. Both levels of care require a referral, an evaluation from a master's level or higher behavioral health clinician, and a planning meeting involving the family, child, BHRS clinician, and other parties as appropriate. The referral, evaluation, and meeting process for traditional BHRS can take up to 19 business days, which is largely due to the required completion of a

BRIEF TREATMENT
What's in a Name?

Since it was introduced in 2004, many prescribers, providers and families have felt confused or hesitant about using Brief Treatment due to its name. The following clarifications address some common misinterpretations:

Brief Treatment is **not** limited to short durations of treatment, and may be prescribed for up to 72 weeks.

Brief Treatment does **not** "work faster" than other types of behavioral treatment

Brief Treatment is **not** associated with brief models of psychotherapy.

Brief Treatment does provide expedited access to master's level community-based behavioral health treatment.

[3] Supervised by the BSC and/or MT, TSS are non-clinical staff who work with the child to reinforce therapeutic activities and behavioral goals.

Best Practice Evaluation (BPE)[4] by a psychiatrist, psychologist or developmental pediatrician. The treatment plan for traditional BHRS is informed by the BPE, and must be completed before services can begin.

Determining MNC for Brief Treatment can be completed in as quickly as a few days. Following a referral to a BHRS provider, the evaluation for Brief Treatment can be completed in one day since it does not need to follow the format of a BPE; it is not uncommon for the evaluation and the planning meeting to occur on the same day. Instead of using the BPE to inform the treatment plan, Brief Treatment clinicians have up to five weeks of treatment and observation in the child's natural setting before a formal treatment plan is written and submitted to Community Care. This allows clinicians to gain better insight into the intensity of services needed and desired, as well as the family's ability to commit to weekly services. The streamlined process for establishing MNC for Brief Treatment provides faster access to services - one of the goals in establishing this level of care - without detracting from the quality of treatment.

If a provider offers both Brief Treatment and traditional BHRS, Brief Treatment also facilitates movement between these services while preserving the relationship between the clinician, child, and family. For example, if at any time during Brief Treatment the clinician and family decide that the child's needs would be met better by traditional BHRS, and MNC for this service is determined, the child may transition to traditional BHRS while maintaining their MT or BSC. The reverse is also true: if a child no longer needs the intensiveness of traditional BHRS, they may "step down" to Brief Treatment while maintaining their MT or BSC. This was another of the original goals of implementing Brief Treatment that has been observed in practice.

Table 1. Comparison of Brief and Traditional BHRS Treatment

	Brief Treatment	Traditional BHRS
Establishing Medical Necessity	Evaluation from a BH provider, and a letter of recommendation from a psychiatrist or licensed psychologist.	Best Practice Evaluation from a psychiatrist, psychologist or developmental pediatrician.
Service Mix	Either MT or BSC services	Combination of MT and/or BSC services, with possible TSS
Treatment Plan	Due within the first five weeks of treatment	Due before treatment begins
Service Duration	Maximum of 72 weeks	No maximum
Service Intensity	Maximum of 6 hours per week	No maximum
Availability of booster sessions	Yes	No

[4] Best Practice Evaluations are a formalized assessment process for determining recommendations for traditional BHRS prescriptions. Guided by the managed care company's performance standards, the format of the written evaluation is highly structured, detailed, and is based on information gathered by a psychiatrist, psychologist or developmental pediatrician during an interview with the child and family.

Brief Treatment Demographics

While the number of children using Brief Treatment has increased in recent years, the gender demographics of this group have been consistent over time, with an average of 65% of Brief Treatment service users being male and 35% being female. While the higher proportion of males to females is not representative of HealthChoices enrollment in Allegheny County for members under 21 years old, it is reflective of the demographics of the diagnostic groups that commonly receive BHRS.

Over time, small changes have occurred in the racial breakdown of Brief Treatment service users, although the majority of children have consistently identified as Caucasian, with the second largest racial group being African-American (see Table 2). These two racial groups have been represented nearly equally in HealthChoices enrollment for members under 21 years old, from 2004 through the first half of 2009, with each representing an average of 48% of enrolled children. Compared to the demographics of children's HealthChoices enrollment, there has generally been an overrepresentation of Caucasian members and an underrepresentation of African-American members among Brief Treatment service users.

Table 2. Race and Age Demographics for Brief Treatment Service Users from 1/1/2004 to 6/30/2009

		2004	2005	2006	2007	2008	2009
Race	**African-American**	39%	35%	43%	46%	38%	38%
	Caucasian	57%	62%	56%	49%	55%	57%
	Other	3%	3%	1%	5%	7%	5%
Age	**0 – 5 years**	5%	3%	4%	7%	7%	10%
	6 – 12 years	46%	45%	45%	41%	49%	49%
	13 – 17 years	43%	45%	44%	43%	37%	35%
	18 – 20 years	5%	6%	7%	8%	7%	6%

Slightly more children identifying as members of other racial groups have used Brief Treatment in recent years than at the time of its introduction. This is likely a reflection of changes that have occurred in the demographics of children's HealthChoices enrollment. All racial groups have seen fluctuations in the number of units of Brief Treatment used per member, but these fluctuations do not follow trends, and do not appear to be indicative of disparities.

The population of members that use Brief Treatment is slightly older than the population of traditional BHRS service users. The majority of Brief Treatment service users are between ages 6 to 17 years old, with a slightly higher proportion of adolescents 18 to 20 years old than traditional BHRS. Beginning in 2007 and 2008, the proportion of young children using Brief Treatment services increased slightly. From the perspective of providers, this is due to increased use of Brief Treatment to start new families with young children in behavioral health services. Many of these families are referred to providers through agencies that focus on increased awareness and early intervention for children experiencing behavioral health problems. Providers have found that

these families tend to find Brief Treatment an appropriate service because it is not extremely time intensive, it is provided in their home and community settings, and because they feel the service is not disruptive to the family.

Common Diagnoses for Children in Brief Treatment

Brief Treatment is not limited to specific diagnostic groups. It is indicated for children who are likely to benefit from mobile service and who are not in need of intensive behavioral interventions. This includes the use of MT or BSC for members and families who need assistance in generalizing therapeutic skills from a clinical setting to their natural environment.

Children with a diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD) make up the largest diagnostic group in Brief Treatment; this has been consistent over time. The proportion of children that used Brief Treatment who had a primary diagnosis of ADHD remained close to 25% until 2008, when it increased slightly to 27%. In the first half of 2009, the ADHD diagnostic group increased to 30% of children that used Brief Treatment.

The proportion of children with a primary diagnosis of Autism Spectrum Disorder (ASD) increased from 7% to 14% of Brief Treatment service users in 2006, and has been consistent since that time. Many children with an ASD diagnosis require higher levels of repetition and practice to reinforce new behaviors, which may necessitate the use of TSS and traditional BHRS. Some providers have increasingly started these children in Brief Treatment services in order to allow a BSC or MT time for a thorough, community-based assessment of the treatment needs and service intensity that the child and family need.

The proportion of children that used Brief Treatment who had a primary diagnosis of an emotional disorder (primarily Oppositional Defiant Disorder) has declined slowly but consistently since 2007. Other diagnostic categories, such as Adjustment Disorder, showed minor increases or decreases from 2004 to June 30, 2009, but there were no clear indications of developing trends in diagnosis.

Brief Treatment Utilization

From its introduction on January 1, 2004 through June 30, 2009, 2,157 children used Brief Treatment services (see Table 3 on the following page). During that time, Brief Treatment service users made up 23% of the total number of children that accessed any type of BHRS. In the first year Brief Treatment was offered (2004), children using Brief Treatment made up 9% of members using any type of BHRS. This proportion increased to 16% in 2008, and remained at 15% through the first half of 2009.

Table 3. Number, Percent of Members that used Brief Treatment, from 1/1/2004 to 6/30/2009

	2004	2005	2006	2007	2008	2009*	Total**
Total BHRS Users	3,137	3,576	3,881	4,190	4,466	3,863	9,488
Number of Brief Treatment Users	293	354	263	350	719	580	2,157
% Brief Treatment Users	9%	10%	7%	8%	16%	15%	23%

*Values for 2009 appear low because they only reflect activity in the first half of the year. Claims data for all of 2009 was not yet complete at the writing of this report.

**Represents non-duplicated numbers. Because many children used both Brief Treatment and traditional services over the course of this 5-year period, but not necessarily in the same calendar year, the total proportion of Brief Treatment users out of all BHRS users is higher than the proportion in any one year.

In contrast to the proportion of service users, Brief Treatment only made up 4% of total BHRS paid claims between January 1, 2004 and June 30, 2009, or approximately $8.7 million. Brief Treatment accounted for approximately 3% of total BHRS paid claims until 2008, when this percentage increased to 7%. In the first half of 2009, the proportion of BHRS claims that were for Brief Treatment increased to 8%.

There are a number of factors that have contributed to the increases in Brief Treatment utilization and paid claims. As a service category, BHRS has grown continuously since 2004, which is a reflection of increased demand for BHRS services for children in Allegheny County with a diagnosis of Autism Spectrum Disorder (ASD) or Attention Deficit/Hyperactivity Disorder (ADHD). The number of HealthChoices members under 21 years old who accessed services and had one of these diagnoses in Allegheny County increased by 60% from 2004 to 2009. As these diagnostic populations have grown, BHRS has expanded in capacity in order to meet the HealthChoices population's need for these services.

In 2008, there was a notable increase in the number of children that used Brief Treatment. This increase was the result of a combination of clinical and operational factors. Observing the value of Brief Treatment, Community Care began to encourage its use by increasing compensation to providers for this service in July, 2008. It made the decision to increase the payment rate for Brief Treatment to encourage BHRS providers to consider opening new cases with a single Master's level clinician (MT or BSC). The rationale for this is that by using Brief Treatment, services can begin immediately, and the clinician has more time to interact with the child and family in their natural environment before developing the treatment plan. Additionally, providers, many of whom had already been using "MT only" or "BSC only" versions of traditional BHRS, began to bill this treatment as "Brief Treatment" as their understanding of the model improved, and hesitancy associated with the name diminished.

Also in 2008, three larger BHRS providers decided to use Brief Treatment exclusively or nearly exclusively, as they believed the therapeutic needs of the individuals they served were better met by this service. In 2008, 45% of the children that used Brief Treatment received treatment from one of these three providers. These providers expressed that they prefer to use Brief Treatment because by limiting the number of hours of service delivered to 6 hours per week, clinicians are

able to maintain the role division between the family and the provider of services. With the family clearly identified as the agent of change, family members are able to take ownership of positive outcomes that occur over the course of treatment, which increases the likelihood that the changes will last beyond the episode of care.

Service Types: MT, BSC, and Boosters

Within Brief Treatment, children may receive treatment services from either a Mobile Therapist or Behavioral Specialist Consultant. As Table 4 shows, MT has consistently been prescribed more frequently than BSC. In 2004, BSC was authorized for 20% of children using Brief Treatment services; by 2007, only 4% of children in Brief Treatment were authorized for BSC. The percentage of children with authorizations for BSC has since increased to 11% in the first half of 2009.

Table 4. Percentage of total Brief Treatment Service Users Authorized for MT, BSC, and Boosters from 1/1/2004 to 6/30/2009

	2004	2005	2006	2007	2008	2009
MT	80%	83%	88%	95%	90%	89%
BSC	20%	13%	9%	4%	11%	11%
Booster	3%	6%	4%	4%	2%	1%
Total Members Authorized for Brief Treatment	299	358	269	359	732	592

Percentages do not sum to 100% because although children will only receive one service at a time, they may receive more than one type of service over the course of a year.

One goal of implementing Brief Treatment was to expand the role of the MT to include behavior consultation and collateral therapy. To meet this goal, the role of the MT was expanded such that MTs with experience in developing and implementing behavior management plans are able to function as the primary behavioral consultant. Before Brief Treatment was introduced, these activities may have been conducted by consultation with a BSC. By expanding the MT role in this way, MTs are now able to provide therapy as well as behavior interventions and consultation to the child, family, school officials and other parties as necessary. Behavioral Specialist Consultants are used less frequently than MT in Brief Treatment because these clinicians cannot deliver both behavior and therapeutic services.

The use of "booster sessions" of Brief Treatment has remained very low. "Booster sessions" are three non-consecutive, two-week sessions of MT or BSC available in the year following discharge from Brief Treatment. The highest number of children authorized to use booster sessions in any year was 20 children in 2005, representing 6% of all children authorized for Brief Treatment in that year. In 2006, the maximum Brief Treatment authorization period was extended from 36 to 72 weeks. Following this change, booster sessions were authorized for fewer than 5% of children with any type of Brief Treatment authorization. Providers have found that if children and families need to access services in the year following their Brief Treatment discharge, the family usually prefers

to open a new, full-length episode of care. In these cases, the family usually feels that the problems they are experiencing are not able to be resolved in the two-week time frame provided by a booster session.

Services Before, During and After Brief Treatment

The percentage of children that used at least one other behavioral health service in the 90 days before their Brief Treatment authorization has fluctuated slightly since 2004 (see Table 5), with an average of 78% of children having claims for other HealthChoices-funded behavioral health care prior to Brief Treatment. An average of 22% of children do not receive HealthChoices services in the 90 days before their Brief Treatment authorization, with a low of 15% in 2008 and a high of 27% in 2006. This indicates that providers are using Brief Treatment to introduce families to behavior health services, or to re-introduce children that have been inactive in the system for at least 90 days.

Table 5. Percentage of Brief Treatment Users That Accessed Other Services Before Brief Treatment

Other Services?		2004	2005	2006	2007	2008	2009
90 Days Before Brief Treatment	Yes	82%	76%	73%	76%	85%	78%
	No	18%	24%	27%	24%	15%	22%

The age group least likely to have received services before Brief Treatment is children ages 6 to 12 years old. It is likely that children in this age group did not access services previously because conduct and/or attention problems are often identified after children begin attending school. The percentage of children ages 0 to 5 years old that did not receive services in the 90 days before Brief Treatment has increased as the representation of that age group has grown within Brief Treatment; however, it should be noted that this remains a very small number of individuals.

The types of services most frequently accessed before Brief Treatment are traditional BHRS (average of 30% of members authorized for Brief Treatment), medication checks (28%), outpatient mental health (27%), and service coordination (26%). The proportion of children that used traditional BHRS in the 90 days before Brief Treatment increased steadily from 20% in 2005 to 43% in 2008, after which it fell sharply in the first half of 2009 to 18%. Many other types of service were accessed by a small number of children in the 90 days before their Brief Treatment authorization, including more restrictive levels of care. This indicates that Brief Treatment has accomplished the goal of being a resource for children active in the behavioral health system who require increases or decreases in the intensiveness of services. This conclusion is also supported by provider feedback; depending on the acuity of the population of children they serve, different providers note that they use Brief Treatment as a step up or down in treatment intensiveness.

During the course of Brief Treatment, an average of 34% of children use medication checks, 33% use service coordination, and 25% access outpatient mental health services (see Table 6). While many other types of services overlapped with Brief Treatment, these three services stand out as the most common concurrently accessed services by children receiving Brief Treatment. These

appointments are for medication maintenance and other non-therapeutic services outside of what the MT or BSC can deliver. Medication checks are appropriate for children that are prescribed psychiatric medications and allow their psychiatrist to evaluate prescription effects and concerns and to make adjustments as needed.

Table 6. Percentage of Brief Treatment Users That Accessed Other Services During Brief Treatment

	2004	2005	2006	2007	2008	2009
Medication Checks	36%	36%	34%	30%	39%	27%
Service Coordination	30%	25%	21%	22%	26%	27%
Outpatient MH	35%	40%	32%	26%	30%	33%

Percentages do not sum to 100% because children may receive more than one type of service over the course of a year.

In the 90 days following discharge from Brief Treatment, an average of 27% of children did not access other types of behavioral health care (see Table 7). This percentage has fluctuated slightly over time, with a low of 24% in 2005, and a high of 31% in 2007. The group of individuals that did not receive services following Brief Treatment is a representative sample of Brief Treatment service users; no single age or diagnostic group was overrepresented. Unlike more acute levels of care, an absence of follow-up after discharge from Brief Treatment is not necessarily seen as an indicator of disengagement. From a provider's point of view, children who are discharged without aftercare (as opposed to children who are referred to other levels of care) and their families should possess the skills needed to be the primary agents of behavior management. Providers state that they only discharge families from Brief Treatment without referrals for other services once they and the family feel that the family is prepared to take on this role.

Table 7. Percentage of Brief Treatment Users Who Access Other Behavioral Health Services After Brief Treatment

Other Services?		2004	2005	2006	2007	2008	2009
90 Days After Brief Treatment	Yes	73%	76%	73%	69%	71%	74%
	No	27%	24%	27%	31%	29%	26%

The most frequently accessed services in the 90 days following discharge from Brief Treatment were service coordination (average of 29% of children discharged from Brief Treatment), medication checks (27%), traditional BHRS (27%), and outpatient care (21%). On average, 19% of children discharged from Brief Treatment go on to begin another episode of Brief Treatment within 90 days (where there is more than a one-day gap in Brief Treatment authorizations), although this proportion has increased continuously, reaching 27% in 2008. The percentage of children that "step up" to traditional BHRS has declined from a high of 37% in 2004, to a low of 14% in the first half of 2009. Again, outpatient and medication checks are accessed mainly for psychiatric medication management, and service coordination provides other non-therapeutic services.

Collectively, this service data indicates that Brief Treatment has generally been used as a way to introduce children to behavior health services, and as a way for children to "step down" from more intensive services. While some children do step up to traditional BHRS after Brief Treatment, many continue with less intensive services, or no services.

Conclusions and Recommendations

Since its introduction in 2004, BHRS Brief Treatment has been increasingly recognized as an important addition to the types of services available for children with mental and behavioral health care needs. As the managed care organization has educated providers about Brief Treatment and encouraged its use, it is clear that Brief Treatment has met many of the goals it was developed to achieve. The continued expansion of Brief Treatment is a positive trend because it facilitates access to treatment, allows for thoroughly informed treatment planning, provides flexibility in service delivery, and allows for transitions to more or less intensive BHRS while preserving the therapeutic alliance and empowering the family.

As the population of children in Allegheny County that need BHRS continues to grow, AHCI recommends that the goals of Brief Treatment be expanded to include starting children and families new to services in Brief Treatment. Once enrolled in Brief Treatment, the extended treatment planning period may be used to inform whether traditional BHRS would address the needs of the family better than a master's level clinician only, and if necessary, how intensive additional services should be. Brief Treatment has the ability to increase the efficiency of service access and delivery, and can help ensure that limited resources are distributed most effectively. This is beneficial to all stakeholders within the service system.

AHCI also recommends that Community Care continue to work internally, and with providers, family members, and the Pennsylvania Office of Mental Health and Substance Abuse Services to formally change the name of Brief Treatment. Since its introduction, the name "Brief Treatment" has been a stumbling block in the acceptance of this service. Prescribers and providers, and many parents, are still hesitant to use Brief Treatment due to confusion about what "brief" really means. Changing the name may help these groups be more open to considering Brief Treatment.

Finally, due to the very low utilization of booster sessions, we recommend that Community Care facilitate a dialogue with providers and family members to discuss the value of maintaining this element of Brief Treatment.

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Allegheny HealthChoices, Inc. (AHCI) is an innovative non-profit agency dedicated to supporting the provision of high-quality mental health and substance abuse treatment. Our mission is to assure equitable access to high quality, cost-effective behavioral health care that promotes positive clinical outcomes, recovery, and resiliency.

Visit us at www.ahci.org to learn more about our projects and services in Allegheny and other Southwestern Pennsylvania counties.

AHCI is a contract agency for the Allegheny County Department of Human Services' HealthChoices Program.