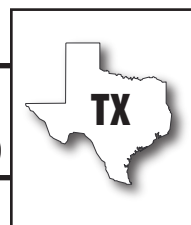

Texas (Group One: State-Developed Guidelines)

- Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)



Overview

For many years, the Texas public mental health system used the Child Behavior Checklist (CBCL) and the Community Functioning and Problem Behavior Rating Scale to measure child outcomes and evaluate system performance, but not for clinical decision making. Presently, the public mental health system is in the midst of implementing a far-ranging new initiative, the Resiliency and Disease Management Initiative, the overall aim of which is to define a service package and financing methodology for community mental health services for both adults and children. The Initiative is intended to better define the following: who is eligible for community mental health services; what services will be provided; methods for managing utilization; consistency regarding the cost and pricing of services; and expected outcomes of services. As part of this Initiative, the State developed its own set of clinical decision making guidelines for required use by local mental health authorities and their providers. The guidelines for children are known as the Child and Adolescent Texas Recommended Assessment Guidelines, or CA-TRAG. The CA-TRAG is used by clinicians at Local Mental Health Authorities (LMHA) and by LMHA providers to assess service needs and to recommend a level of care for children and adolescents, ages 3-17, in the public mental health system. It yields quantitative scores that determine eligibility for services and level of care. The guidelines are fundamental to utilization management in the system. In addition, the CA-TRAG forms the basis of the mental health system's Child and Adolescent Evaluation Assessment, which is the instrument the State uses to assess system outcomes.

Goals

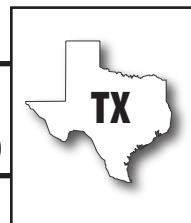
The State's User Manual for the CA-TRAG describes the goals of the CA-TRAG as two-fold: "first, to develop a systematic assessment process for measuring mental health service needs among children and adolescents based on their principal diagnosis and ten domains; and, second... to propose a methodology for quantifying the assessment of service needs to allow reliable recommendations for authorization into the various levels of care with specified types and amounts of services."³⁰ The manual notes that the CA-TRAG was developed in response to concerns expressed both by clinicians and system administrators about the need for a common framework across the State for making decisions on level of care placement and outcomes related to the treatment of children and adolescents in the public mental health system. In addition, the manual describes a history in children's mental health of: "inequities in care" and "great variability in the types and amounts of services provided to children and adolescents that cannot be explained by differences in specific needs for care (e.g., diagnosis, intensity of symptoms, level of functioning)." ³¹ It notes that, "in a system constrained by limited resources, it is critically important to distribute treatments and services in accordance with identified needs

³⁰ State of Texas, Department of State Health Services (November, 2005). User's manual for the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG), Version 3.0. Available http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf <http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf>.

³¹ Ibid.

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and appropriateness of the service modality.³² The State's goals in developing the CA-TRAG had both to do with consistency and equity in service provision and a desire to move the system toward evidence-based, best practice service delivery consistent with principles of resiliency, disease management, and recovery.

Background

Before making the decision to develop its own set of guidelines, the State looked at numerous existing guidelines, including some developed by clinical researchers, some developed by managed care companies, and some developed by other states. These were rejected for a variety of reasons. With over 40,000 children and adolescents involved in the public mental health system, the State wanted to promulgate use of guidelines that would be relatively easy for many providers to use, and, based on its experience with using the CBCL, the State reportedly was not particularly interested in using another proprietary instrument or in having providers use multiple instruments. For example, the State found that several other states use proprietary instruments, such as the Child and Adolescent Functional Assessment Scale (CAFAS), for subsets of children, but Texas was interested in using only one instrument for all children. In addition, philosophically, some State stakeholders felt that models developed with public funds should be in the public domain and that states should not have to use limited dollars to purchase them. As another example, the State decided not to use the CALOCUS (now CASII) because, according to Texas stakeholders, it encompassed levels of care that Texas did not have and thus would need adaptation. Other instruments were rejected as too costly to train clinicians in their use, too complicated or long for clinicians to use, or not sufficiently attentive to the needs of children and adolescents or to issues of poverty or to co-occurring disorders in children.

The State developed a set of principles to guide development of its own clinical guidelines. These principles included:

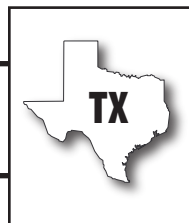
- The instrument should be easy to understand and use by clinicians
- The domains assessed should be quantifiable and should promote consistent clinical judgment
- Level of care or service package descriptions should be brief and clear to ensure uniformity and efficiency
- Level of care recommendations should be made appropriately to ensure correct responses to the needs of children and adolescents.³³

³² Ibid.

³³ Ibid.

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The process the State used to develop the CA-TRAG included holding a Consensus Conference with national experts and Texas stakeholders, including family members, review of the literature and state of the science, and a small workgroup that included representatives from the State, the local mental health authorities, and family members.³⁴ In addition to the principles and goals noted earlier, the workgroup reportedly was guided by the very real concern of using extremely limited dollars wisely. State-level stakeholders thus wanted to ensure that the clinical decision making process would encourage provision of services shown to be effective in the literature. State-level stakeholders believe that the CA-TRAG does allow for an individualized approach to care but within parameters that promote certain proven treatment approaches. Some family members, however, have expressed concern that, by choosing specific treatment models, the CA-TRAG moves away from an individualized, wraparound approach to service planning.

The State developed an initial version of the CA-TRAG, which it tested for reliability and validity in the summer of 2003, and then issued a second version in the fall of 2003. The State began implementation in four pilot sites but went statewide with implementation in the fall of 2004 in accordance with Texas House Bill 2292. The State Medicaid Plan was changed in order to encompass the service packages described in the CA-TRAG.

State-level stakeholders reported that as they began implementation with the first four pilot sites, they did meet initial resistance, particularly from licensed clinicians, and that certain decisions made with respect to evidence-based practices were controversial. For example, the State's review of effective practices indicated mixed evidence of efficacy for day treatment and so, ultimately, it was not included within Resiliency and Disease Management levels of care, creating concerns among day treatment providers. On the other hand, families reportedly were more supportive of dropping day treatment as they preferred having their children remain in regular classroom settings with appropriate supports and were sensitive to the expense of day treatment within the context of resource limitations. As another example, cognitive behavioral therapy, an evidence-based practice, is not practiced by all licensed clinicians and thus requires a change in practice not necessarily easy or possible for all clinicians to make. Family preservation programs, around which evidence was mixed, are not included in CA-TRAG while Multisystemic Therapy (MST), is. On the other hand, stakeholders noted that for some providers, for example BA-level staff that can provide skills training, the guidelines and manualized approach of CA-TRAG create greater confidence and consistency for service delivery.

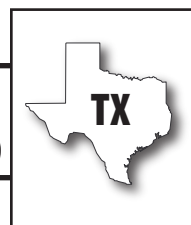
Description

The CA-TRAG includes diagnostic categories and ten domains for assessment purposes. Diagnosis is organized under three large categories: Externalizing Disorders; Internalizing Disorders; and Bipolar, Schizophrenia, Major Depressive Disorder with Psychosis and Other Psychotic Disorders. Diagnosis is considered one key factor for determining the level and type of service that may be needed, and each level of care includes diagnosis-specific interventions

³⁴ Papers from the Consensus Conference are available on the Texas website: www.dshs.state.tx.us/mhprograms/RDM.shtml

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documented in the literature. For example, cognitive behavioral therapy is a recommended treatment associated with diagnoses under the Internalizing Disorders category. The User Manual acknowledges that sometimes children have multiple diagnoses or do not fit clearly into any one major category. The manual provides guidance that, in those instances, three factors should be considered: (1) what problem is causing the most impairment; (2) what issue is the most amenable to treatment; and (3) what services do the child or family see as being most beneficial.³⁵

In addition to diagnostic category, the CA-TRAG requires assessment across ten domains, which are associated with intensity of services needed. The ten domains include:

1. Ohio Youth Problem Severity Scale (OYPSS; Ogles et. al., 1999)
2. Ohio Youth Functioning Scale (OYFS; Ogles et. al., 1999)
3. Risk of Self-Harm
4. Severe Disruptive or Aggressive Behavior
5. Family Resources
6. History of Psychiatric Treatment
7. Co-Occurring Substance Use
8. Juvenile Justice Involvement
9. School Behavior
10. Psychoactive Medication Treatment.

Texas stakeholders noted that they incorporated the Ohio Scales in order to support family and youth input as the best source of information on problem severity and functioning. In most instances, multiple criteria are listed under each domain, although only one criterion is needed to assign a rating within a domain. For the most part, domains are rated on a scale of one (e.g., no notable limitations) to five (e.g., extreme limitations).³⁶

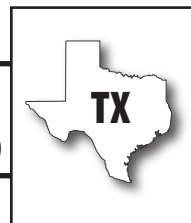
The CA-TRAG is used as part of the clinical intake interview for children and adolescents involved in the public mental health system. The CA-TRAG score determines eligibility for services and determines assignment to one of four levels of care. It also is used for outcome measurement and must be completed at intake, every 90 days, and at termination of services. Finally, the CA-TRAG scores also are used for purposes of re-authorizing service provision. While the CA-TRAG may be administered by a case manager, the diagnosis (which is part of the level of care determination) must be made by a licensed professional. Clinicians are not allowed to use other instruments to make level of care recommendations, which essentially are approved through the public mental health system's utilization management process. For children who were already involved in the system prior to implementation of CA-TRAG, there

³⁵ Ibid

³⁶ State of Texas, Department of State Health Services (November, 2005). User's manual for the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG), Version 3.0. Available http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf <http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf> .

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was a retroactive assessment process using the CA-TRAG. In addition, the old assessment system was “turned off,” and CA-TRAG was fully automated such that the computer assigns level of care based on the clinician’s data. Providers are not reimbursed for services if they fail to use the CA-TRAG for initial evaluations and 90-day re-evaluations (re-evaluations can occur at any time but no less than 90 days).

The four levels of care associated with the CA-TRAG include the following:

- **Crisis Services**
- **Level of Care 1:** Brief Outpatient
 - Service Package 1.1: Brief Outpatient (Externalizing Disorders)
 - Service Package 1.2: Brief Outpatient (Internalizing Disorders)
- **Level of Care 2:** Intensive Outpatient
 - Service Package 2.1: Intensive Outpatient (Externalizing Disorders— Multi-Systemic Therapy [MST])
 - Service Package 2.2: Intensive Outpatient (Externalizing Disorders)
 - Service Package 2.3: Intensive Outpatient (Internalizing Disorders)
 - Service Package 2.4: Intensive Outpatient (Bipolar Disorder, Schizophrenia, Major Depressive Disorder with Psychosis or other psychotic disorders)
- **Level of Care 3:** Treatment Foster Care
- **Level of Care 4:** After Care, which essentially is medication maintenance and case coordination.

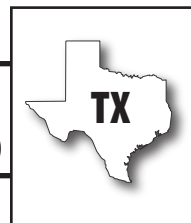
Each level of care describes particular packages of services. The User’s Manual encourages clinicians to recommend the level of care that is most effective while also the least restrictive.³⁷ The packages of services associated with each level of care include:

- **Crisis Services:** 24-hour triage; crisis assessment; case coordination; physician services; inpatient hospitalization, crisis respite (if available); and 23-hour observation.
- Brief Outpatient (**Level 1**) (Externalizing Disorders): psychosocial skill development; parenting skills; behavior management skills; support group; may also include medication management. This service package is considered to be relatively short-term, usually terminated within 90 days, for youth who do not have serious emotional disorders.
- Brief Outpatient (**Level 1**) (Internalizing Disorders): cognitive behavioral therapy; case coordination; family support, parent education. This service package is considered to be relatively short-term, usually terminated within 90 days, for youth who do not have serious emotional disorders.
- Intensive Outpatient (**Level 2**): This service package essentially includes four service clusters: For youth with externalizing behaviors: (a) Multi-systemic Therapy (MST), which

³⁷ Again, readers are encouraged to read the User’s Manual for a full description of the levels of care associated with the CA-TRAG.

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the mental health system is funding in partnership with the juvenile justice system, at present funding four teams in the Fort Worth area; (b) in areas without MST, intensive case management, skill-building, family peer mentors, wraparound service planning with some flexible support dollars. For youth with internalizing disorders: (c) cognitive behavioral therapy plus intensive case management, family peer support, wraparound service planning with flexible support dollars. For youth with Bipolar Disorders, Schizophrenia, Major Depressive Disorder with Psychosis or other psychotic disorders: medication management and stabilization, cognitive behavioral therapy, skill training, intensive case management, family peer mentors, wraparound service planning with flexible support dollars.

- Treatment Foster Care (**Level 3**): This level of care is available to children and adolescents at imminent risk of residential treatment due to severe aggressive or disruptive behavior. State-level stakeholders noted that, originally, they intended to use the Oregon Social Learning Model of Multidimensional Treatment Foster Care but were deterred by the cost and noted that they are still wrestling with how to build in sufficient training and supervision that is affordable.
- Aftercare (**Level 4**): Intended for children who have stabilized, includes medication maintenance and case coordination.

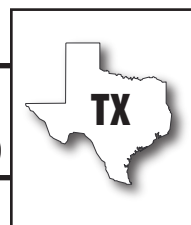
Individualized, Culturally Competent Family-Focus

One national expert reportedly advised the State during planning that particularly because of its severe resource limitations, the State should consider trying to have a “trans-generational impact” and reduce long term dependency on the system by incorporating strong supports for children, parents, grandparents, and extended family networks, and build child and family resiliency. In terms of CA-TRAG, all parents have access to family support groups, regardless of level of care, and all services can be provided out of the office (e.g., in home, at school etc.). In addition, all local mental health authorities are required by the State to employ or contract with family partners, and the State provides funding to the statewide family organization. The State is trying to support creation of family-run chapters in every locality but acknowledges this as a difficult effort, and has not yet been able to change Medicaid to support coverage of family peer mentors. As noted earlier, while State-level stakeholders believe that the CA-TRAG has sufficient flexibility to support an individualized approach to care, some family members argue that, by definition, level of care criteria create a certain rigidity around service decision-making.

The Ohio Youth Scales, an instrument that forms a part of the CA-TRAG, has been translated into Spanish. As discussed more fully below, State-level stakeholders expressed concerns that translation issues with some of the instruments—how they translate from English to Spanish—may be affecting accurate assessment of functional impairment issues among Hispanic children.

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Impact of Service Availability

State-level stakeholders noted that service capacity is basically unchanged since implementation of the CA-TRAG and is limited. There is recognition that children and adolescents who are assessed using the CA-TRAG may be recommended for service packages that are not available. State-level stakeholders noted that they expect to find, over time, that the CA-TRAG is assessing for higher levels of care than are available. That is a major reason why the State’s evaluation is documenting outcomes with respect to children who do receive recommended levels of care as compared to those who do not.

The User Manual, for example, discusses the possibility of “clinical over-ride” of CA-TRAG as primarily driven by resource limitations and suggests that clinicians indicate the appropriate CA-TRAG level of care recommendation even if they know the services are not available. The manual notes that “only then will it be possible to understand the real needs of children and adolescents as part of the evaluation...”³⁸ State-level stakeholders indicated their intention to use data from CA-TRAG to promote changes in the service array with the State legislature and executive budget staff. In the meantime, they believe CA-TRAG is being used to drive practice change.

Training, Fidelity, and Oversight

The State conducts its own one-day training on the CA-TRAG instrument and has contracted for training in some of the key effective practices encouraged by the CA-TRAG, including cognitive behavioral therapy, intensive case management, and a wraparound approach to service planning. The State has adopted a “train-the-trainers” approach in order to extend the reach of limited training resources and indicated that it has taken a lot of time to train providers.

The State has developed written fidelity measures for each level of care within the CA-TRAG, and has put in place performance contracts with all of its local mental health authorities. These contracts mandate the use of CA-TRAG and utilization of training that is available, in addition to program measures, such as that 85% of the Ohio Scales have to be reported by parents and a certain number of hours of skills training has to be provided.

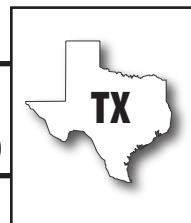
The Resiliency and Disease Management Initiative, of which the CA-TRAG is a part, incorporates a major evaluation component, which includes three elements:

- **Fidelity Toolkit and Quality Management**—includes both State oversight, using a small, internal research and evaluation staff working with program staff, who, in turn, are supported by the data warehouse Texas has created, and self-evaluation and reporting by the local mental health authorities
- **Individual Outcome Monitoring**—tracked by providers

³⁸ State of Texas, Department of State Health Services (November, 2005). User’s manual for the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG), Version 3.0. Available http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf <http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf> .

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- **Resiliency and Disease Management Examiner**—reports semi-annually on overall system-wide progress, using aggregated individual data.

There are specific evaluation criteria for both adult and child and adolescent service provision to assess system outcome objectives. The Children’s Criteria include: access; time between authorization and first encounter; appropriateness of service; adherence to clinical guidelines; juvenile justice involvement; functioning; problem severity; school behavior; family re-unification; Medicaid enrollment status; and, youth/parental perception of services.³⁹

In its first six-month evaluation report on the four pilot sites, the State described the following promising results: high access to services following assessment; high percentage of children who were appropriately served (i.e., percentage where authorized levels of care matched recommended levels of care, compared to children who were either under-served or over-served, that is, level of care authorizations did not match level of care recommendations); more children who were appropriately served rather than under-served experienced improvement in functioning, problem severity, and school behavior. The report also noted two areas of concern: too big a time gap between authorization for service and commencement of services; and, a need for greater adherence and fidelity to the clinical guidelines to achieve recommended average monthly hours of service.⁴⁰

Experience To Date

One hundred percent of local mental health authority clinicians and providers in the pilot sites reportedly are using CA-TRAG. In addition to the first six-month evaluation results described above, State-level stakeholders shared a number of observations based on their experience to date...

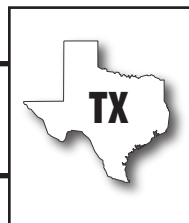
- Stakeholders have noted some problems with use of the Ohio Scales in representing accurately levels of functional impairment among Hispanic children and adolescents. The State is finding that Hispanic families may be under-reporting the level of functional impairment in such areas as school behavior, due apparently to the way that the Ohio Scales translate into Spanish. State-level stakeholders noted that they experienced similar problems with the CBCL in the past.
- Stakeholders also are finding that the Ohio Scales may lack sufficient sophistication to pick up internalizing disorders and may under-represent the severity of these disorders
- State representatives are hearing anecdotal reports that they may have to create a different range to better distinguish between Levels 1 and 2 of the CA-TRAG. Currently, Level 2 includes a wraparound approach and case management, but use of the Ohio Scales is suggesting that Level 2 does not always indicate a need for wraparound and case management.
- Some of the other child-serving systems, juvenile justice for example, are critical because they want more intensive services covered.

39 A full description of these criteria can be found on the above cited website.

40 A complete summary of the evaluation report can be found on the Texas website.

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State-level stakeholders view the CA-TRAG as inevitably a work in progress given the evolving nature of efficacy studies of children’s mental health practice. They indicated that changes will be made over time just as they are being made in the adult guidelines, which is in its third iteration. Texas has set aside dollars from its mental health block grant to support additional Consensus Conferences to identify new practices that should be incorporated into the CA-TRAG. What State-level stakeholders do not see changing, however, is the State’s focus on holding clinicians to a set of guidelines that supports effective practice.

Major Benefits, Concerns and Lessons Learned

State-level stakeholders believe that a major benefit of the CA-TRAG is that it provides a uniform, objective instrument that can serve multiple purposes (i.e., assessment, service authorization and re-authorization, outcomes monitoring) and that it encompasses a family/youth perspective by incorporating the Ohio Scales. They do not view the CA-TRAG as a “Cadillac,” but one that still accomplishes key system goals. They believe that the CA-TRAG creates consistency in clinicians’ approaches to evaluating children and adolescents and a “standard of care,” and ensures that re-evaluations will occur so that children are not “stuck” in inappropriate or too restrictive settings. Also, these stakeholders feel that the instrument ensures that the State has data on children in care and supports the State’s outcomes monitoring efforts.

State-level stakeholders consider the CA-TRAG as a first step in an evolving process. They have concerns over the cultural sensitivity of the instrument with respect to the Spanish version in particular. Some clinicians and some families have been critical that the CA-TRAG is too prescriptive, but the State argues that, with limited resources, the State should be linking resources to evidence-based and best practices. In addition, State-level stakeholders believe that the CA-TRAG does lend itself to an individualized approach to service planning and delivery far more than some of its critics understand. State-level stakeholders noted, for example, that the CA-TRAG is not based just on a numerical value, that wraparound flexible dollars are incorporated into the levels of care (though the dollars are limited), and that clinicians can exercise “clinical override.” However, they also have concerns that, whenever guidelines are used, clinicians may have a tendency to use them too rigidly, and that there is an inherent tension in their system between a desire for clinical flexibility and a need to manage scarce dollars. One of the major pieces of advice that the State-level stakeholders offered to other states is to build protections and training into the clinical guidelines process as they have done and continue to try to strengthen in the Texas system.