# Mental and Emotional Wellness for All:

## Practical, Scalable Approaches to Building Effective Public Behavioral Health Systems for Youth


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**WSU-Vancouver Innovation and Outreach Speaker Series**

**November 15, 2017**

# Summary of main points

- Mental health problems are the number one health condition of childhood – and the rates are rising…
- Yet, utilization and quality of MH care is low
- Evidence for effectiveness of prevention and intervention is strong, but service approaches and public health policies rarely support its application
- New approaches are needed for:
  - Organizing systems
  - Funding services
  - Delivering care
- There are many opportunities to build on – including many here in Washington State

# Connections to our work

NWIC
National Wraparound Implementation Center

SMART
School Mental Health Assessment Research & Training Center

- National Wraparound Initiative/NWIC:
  - Promoting effective care coordination and supportive policies for the 3-5% that account for 50-70% of all youth behavioral health $$$
- UW SMART Center:
  - Develops and evaluates effective, efficient school-based prevention and intervention strategies for youth MH AND their implementation strategies
- UW Evidence-Based Practice Institute:
  - Supports “real world” EBP implementation in WA through research, evaluation, training, and policy support

# Acknowledgments

## Major Funding Sources:

NIH National Institute of Mental Health

Washington State Department of Social & Health Services

ies INSTITUTE OF EDUCATION SCIENCES

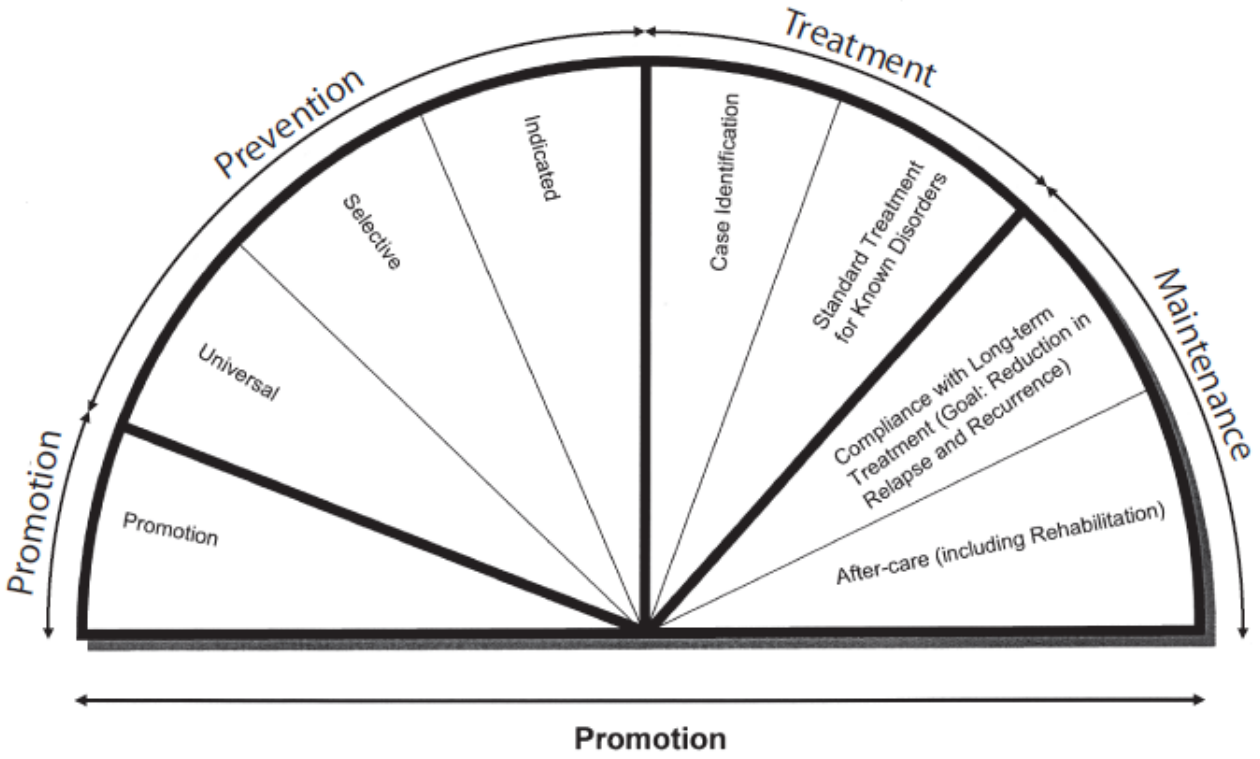
Substance Abuse and Mental Health Services Administration SAMHSA

pcori®

Part 1: Intro and Context

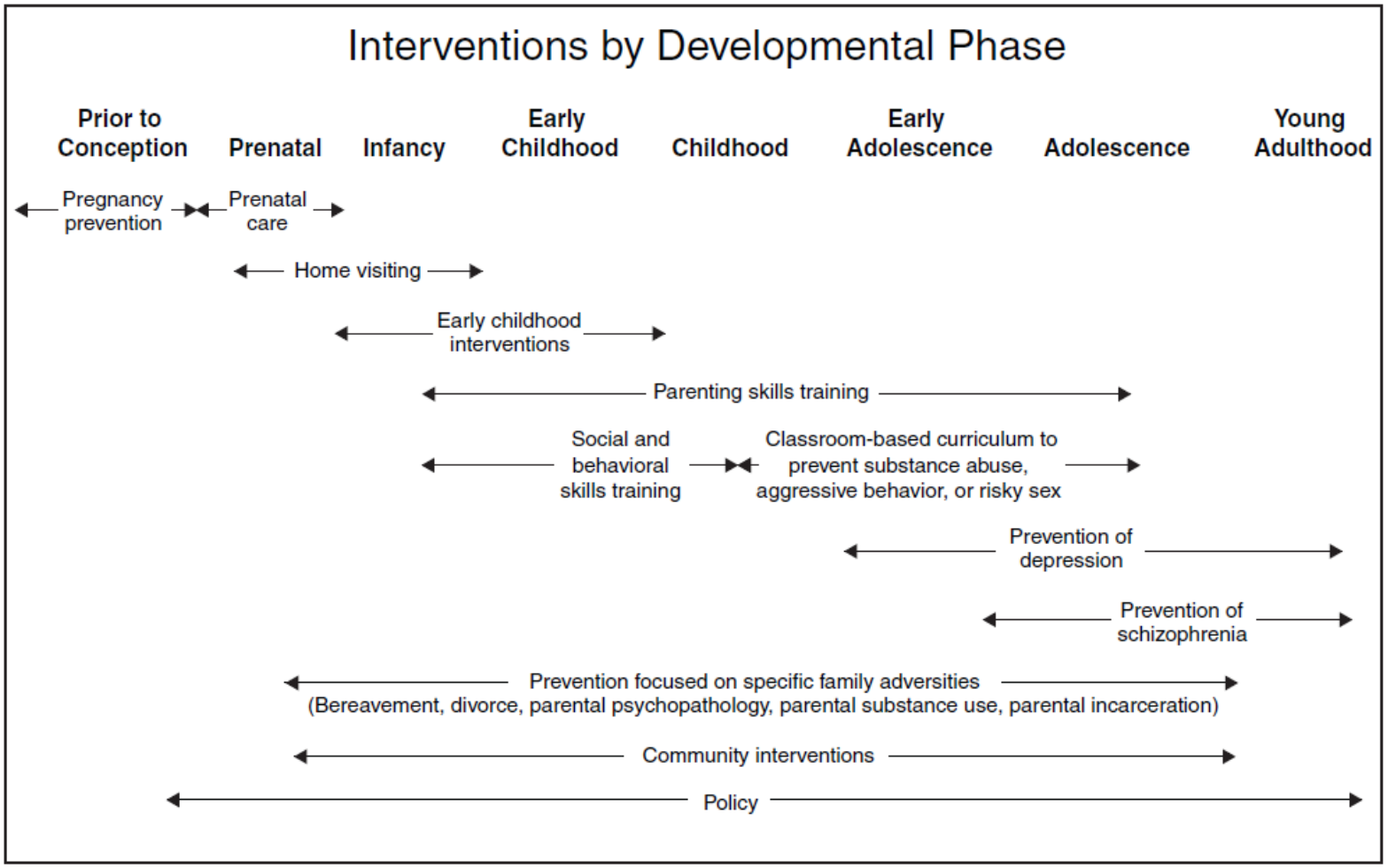
# OPPORTUNITIES AND CHALLENGES

# System building: The aspiration




Source: Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, 2009

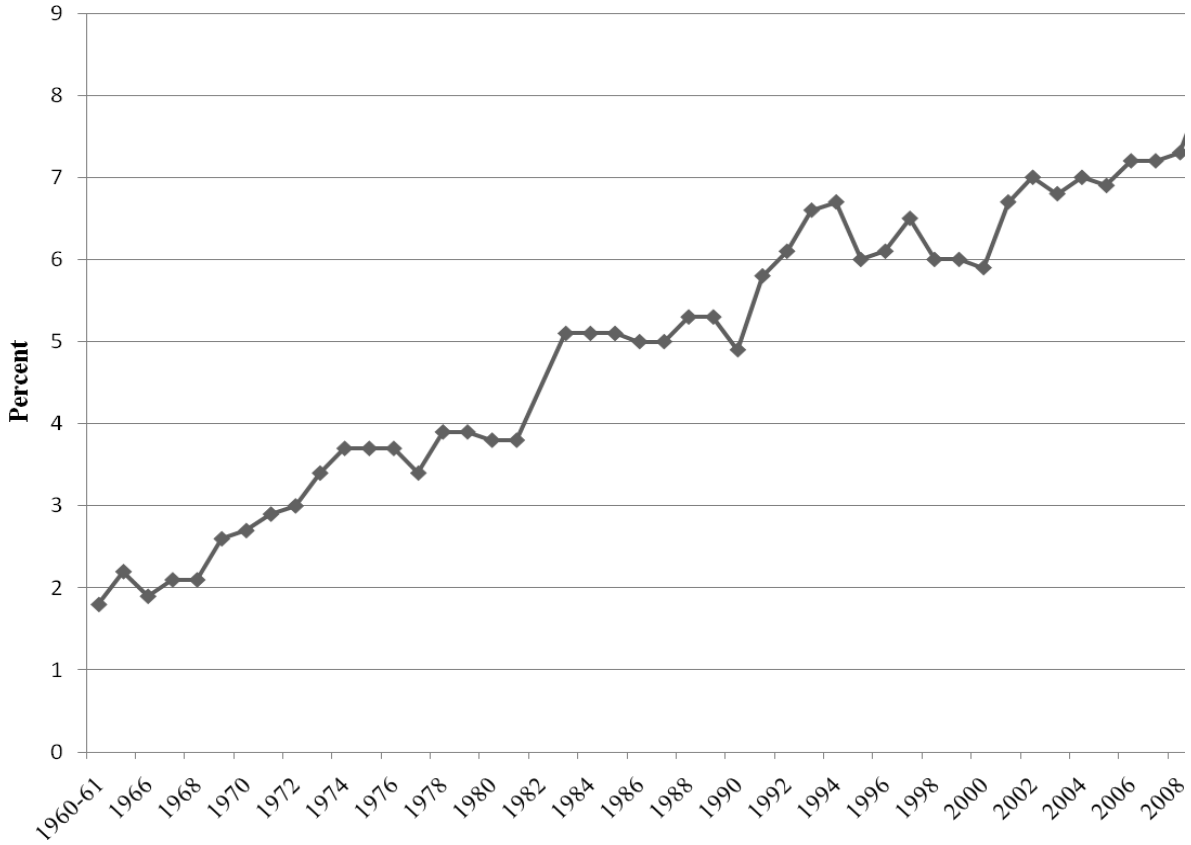
# System building: The aspiration




# System building: The aspiration

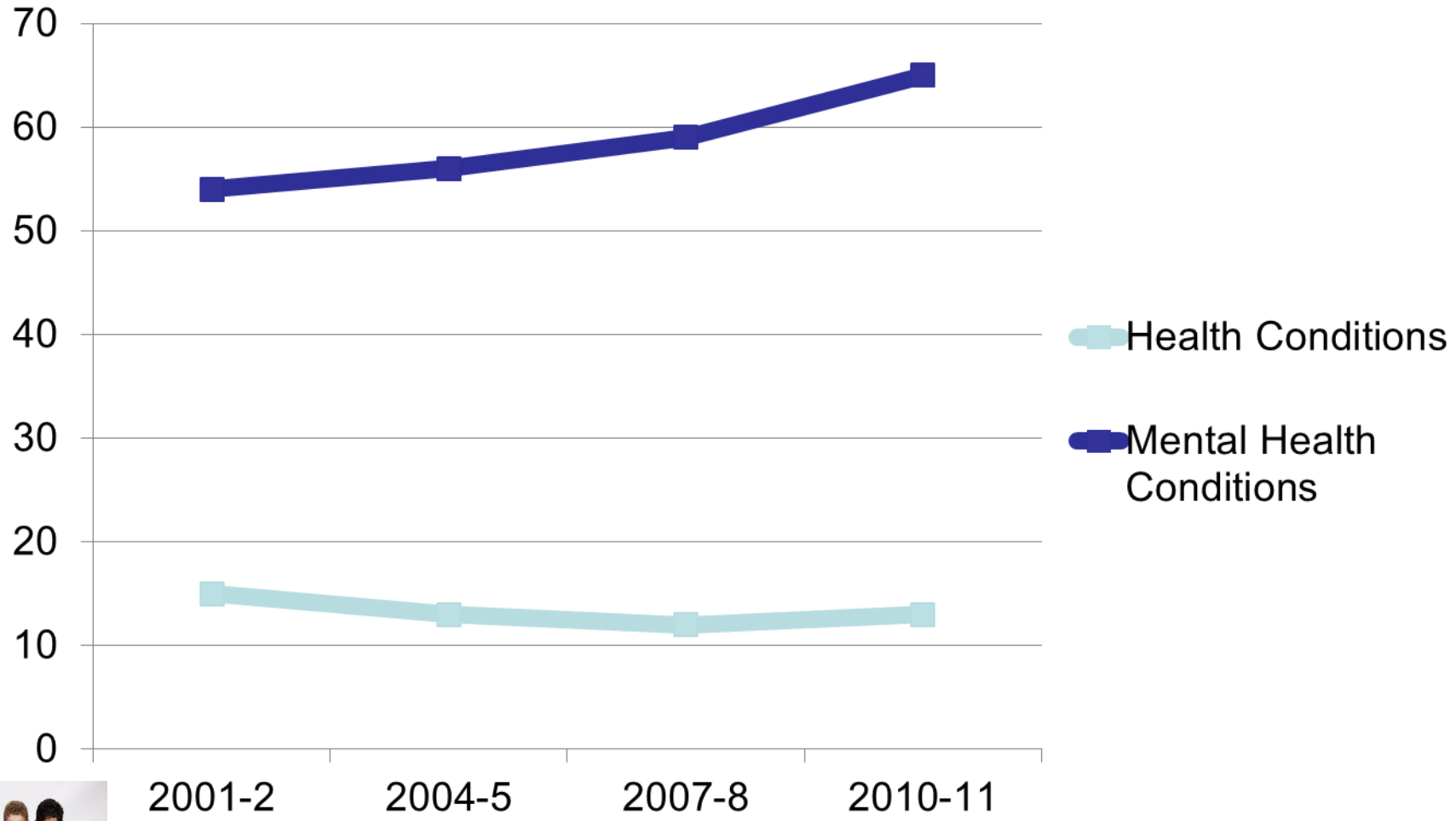

# System building: What it often feels like


# Impairments due to Mental Conditions for U.S. Children, 1960-2008




Source: Halfon & Houtrow, 2014; IOM Presentation, Disability in Childhood: Trends and Lifecourse Complications

# Impairment due to Chronic Conditions for U.S. Children, 2001-2011 (Rate per 1,000)

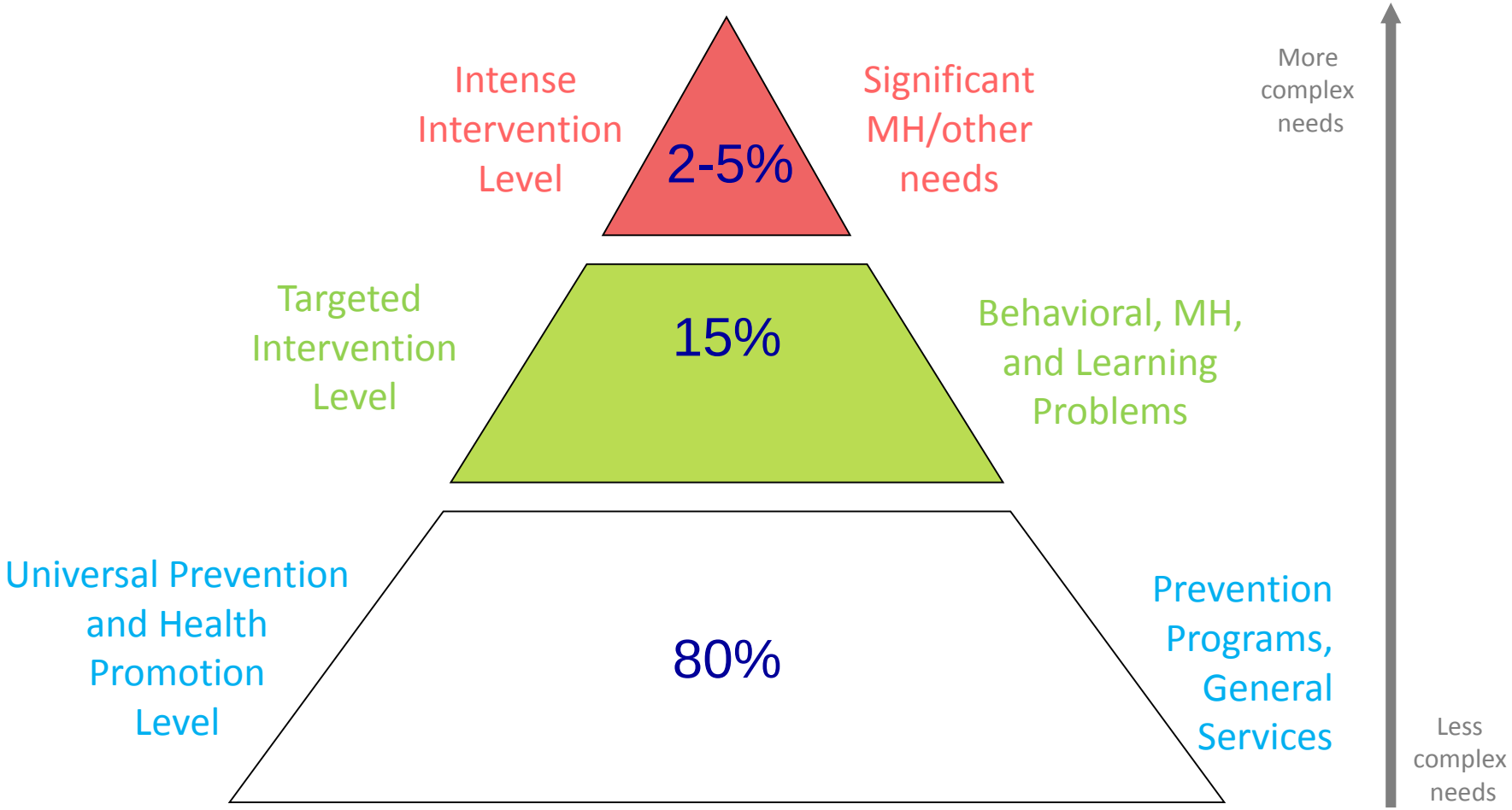



Houtrow etal., 2014 *Pediatrics*

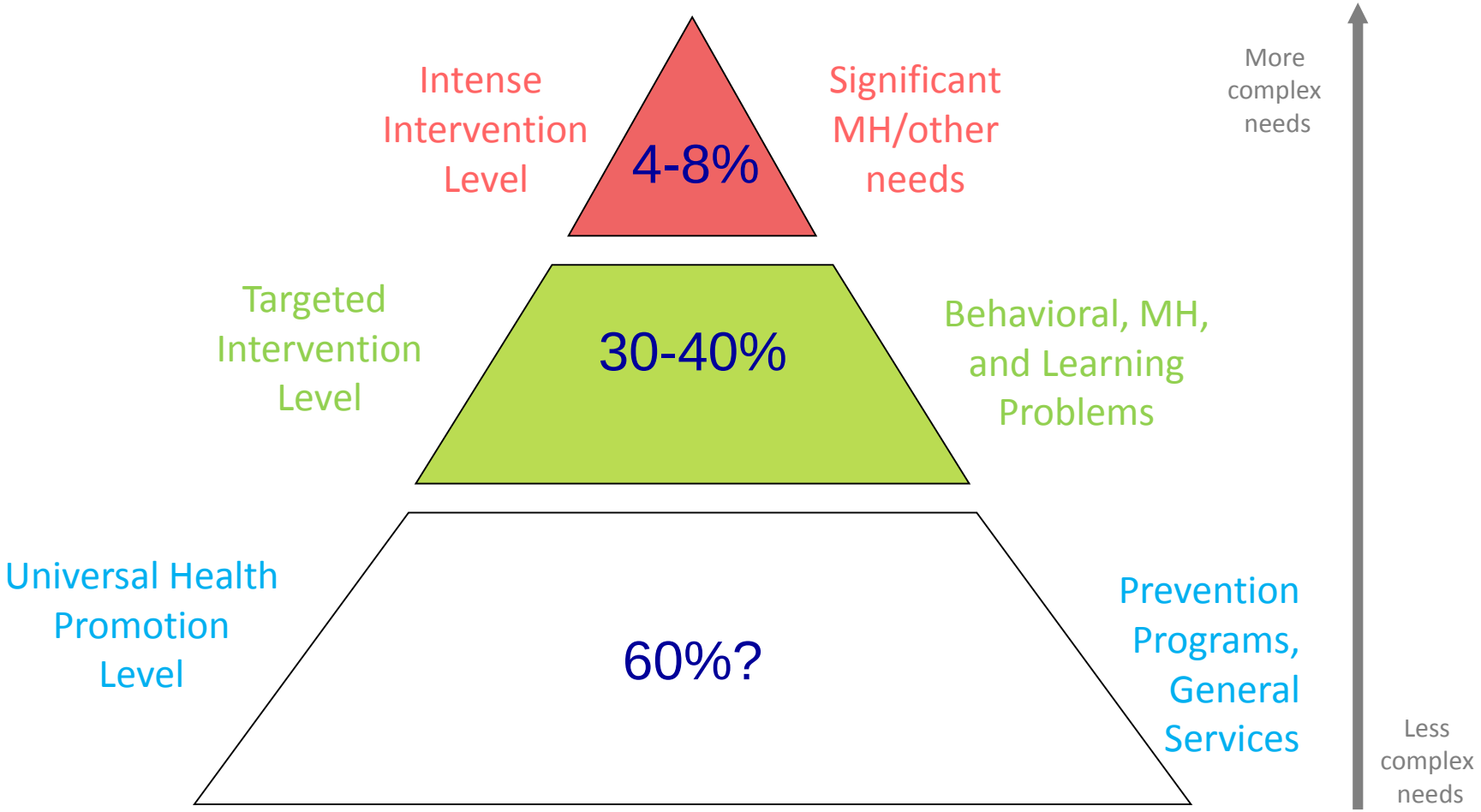
# More Alarming Statistics

- 22.8 % of adolescents have a mental disorder with impairments
  - (Merikangas et al *JAACAP* 2010)
- 30% of adolescents felt sad or hopeless almost every day for 2 or more weeks in the past year
  - (CDC, 2016)
- Prevalence of all mental disorders in children enrolled in Medicaid rose 40% to 8.2 M from 2001 to 2010
  - (National Academies of Science, 2015)

# Tailoring our systems to the need




# Tailoring our systems to the need




# A Facilitative National Context?

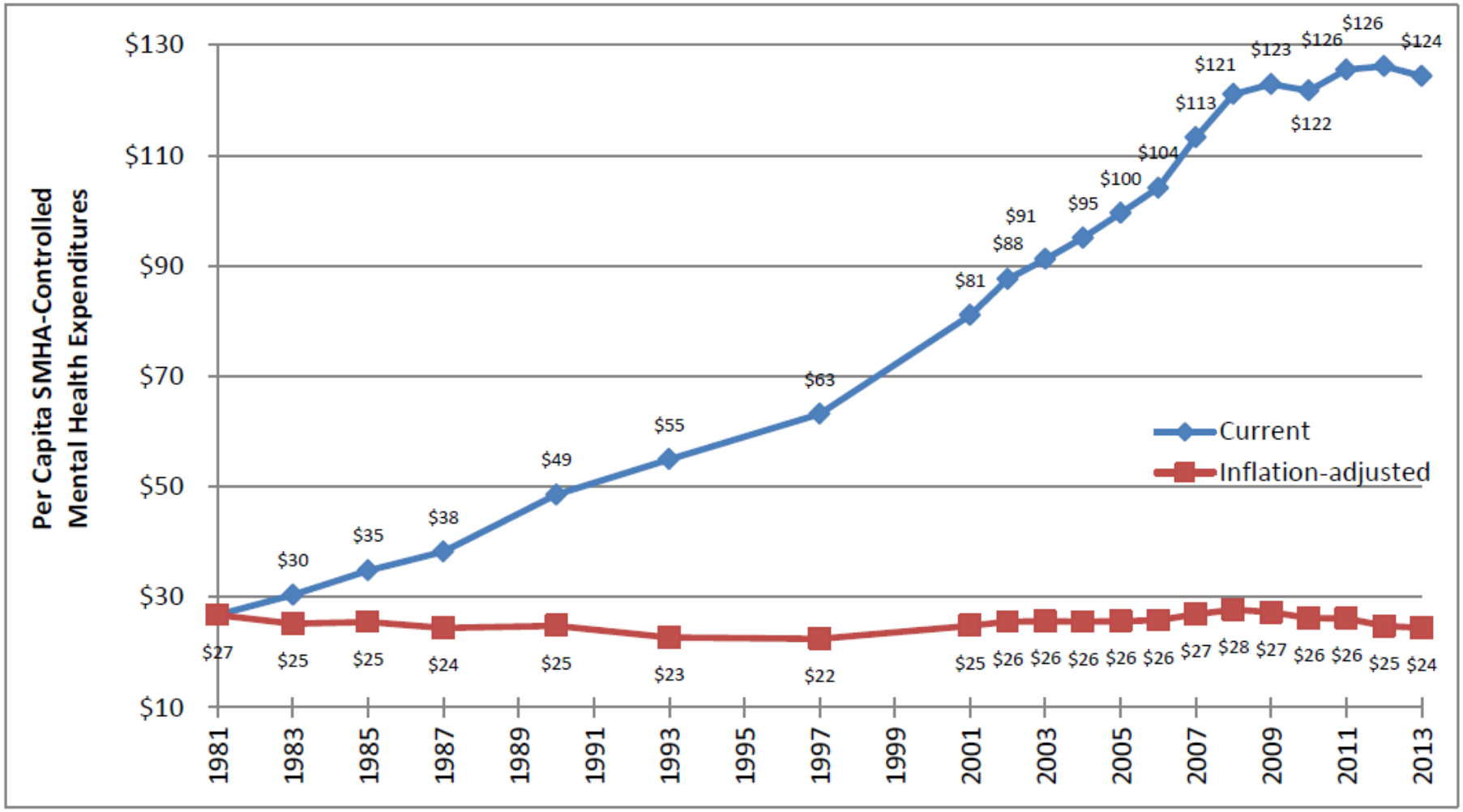
- Relevant Federal Initiatives
  - 2008: Mental Health Parity and Addiction Equity Act
  - 2010: The Patient Protection and Affordability Care Act (ACA)
    - Expansion of Medicaid coverage
    - New Incentives for care coordination, electronic data systems, pay for performance
    - Focus on quality measures, accountability, and outcomes
    - Greater involvement of consumers and investment in peer models
    - Workforce shortages and task shifting
  - 2015: Every Student Succeeds Act (ESSA)
    - Incentives and expectations for school MH and intensive student support (ISS)

# Fiscal Realities for State Mental Health Systems

- 73-76% of 47 state mental health agencies reported budget cuts in 2011-2013
- State mental health agencies' response to budget cuts in 2011-12:
  - 24% reduced community mental health services
  - 27% reduced the number of clients served in the community
  - 39% reduced funds to community providers
  - 52% cut staff
  - 82% reduced administrative expenses
- 88% of states in 2013 using managed care to provide behavioral health services

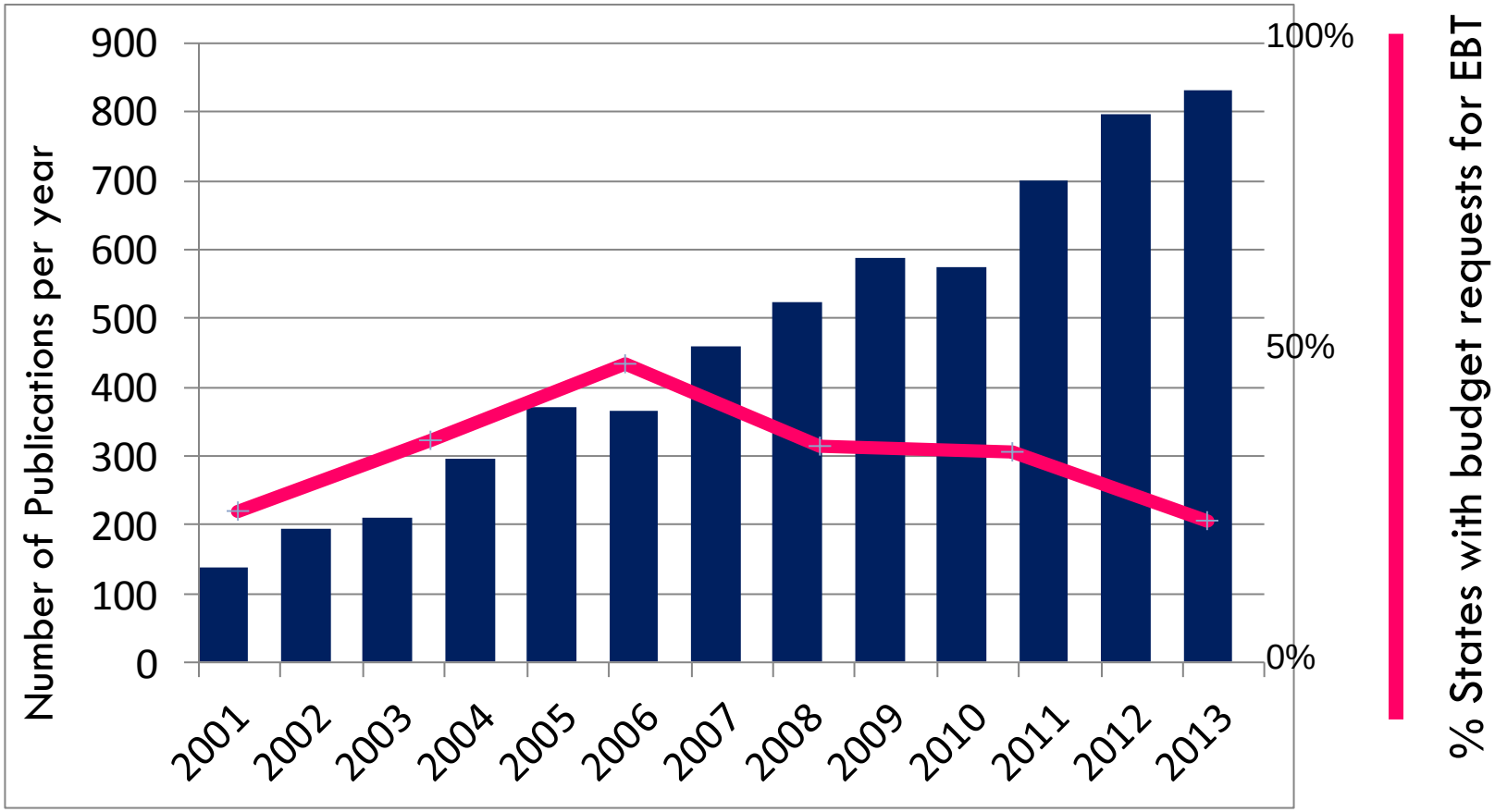
Source: NASMHPD Research Institute, 2014

# Trends in state mental health expenditures




Source: NASMHPD Research Institute, 2014

# Published papers on evidence based MH practice, 2001-2012 vs. trends in state EBP investment




Bruns et al., 2015 , *Psychiatric Services*

# Penetration rates of EBTs by state MH authorities is miniscule

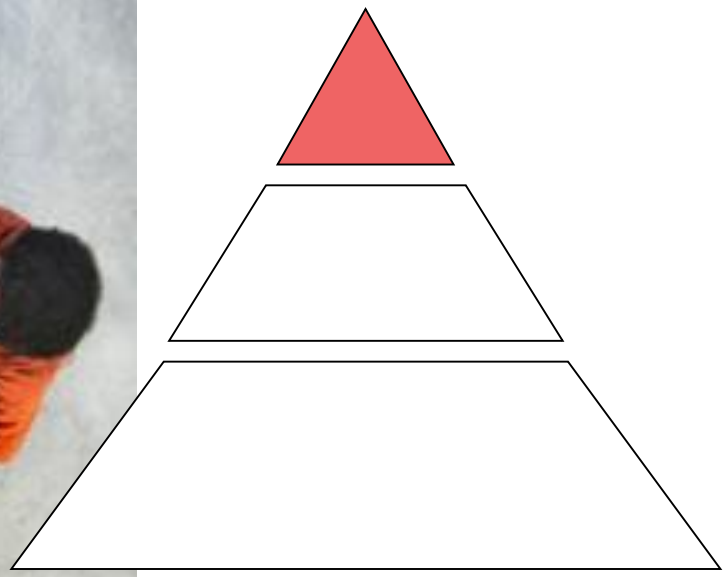
- 65-80% of states use selected adult EBTs
  - Median clients served in these states 400-700
  - Penetration rates = 1.5% - 3.0% of estimated adults with SMI
- 25%-50% of states use selected child EBTs
  - Median clients served in these states 250-400
  - Penetration rates = 0.75% - 2.5% of all youths with SED
- Several EBTs showed increases in early 2000s followed by decreases or flattening from 2007-2012

# Efforts to address the crisis

NWIC
National Wraparound Implementation Center

SMART
School Mental Health Assessment Research & Training Center

- Care Coordination / Wraparound
  - Bending the cost curve
  - Keeping families together
- School Mental Health
  - Effective prevention and Intervention strategies that reach children and youth “where they are”
- Evidence Based Practices for the “Real World”
  - Democratizing knowledge for the benefit of all



Part 2: Better use of resources, Better lives for families

# WRAPAROUND AND CARE MANAGEMENT FOR YOUTH WITH COMPLEX NEEDS

The New York Times

# The Opinion Pages

WORLD U.S. N.Y. / REGION BUSINESS TECHNOLOGY SCIENCE HEALT

EDITORIAL

## Waste in the Health Care System

Published: September 10, 2012

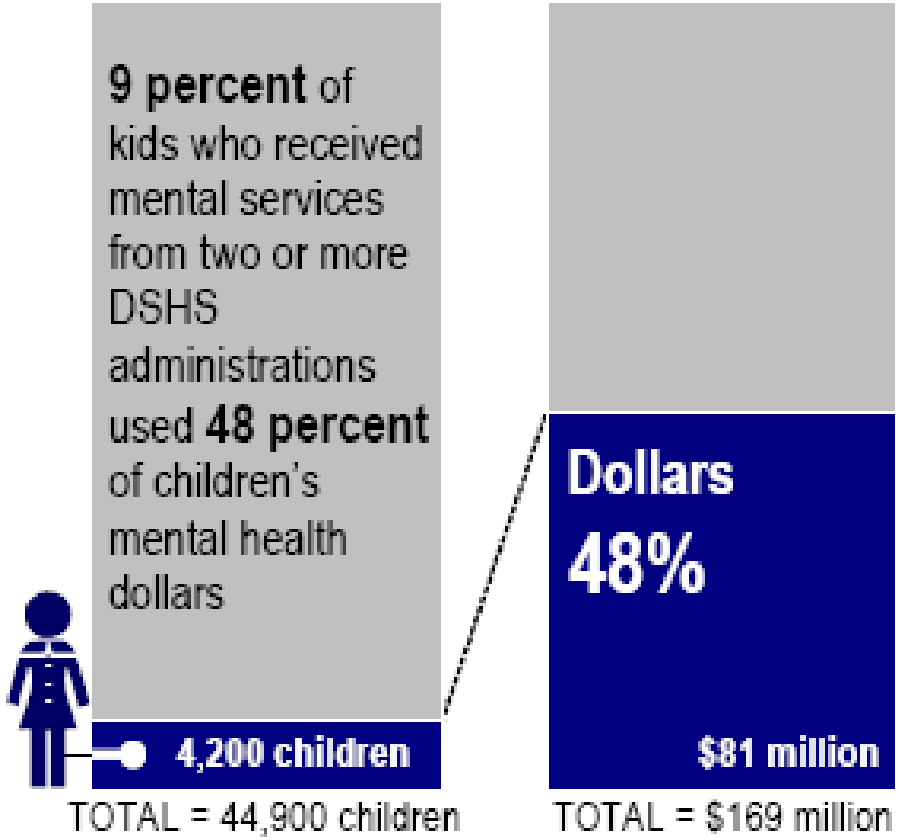
A new report from a panel of experts convened by the Institute of Medicine estimated that roughly 30 percent of health care spending in 2009 — around $750 billion — was wasted on unnecessary or poorly delivered services and other needless costs. Lack of coordination at every point in the health care system is a big culprit.

The panel cited studies showing that

# Out of community utilization and costs

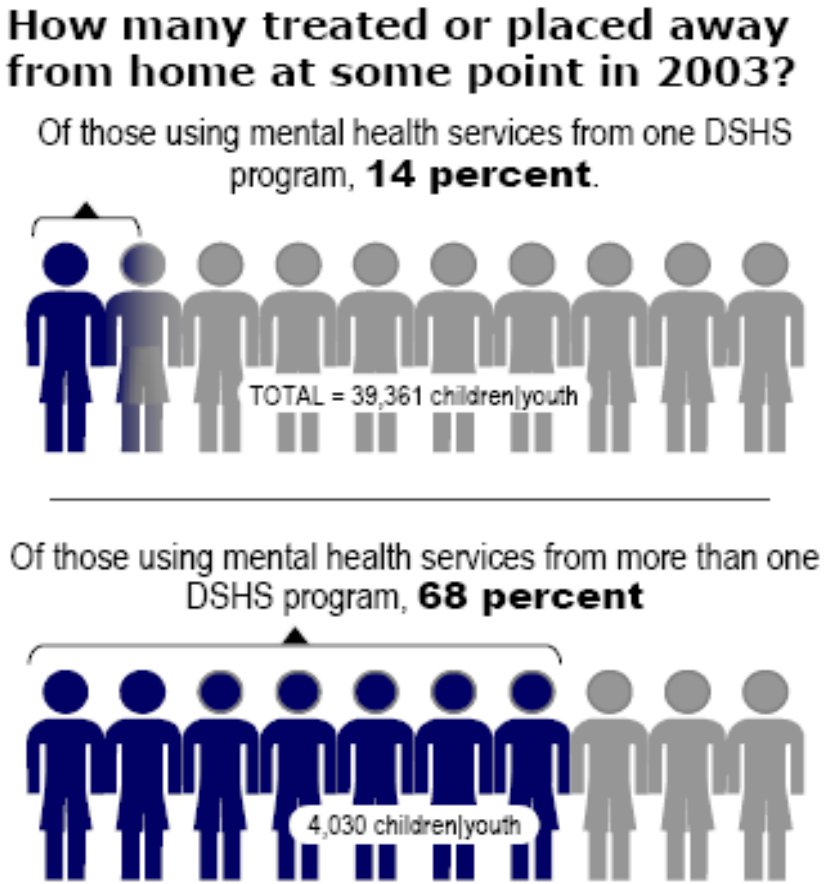
- Inpatient admissions
  - Increased 24% between 2007-2010
    - (Olson et al *JAMA Psych* 2014)
- Medicaid spending on Residential and group care
  - Increased from $1.5 billion to $2.5 billion from 2005 to 2011 (Pires, 2017)
- Child welfare
  - 14% (56,188) of all youth in CW custody in RTCs
    - (ACF, 2014)
  - 34% of all youth spend 9 months or more in facilities
    - (Casey Family Programs, 2016)

# A small number of youth & families account for a lot of our spending




Source: WA DSHS, 2004

# Children served by >1 system are 6 times more likely to be out of home




# The Evans Family

With thanks to Jim Rast and John VanDenBerg

- Crystal, 34
- Tyler, 36
- David, 14
- Kyle, 12
- Kaia, 12

Major Challenges :

- Crystal has depression and suicide ideation
- Tyler is in recovery from alcoholism and can not keep a job
- David has been arrested multiple times for theft, vandalism, drug and alcohol use and assault
- David is in juvenile detention
- David is two years behind in school
- Tyler was seen using inappropriate discipline and the twins are now in foster case
- The twins are often very aggressive and have been diagnosed with bipolar disorders
- The twins are very disruptive at school and are 2-3 years below grade level

# The Evans Family

With thanks to Jim Rast and John VanDenBerg

- Crystal, 34
- Tyler, 36
- David, 14
- Kyle, 12
- Kaia, 12

Major Strengths:

- Tyler and Crystal are determined to reunite their family
- The family has been connected to the same church for over 30 years
- Tyler is committed to his recovery from alcoholism
- Tyler has been attending AA meetings regularly
- Crystal has been employed at the same restaurant for 8 years
- Crystal's boss is a support for the family and allows her a flexible schedule to meet needs of her family
- David is a charming and funny youth who connects easily to adults
- David can recite all the ways he could get his GED instead of attend school
- Kyle is athletic and can focus well and make friends when doing sports
- Kaia uses art and music to soothe herself when upset

# 26 Helpers and 13 Plans

**Helpers:**

- School (5)
- Technical School (2)
- Bailey Center (2)
- Child Welfare (1)
- Specialized Foster Care (2)
- Juvenile Justice (1)
- Children's Mental Health (6)
- Adult Mental Health (3)
- Employment Services (2)
- Alcoholics Anonymous (1)
- Housing Department (1)

**Plans:**

- 2 IEPs (Kyle and Kaia)
- Tech Center Plan
- Bailey Center Plan
- Permanency Plan
- Specialized Foster Care Plan
- Probation Plan
- 3 Children's MH Tx Plans
- 2 Adult MH Tx Plans
- Employment Services

- **35 Treatment Goals or Objectives**

# Monthly Appointments for the Evans Family

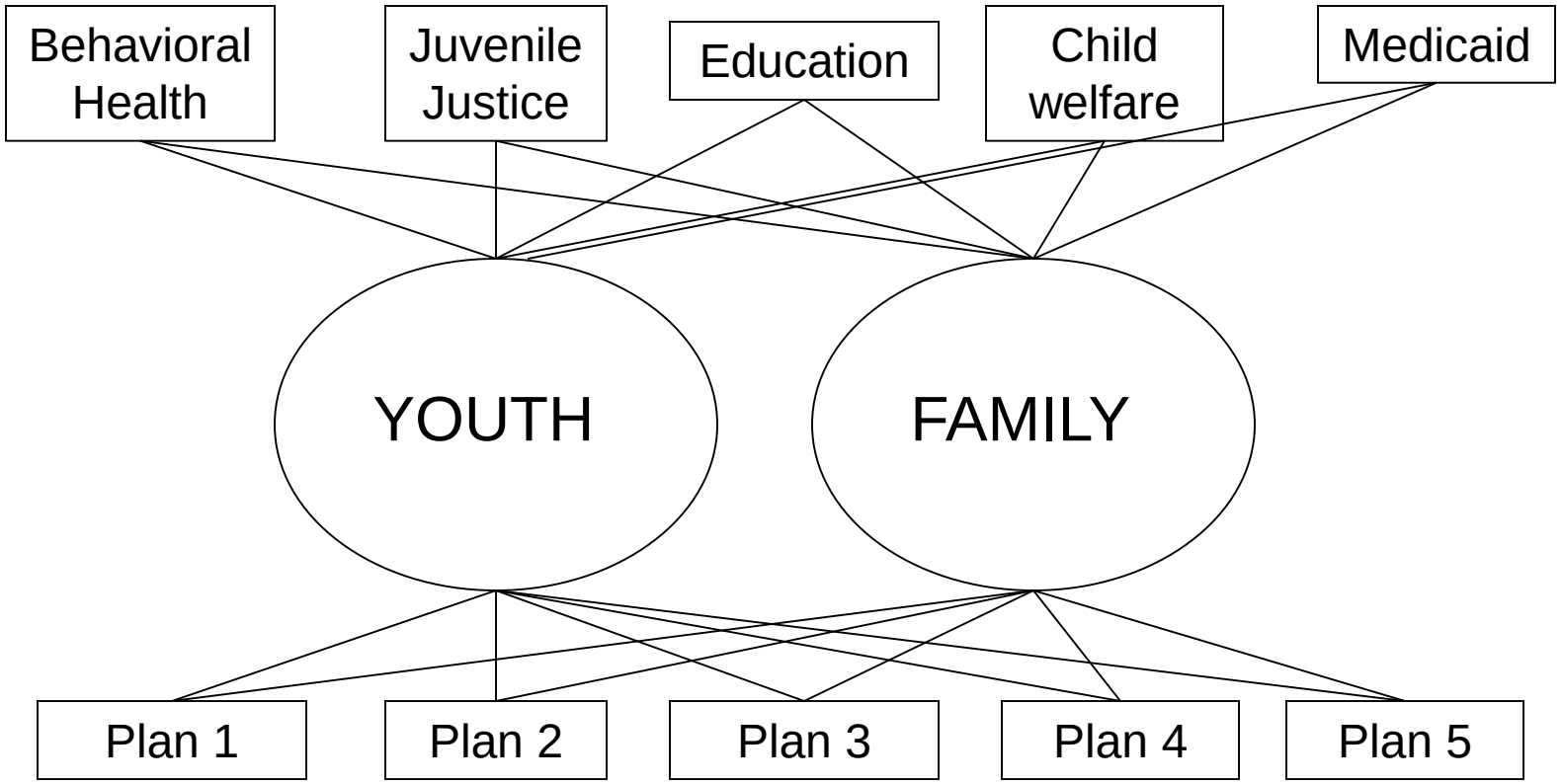
| | |
|---|---|
| Child Welfare Worker | 1 |
| Probation Officer | 2 |
| Crystal's Psychologist | 2 |
| Crystal's Psychiatrist | 1 |
| Dave's therapist | 4 |
| Dave's restitution services | 4 |
| Appointments with Probation and School | 2 |
| Family Based | 4 |
| Twins' Therapists | 4 |
| Group Rehabilitation | 8 |
| Tyler's anger management | 4 |
| Children's Psychiatrist | 1 |
| Other misc. meetings:, Housing, Medical | 5 |
| **TOTAL** | **42** |

*Also: 16 AA meetings each month, + 20 or more calls from the schools and other providers each month.*

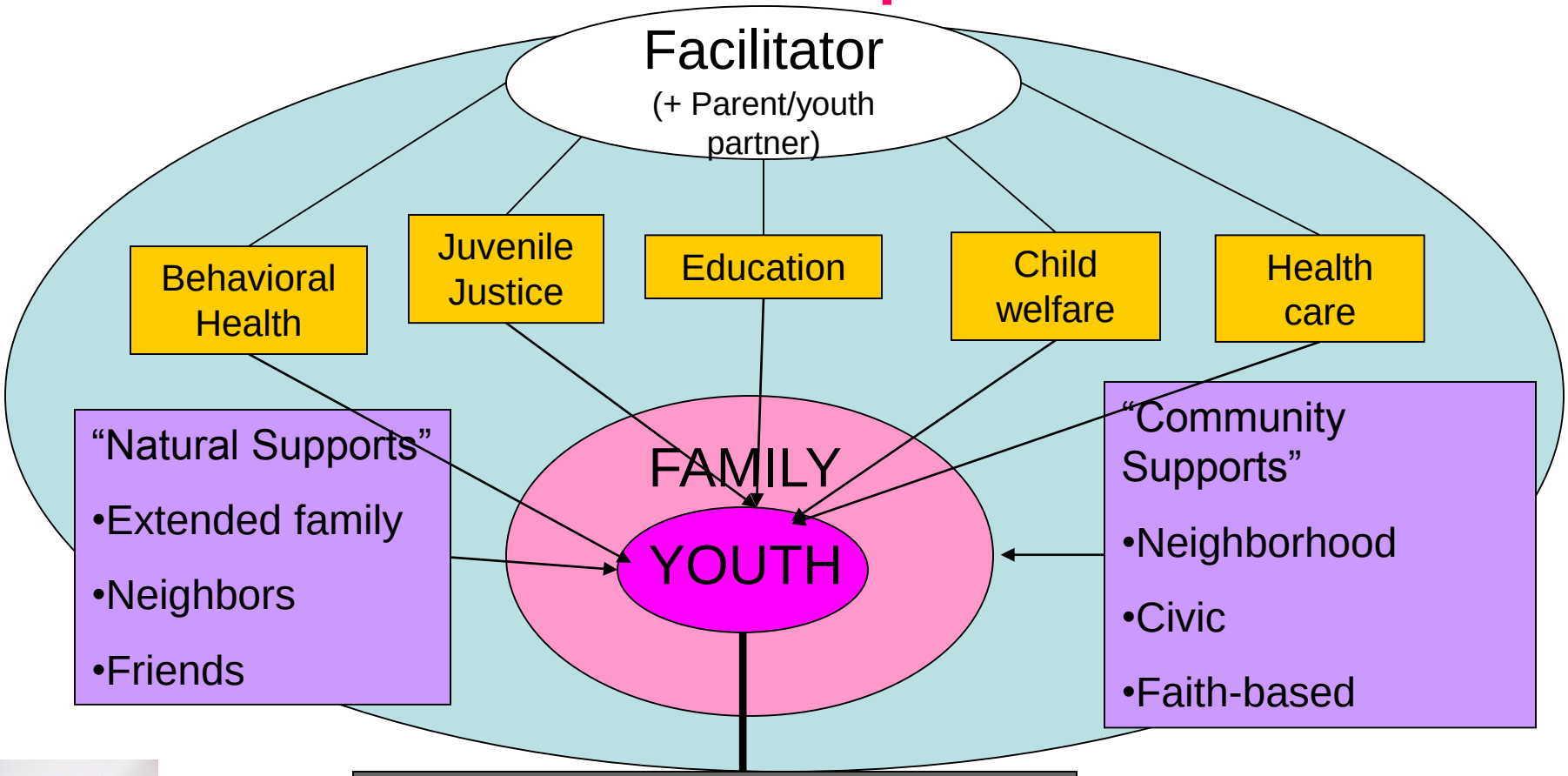
# Comments from the Files

- Parents don't respond to school's calls
- Family is dysfunctional
- Parents are resistant to treatment
- Home is chaotic
- David does not respect authority
- Twins are at risk due to parental attitude
- Mother is non-compliant with her psychiatrist
- She does not take her meds
- Father is unemployable due to attitude
- Numerous missed therapy sessions
- Attendance at family therapy not consistent
- Recommend court ordered group therapy for parents

# The silo issue: Traditional services rely on professionals and result in multiple plans




# In wraparound, a facilitator coordinates the work of system partners and other natural helpers so there is one coordinated plan




# The Phases of Wraparound

Phase 1A — Engagement and Support

Phase 1B — Team Preparation

Phase 2 — Initial Plan Development

Phase 3 — Implementation

Phase 4 — Transition

NATIONAL WRAPAROUND INITIATIVE

# An Overview of the Wraparound Process

Child and caregivers referred

Eligibility determined & Facilitator assigned

Engagement and safety/stabilization plan (provisional POC)

Family Story, strengths, vision, needs and initial team members

Engagement and Preparation Phase: Up to 30 days

Convene team and begin planning process

Team agrees on mission and prioritizes needs

Brainstorm options, chose strength-based strategies

Initial plan of care with tasks, timelines and outcomes

Planning Phase: 1 meeting also within first 30 days

Implement plan

Team tracks options, outcomes, & resolves conflicts

Adjust plan and team membership as needed

Begin seeing consistent and sustained progress

Implementation Phase: 9-18 months

Develop a vision of how things will work post-wrap

Establish any needed post-wrap connections

Prepare transition and aftercare plan

Family team closure celebration

Check-in and Post-Service Evaluation

# Research-based components of the wraparound process

NWIC
National Wraparound Implementation Center

- Integration of care
  - Multiple systems working together → one coordinated plan
- High-quality teamwork
  - Clear goals, shared mission, blended perspectives, creative brainstorming
- Family / youth engagement
  - Engagement phase with active listening, family story telling
  - Youth/family set priorities
  - Examining and addressing potential barriers
  - Appointment and task reminders/check-ins
- Broad service array to meet needs, including EBP
- Attention to social support (via peers or natural supports)
- Measurement and feedback of progress

# Wraparound literature: 30 years and 206 publications

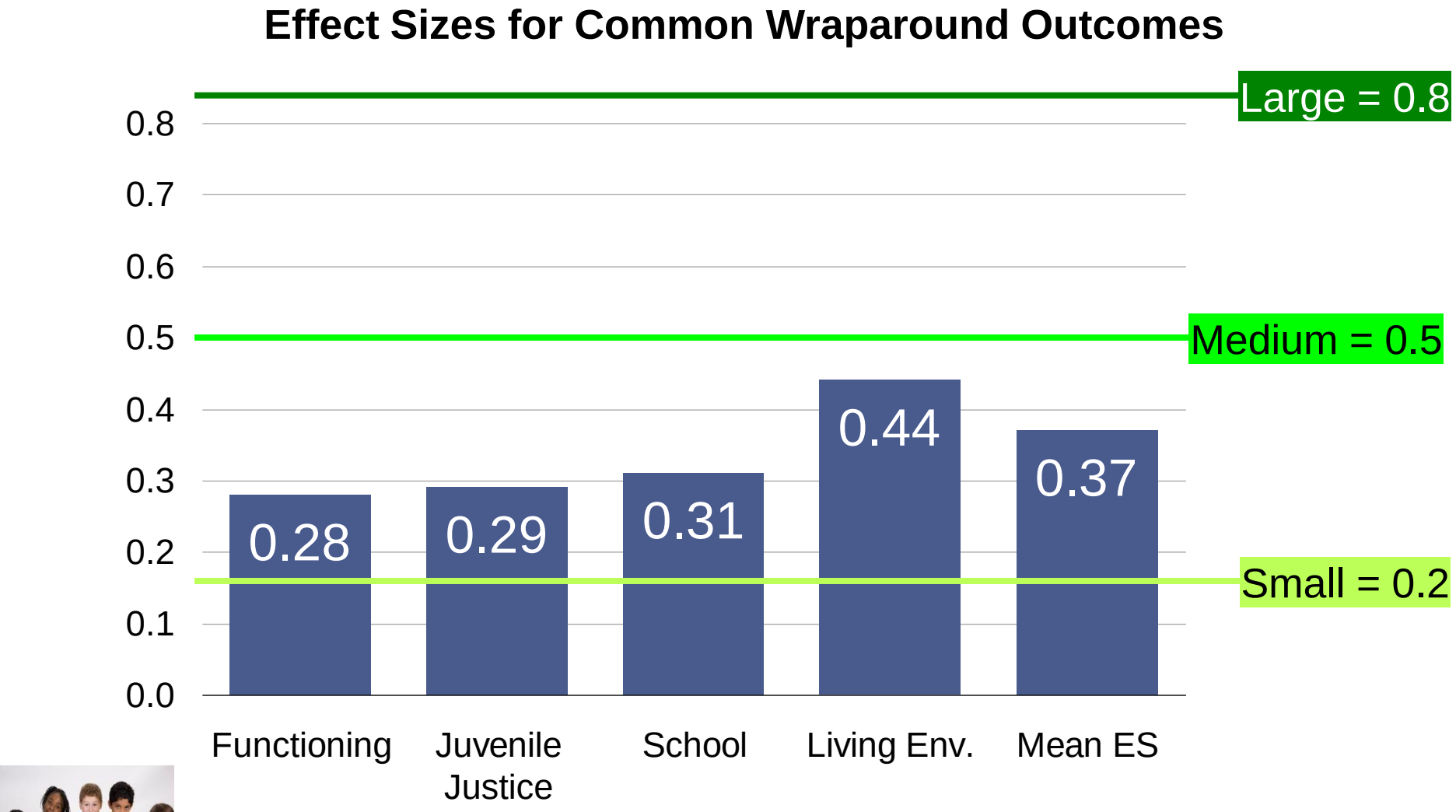
J Child Fam Stud
DOI 10.1007/s10826-016-0639-7

ORIGINAL PAPER

## A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014

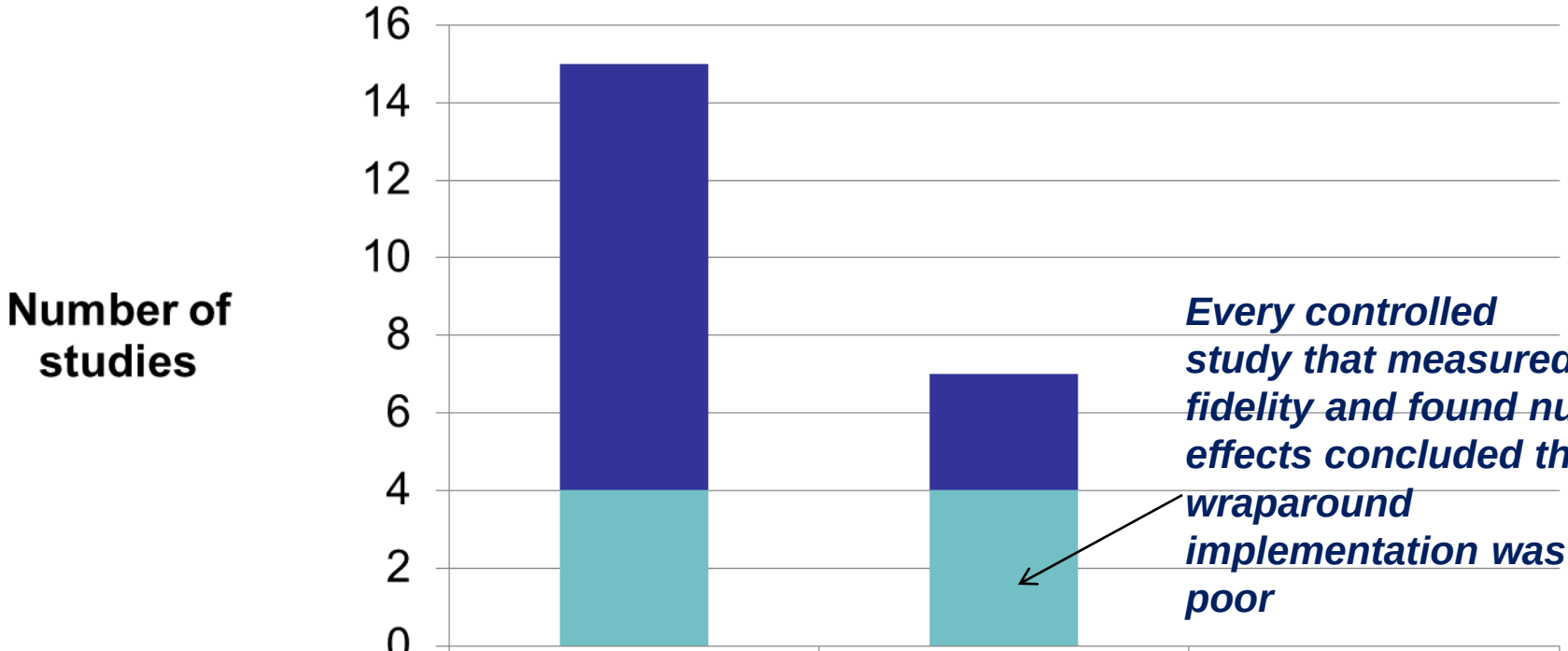
Jennifer Schurer Coldiron[1] · Eric Jerome Bruns[1] · Henrietta Quick[1]

# A 2009 meta-analysis found significant, small to medium effects




Suter & Bruns, 2009

# Controlled outcome studies of wraparound (N=22)




| | Positive effects for Wraparound | Null effects | Positive effects for comparison |
|---|---|---|---|
| Did not measure fidelity | 11 | 3 | 0 |
| Measured fidelity | 4 | 4 | 0 |

Coldiron, Bruns, & Quick, 2009

# Outcomes of wraparound
## (22 controlled, published studies; Coldiron et al., 2017)

- Better functioning and mental health outcomes
- Reduced arrests and recidivism
- Increased rate of case closure for child welfare involved youths
- **Reduced residential placements**
- **Reduced costs**

# MA Mental Health Services Program for Youth (Grimes et al., 2011)

- One year pre-/ post-enrollment showed decreases in out-of-home treatment
  - Hospital admissions down 70%
  - Long term residential care down 82%
  - Acute residential down 44%
  - Foster care down 83%
- Versus matched comparison
  - Total Medicaid claims expenses were lower by $811/month ($9732/year)
  - Inpatient psychiatry down 74%
  - ER down 32%

# New Jersey

- Data from New Jersey Office of of Children's Behavioral Health
  - savings of $40 million from 2007 to 2010 by reducing the use of acute inpatient services alone
  - residential treatment budget was reduced by 15% during the same time period.
  - length of stay in residential treatment centers decreased by 25%

*Guenzel, J. (2012, July). System of care expansion in New Jersey. Presentation at the Georgetown University Training Institutes 2012: Improving Children's Mental Health Care in an Era of Change, Challenge, and Innovation: The Role of the System of Care Approach, Orlando, FL.*

# Wraparound Maine
# (Yoe, Ryan & Bruns, 2011)

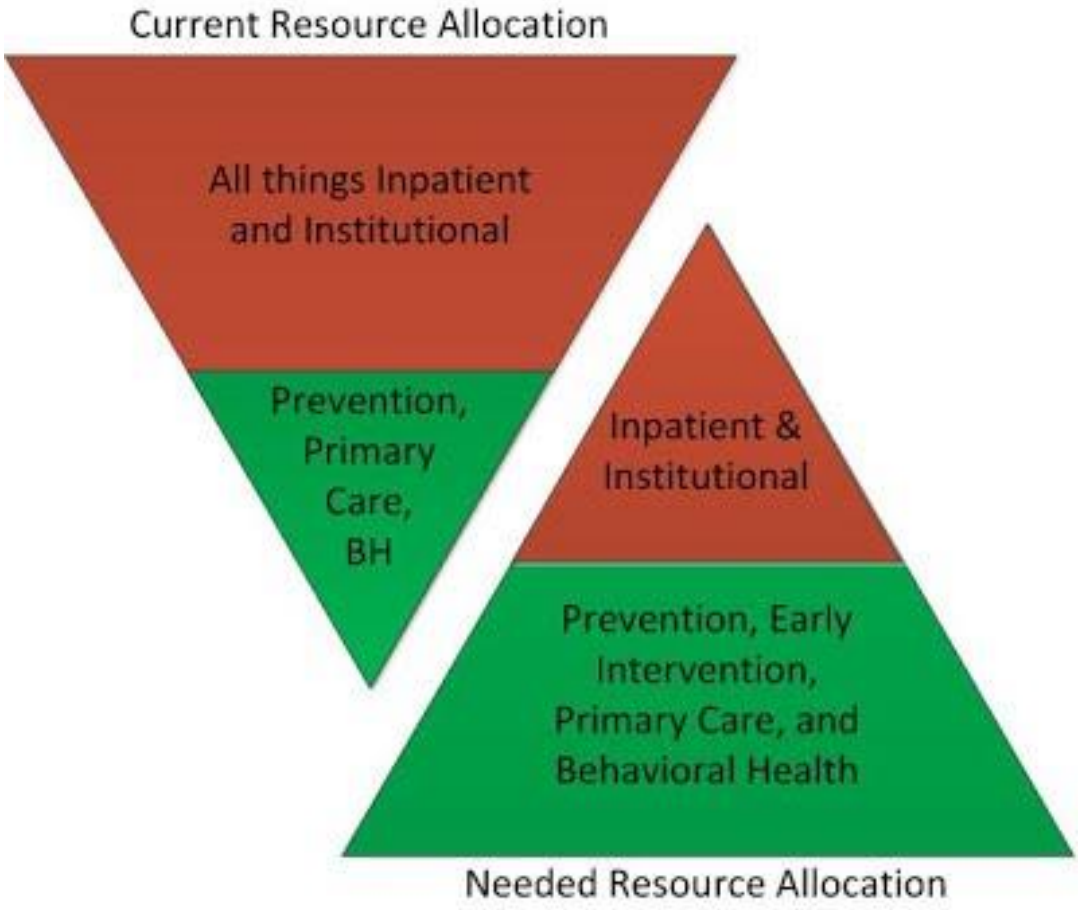
**Pre-Post Wraparound Average Per Child Per Year Mental Health Expenditures**

| Service Type | Pre-Wraparound Average Per Child Expenditures | Post-Wraparound Initiation Average Per Child Expenditures | Pre-Post Difference | Percent Change |
|---|---|---|---|---|
| Targeted Case Management (Wraparound Maine) [1] | $3,858.02 | $7,664.15 | $3,806.13 | ⇧ 99% |
| Emergency Room (MH) | $441.16 | $467.47 | $26.31 | ⇧ 6% |
| HCT Services | $7,456.25 | $6,735.99 | -$720.26 | ⇩ 10% |
| Crisis Intervention & Resolution | $2,343.48 | $1,637.15 | -$706.33 | ⇩ 30% |
| Residential (PNMI) Services [2] | $60,293.95 | $43,027.68 | -$17,266.27 | ⇩ 29% |
| MH Outpatient Treatment (Sec 65) | $1,406.07 | $1,835.59 | $429.52 | ⇧ 31% |
| Medication Assessment & Tx | $810.88 | $779.16 | -$31.72 | ⇩ 4% |
| Psychiatric Inpatient Tx | $55,488.75 | $31,667.34 | -$23,821.41 | ⇩ 43% |
| Outpatient Psychiatric Tx | $551.19 | $693.23 | $142.04 | ⇧ 26% |
| Other MH Services | $786.21 | $968.82 | $182.61 | ⇧ 23% |
| Child ACT | $8,712.24 | $6,998.02 | -$1,714.22 | ⇩ 20% |
| Day Treatment | $9,544.98 | $7,925.49 | -$1,619.49 | ⇩ 17% |
| Day Habilitation | $10,545.00 | $14,639.64 | $4,094.64 | ⇧ 39% |
| **Total Mental Health** | **$58,403.91** | **$41,873.16** | **-$16,530.75** | ⇩ **28%** |

[1] Targeted Case Management (TCM) expenditures pre-Wraparound initiation reflect use of non-wrap TCM services. Wraparound Maine services are billed through Section 13 Targeted Case Management. The increase in TCM expenditure pre to post reflect the initiation of Wraparound services.

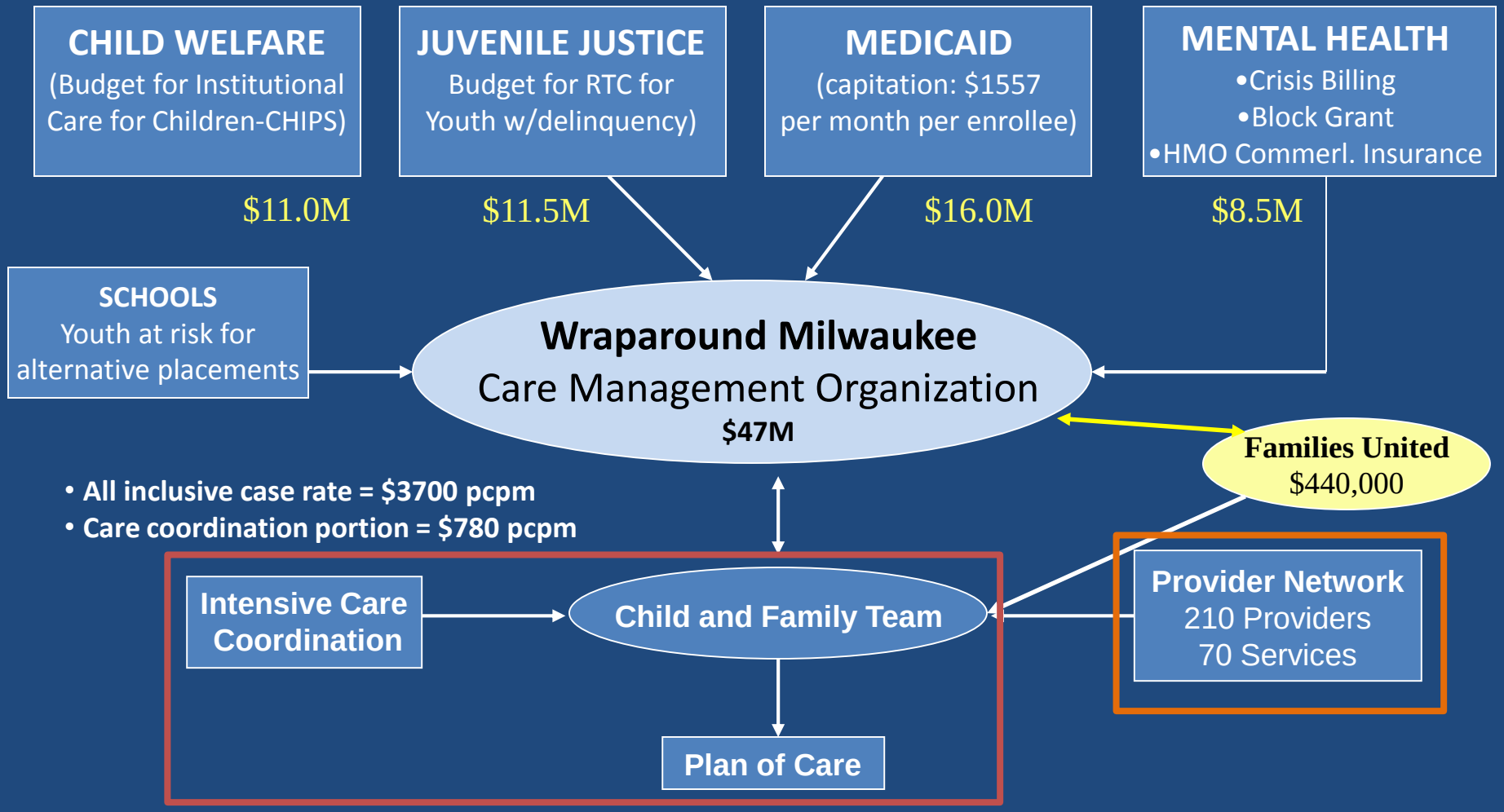
[2] Residential Treatment Services includes all PNMI Child Care and Crisis Residential facility expenditures.

# Flipping the triangle



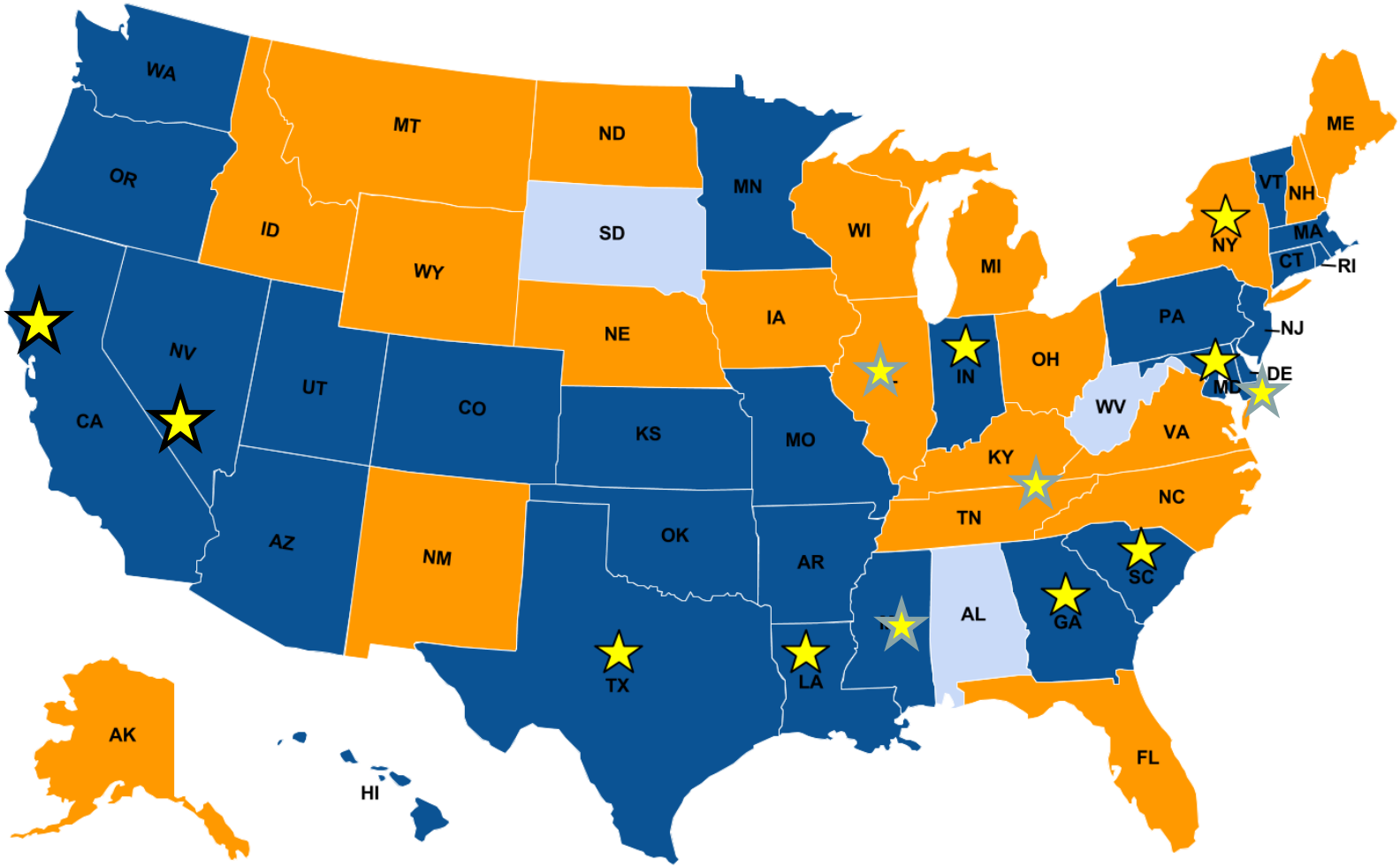

Source: Dale Jarvis and Associates

# Care Management Entities: Ensuring Accountability for Resources and Families



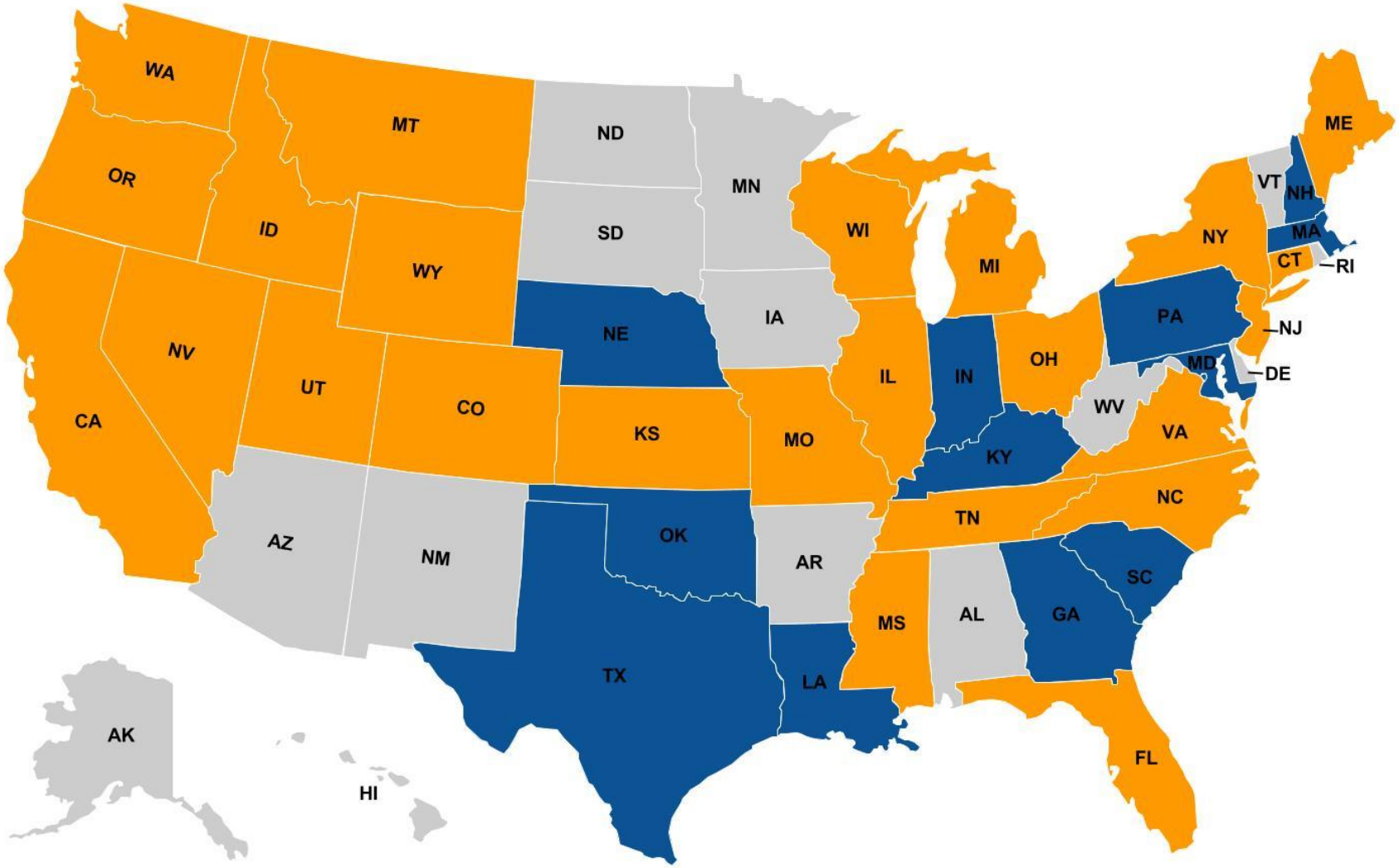

Wraparound Milwaukee. (2010). *What are the pooled funds?* Milwaukee, WI: Milwaukee Count Mental Health Division, Child and Adolescent Services Branch.

# Wraparound Implementation in the U.S.



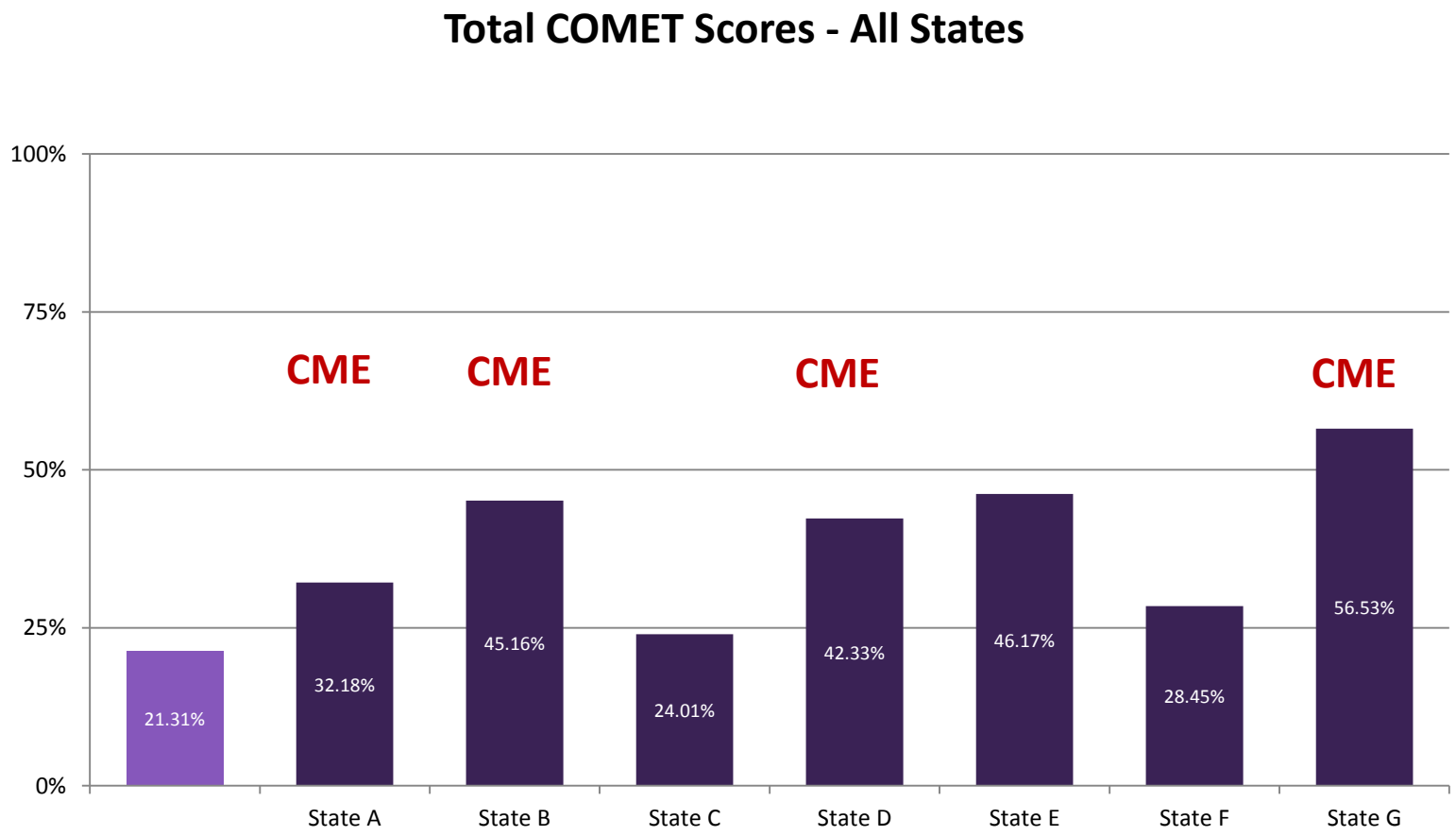

Legend: ★ Workforce support from NWIC  Statewide  One or more sites or jurisdictions

# Wraparound Fidelity Tools Used in the U.S.

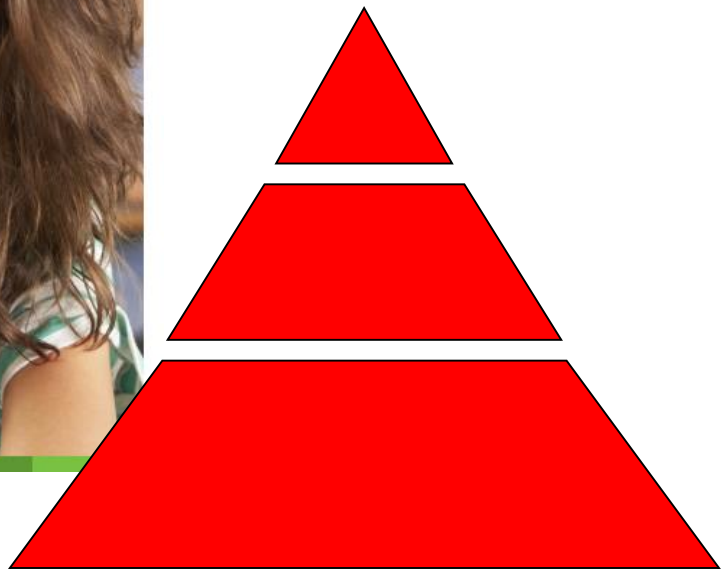



Legend: WFAS tool(s) used statewide  WFAS tool(s) used by one or more local sites

# Wraparound fidelity varies as function of system features




Hensley, Bruns, et al., 2016; in prep



Part 3: Serving youth where they are, across the tiers of need

# SCHOOL MENTAL HEALTH

College OF Education

UW Medicine
SCHOOL OF MEDICINE

# SMART

School Mental Health Assessment
Research & Training Center

@SMARTctr

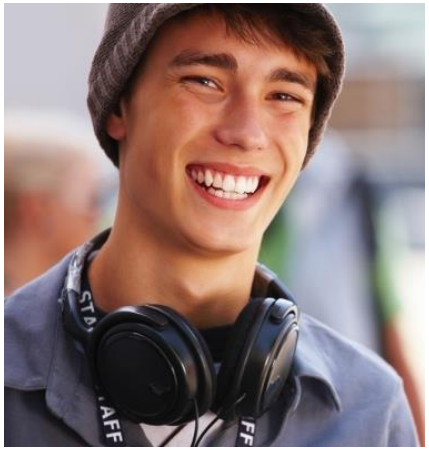
# Mental Health & Academics are Inexorably Linked

- The relationship between school performance and MH problems is bidirectional (DeSocio & Hootman, 2004)
  - School problems are risk factors for MH problems;
  - MH problems impede school performance

# Schools play a major role in fostering children's mental wellness

- Most youth who require mental health services do not receive them


SMH accounts for >70% of all MH services – and can improve service access for underserved youth



Positive school climate can buffer youth from external risk factors.

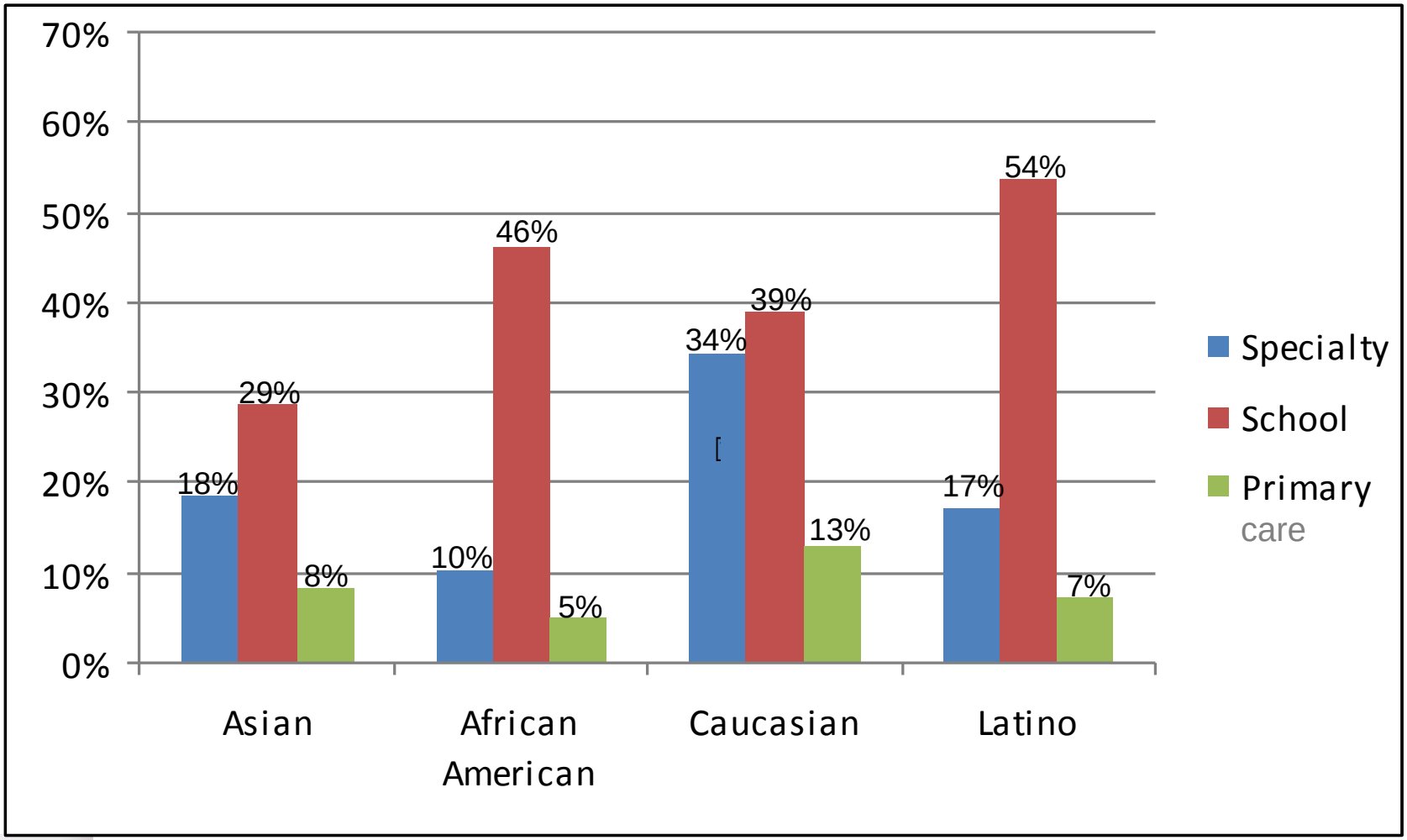
Social-emotional learning programs improve school achievement by 11% on average (Durlak et al., 2011).

# Seattle School-Based Health Centers

## *primary care and mental health services*

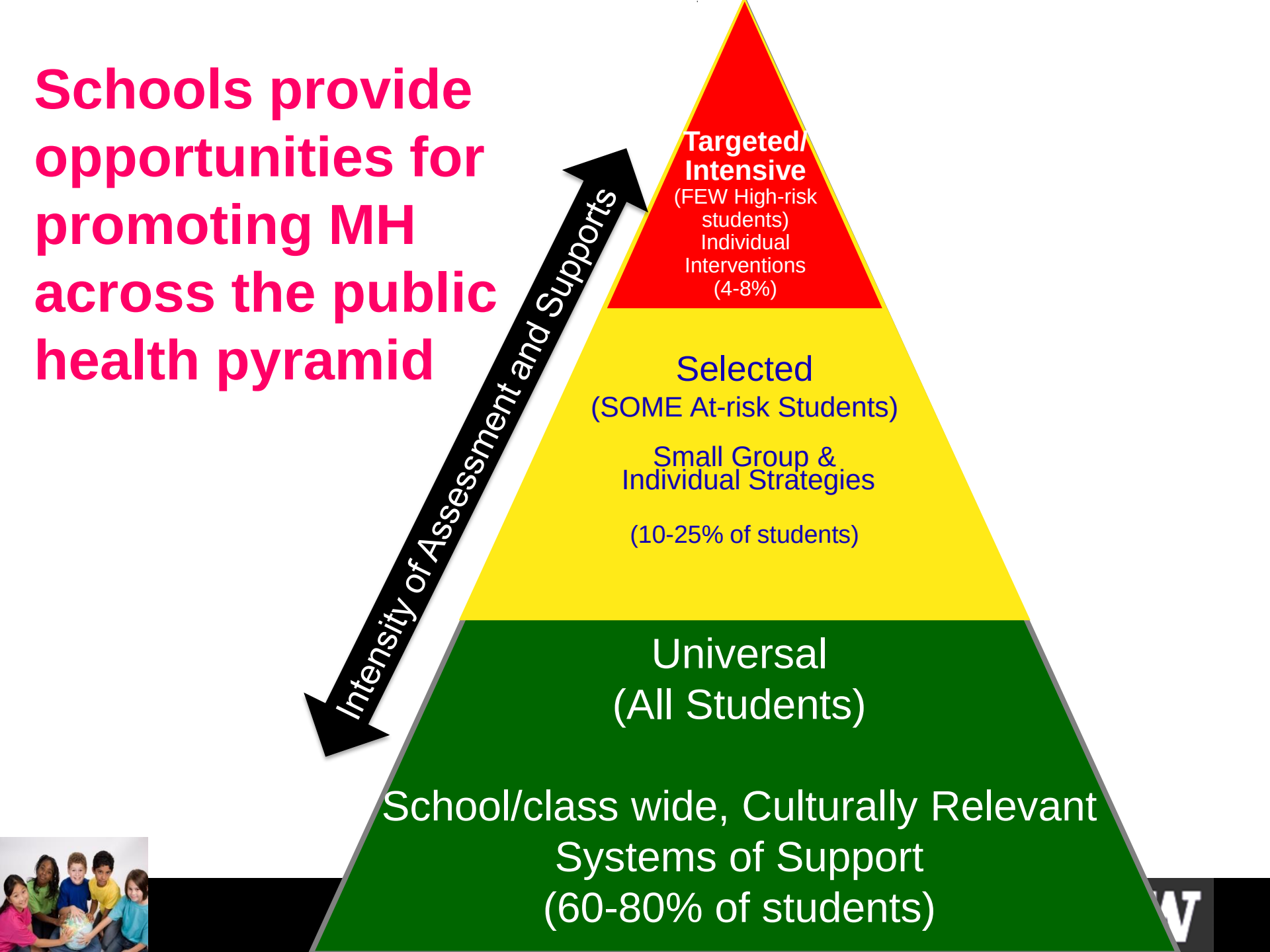
- **Full time Nurse Practitioner, MH clinician, and admin staff**
- 30+ SBHCs in high schools and middle schools
- Funded by the Seattle *Families and Education Levy*
- Staffed by sponsor organizations
- Managed by SPS and PHSKC
- ***Increasing service access***
- ***Evidence of positive effects***

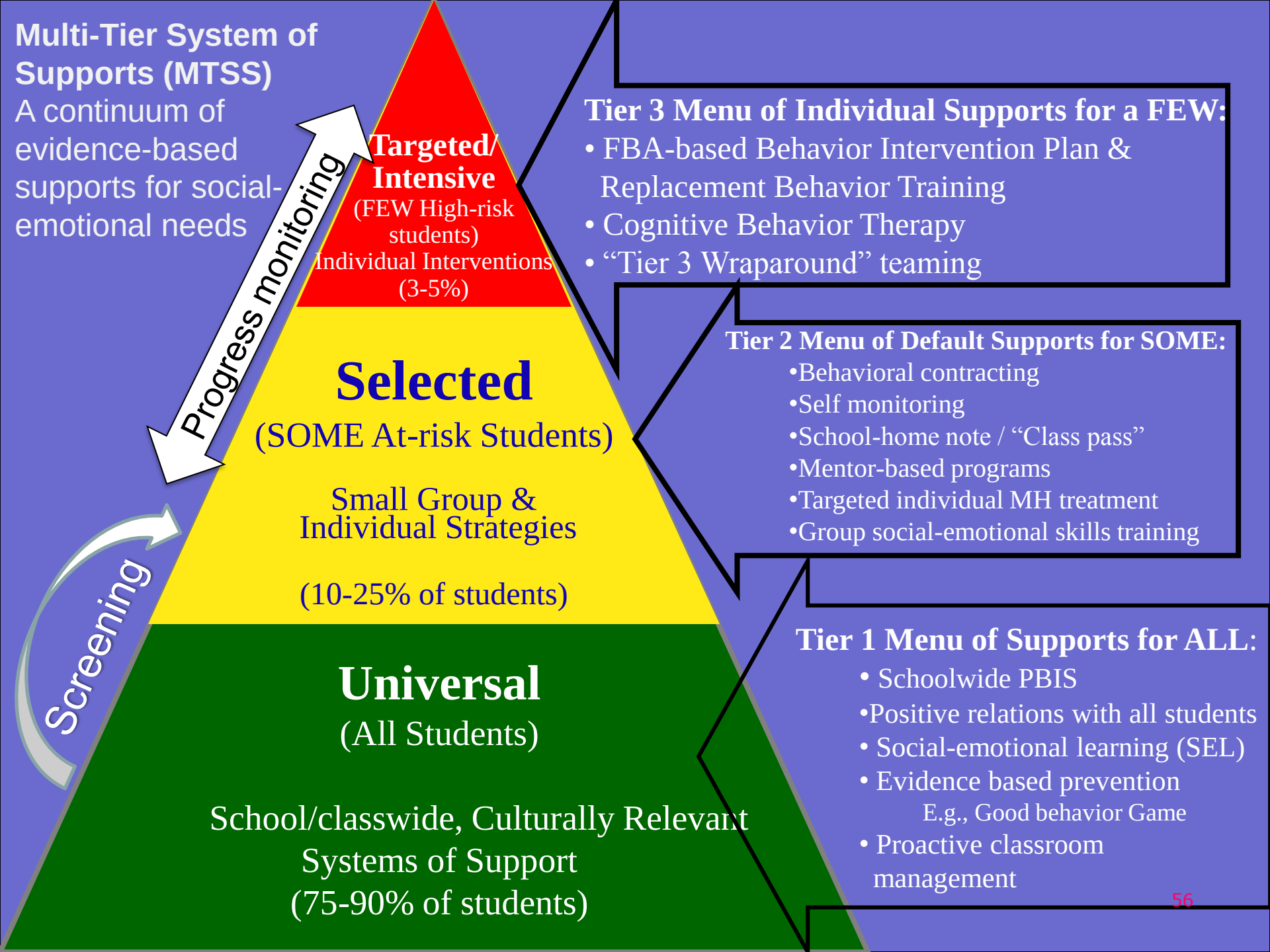
# Schools Improve MH Service Access for underserved populations




Lyon, Bruns, et al. (2013)

# Schools provide opportunities for promoting MH across the public health pyramid




Multi-Tier System of Supports (MTSS)
A continuum of evidence-based supports for social-emotional needs
Progress monitoring
Screening
Targeted/ Intensive
(FEW High-risk students)
Individual Interventions
(3-5%)
Selected
(SOME At-risk Students)
Small Group & Individual Strategies
(10-25% of students)
Universal
(All Students)
School/classwide, Culturally Relevant Systems of Support
(75-90% of students)
Tier 3 Menu of Individual Supports for a FEW:
• FBA-based Behavior Intervention Plan & Replacement Behavior Training
• Cognitive Behavior Therapy
• "Tier 3 Wraparound" teaming
Tier 2 Menu of Default Supports for SOME:
•Behavioral contracting
•Self monitoring
•School-home note / "Class pass"
•Mentor-based programs
•Targeted individual MH treatment
•Group social-emotional skills training
Tier 1 Menu of Supports for ALL:
• Schoolwide PBIS
•Positive relations with all students
• Social-emotional learning (SEL)
• Evidence based prevention
E.g., Good behavior Game
• Proactive classroom management

# Access ≠ Effectiveness

1. **Access & Utilization** of Services
2. Enhancing **Service Quality**


# Brief Intervention for School Clinicians (BRISC)

**Institute of Educational Sciences**
**R305A120128** ***(PIs: McCauley & Bruns)***
**R305A160111** ***(PIs: Bruns & McCauley)***

ies INSTITUTE OF EDUCATION SCIENCES

# School Mental Health

- Over 100,000 providers in the U.S.
- Operating costs of $20 billion (Wong, 2008)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# BRISC: Finding a “Good Fit” for Schools

| ***School-Based Usual Care*** | ***BRISC*** |
|---|---|
| Intervention is often crisis-driven | Structured / systematic identification of treatment targets |

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| Often focused on providing nondirective emotional support | Skill building / problem solving |

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| Many students in need; only a handful get help (many continue after it's needed) | Aimed at efficiency, so the clinician can get to the next student in need |

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| Many students in need; only a handful get help (many continue after it's needed) | Aimed at efficiency, so the clinician can get to the next student in need |
| Students feel like therapy is just "a lot of talking" | Active engagement of the student by focusing on their needs as they describe them |

# Core BRISC Process

- Engage, Assess
- ID Top Problems
- Collaborative Problem Solving
- Did student successfully implement step?

No

If NO: What was the BIGGEST BARRIER to moving forward?

- Wrong Problem/ Solution
- Can't Manage Stress/Mood
- Unable to Express Needs
- Stuck in Negative Thinking

THEN: Individualized, skill-based response

- Revisit Problem List/PS Steps
- Stress and Mood Management Guide
- Communication Guide
- Realistic Thinking Guide

YES

- More to Work on
- Choose a New Problem
- Done with Counseling

# Lessons Learned thus far: Four Core Post-BRISC Pathways (Bruns et al., in press)

1. Come back if you need it (54%)
2. Supportive monitoring (18%)
3. Continue BRISC or other school MH service (18%)
4. Intensive services – (2%)

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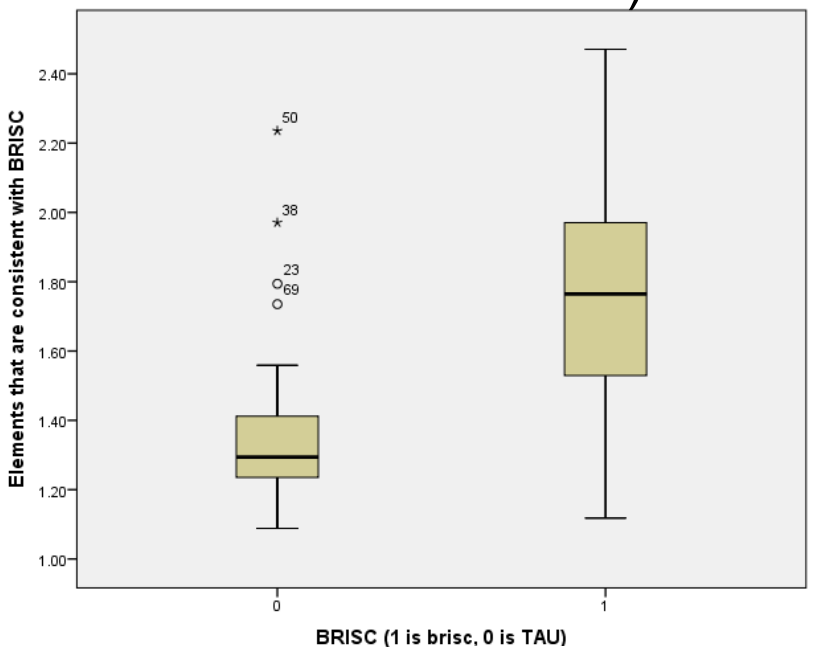
SCHOOL MENTAL HEALTH-ASSIST
ÉQUIPE D'APPUI POUR LA SANTÉ MENTALE DANS LES ÉCOLES

UW Medicine SCHOOL OF MEDICINE

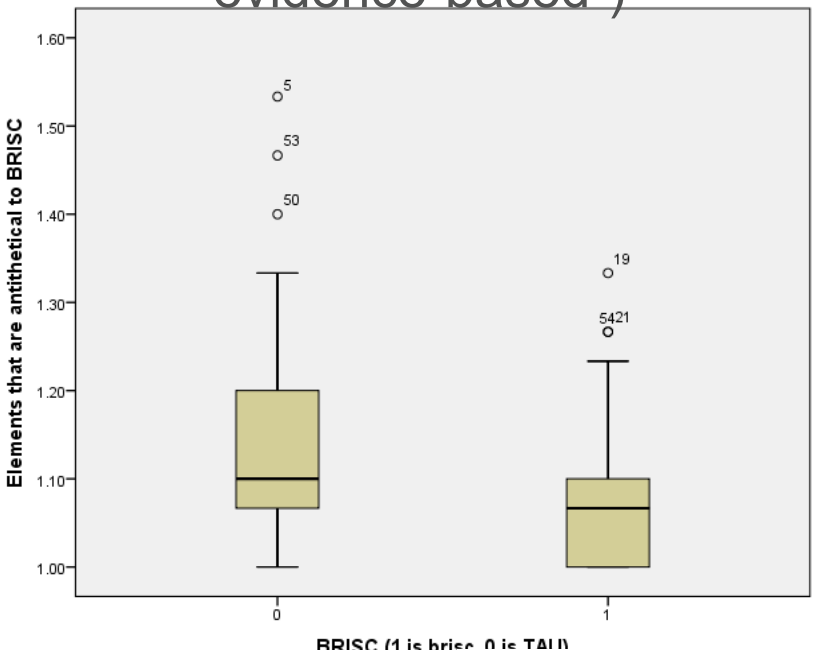
# Lessons learned thus far: SMH Clinicians' practice shifted

Use of Practice Elements Consistent with BRISC (more "evidence-based")




SMH SAU (38 tapes) BRISC (46 tapes)

Use of Practice Elements Antithetical to BRISC (less "evidence-based")

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# Lessons learned thus far: Positive outcomes of BRISC (Bruns et al., under review)

- Clinician-rated feasibility of BRISC was high (3.8 – 4.1 on 5 point scale)
- BRISC was higher than SAU on student alliance
- BRISC higher than SAU on student satisfaction
- BRISC students improved more on certain Outcomes

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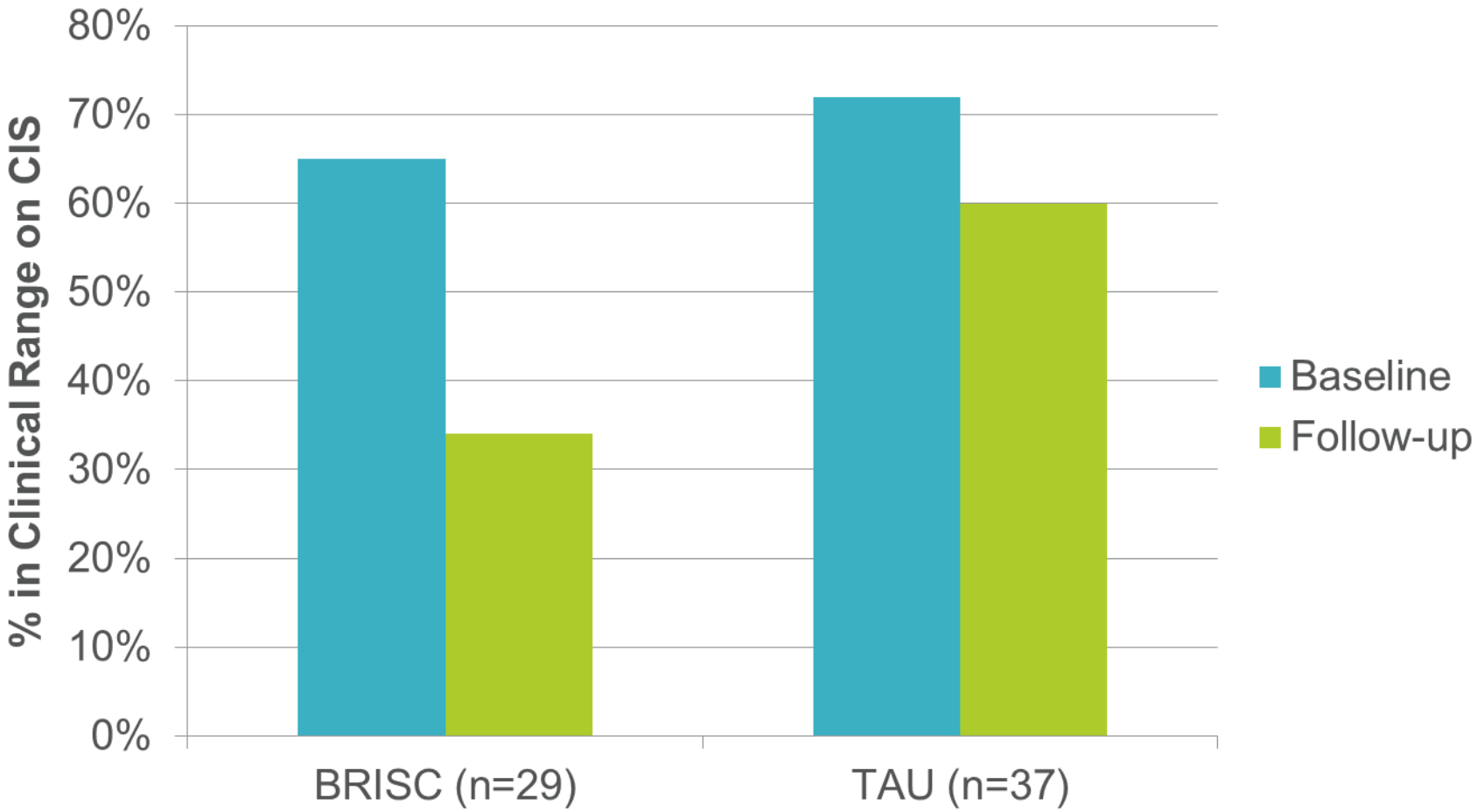
# BRISC youth showed improved functioning after 4 sessions

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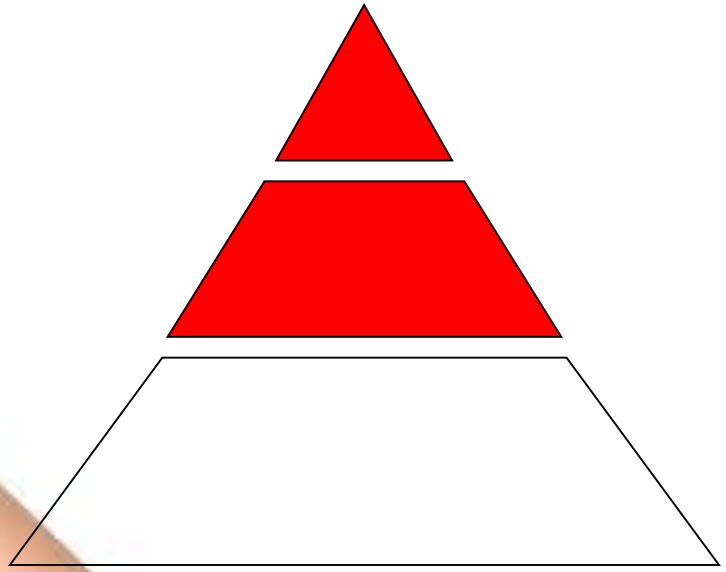
# Opportunities in SMH

- Training and TA on school-wide MTSS
- “Tier 1” social-emotional learning programs
- Trauma-informed schools
- Group-based, skills-based programming for students with depression, anxiety, past trauma
- Improving discipline and reducing disparities by improving student-teacher relationships
- Behavior management skills for teachers
- Reducing burnout among school staff
- … much much more…

Part 4: Getting to What Works

# EVIDENCE-BASED MH FOR THE REAL WORLD

ANALYSIS

# Washington State Leads in Evidence-Based Policymaking

## How the state routinely identifies 'what works' to achieve better outcomes for taxpayers

February 07, 2017 | Pew-MacArthur Results First Initiative | By Sara Dube and Darcy White

# HB 2536: Concerning the use of evidence-based practices for the delivery of services to children and juveniles

"Aims to increase the proportion of contracted services that have a sound scientific evidence base. This new law requires agencies that deliver prevention and intervention services to meet graduated requirements for increasing the percentage of funds expended on evidence-based programs."

family advisory committee, the state racial disproportionality advisory committee, a university-based child welfare research entity in the state, regional support networks, the

Condotta, Ladenburg, Appleton, Jinkins, and Maxwell

MORE ABOUT THIS BILL

# Evidence based practice

- The good
  - We have hundreds of research studies that demonstrate what works
  - Lots of common problems are covered:
    - Anxiety, conduct, depression, trauma
  - Manuals help practitioners know what to do
- The bad
  - You cant learn all the manuals
  - All kids aren't covered
  - When kids have multiple issues, doesn't tell you how to pick or move between them
  - Therapists don't really like using manuals
  - **Manualized EBPs don't work well in the real world**

**“Good to see you, Maggie. As soon as I finish reading these papers, we can start our session today.”**

*January 31, 2013*

# Inventory of Evidence-Based, Research-Based, and Promising Practices

For Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems

| | | | Current Definitions | | | Proposed Definitions | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Budget Area | Program/Intervention | Manual | Evidence-Based | Research-Based | Promising Practices | Evidence-Based | Research-Based | Promising Practices | Cost-beneficial | Reason Program Does Not Meet Proposed Evidence-Based Criteria (see full definitions for notes below) | Percent Minority |
| Child Welfare | Intervention | | | | | | | | | | |
| | Family Search and Engagement | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Functional Family Therapy (FFT) for children in the child welfare system | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Intensive Family Preservation Services (Homebuilders) | Yes | Yes | – | -- | Yes | -- | – | Yes (99%) | | 48% |
| | Multisystemic Therapy (MST) for children in the child welfare system | Yes | No | Yes | -- | No | Yes | – | N/A | Single evaluation | 18% |
| | Other Family Preservation Services (non-Homebuilders) | | No | Yes | -- | No | No | Yes | No (0%) | Weight of evidence | 68% |
| | Parent Child Assistance Program | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Parent-Child Interaction Therapy | Yes | Yes | – | -- | Yes | -- | – | Yes (100%) | | 33% |
| | Parents for Parents | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Partners with Families and Children | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Pathway to Reunification | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Safecare | Yes | No | Yes | -- | Yes | -- | – | Yes (100%) | | 44% |
| | Prevention | | | | | | | | | | |
| | Circle of Security | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Healthy Families America | Yes | Yes | – | -- | No | Yes | – | No (26%) | Benefit-cost | 73% |
| | Nurse Family Partnership | Yes | Yes | – | -- | Yes | -- | – | Yes (80%) | | 51% |
| | Other Home Visiting Programs for At-Risk Parents | | Yes | – | -- | No | Yes | – | No (44%) | Benefit-cost | 50% |
| | Parent Child Home Program | Yes | No | Yes | -- | No | No | Yes | No (38%) | Mixed results within an outcome/Weight of evidence | 64% |
| | Parent Mentor Program | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Parents as Teachers | Yes | Yes | – | -- | No | Yes | – | No (57%) | Benefit-cost | 52% |
| | Promoting First Relationships | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Triple P (system) | Yes | No | Yes | -- | Yes | -- | – | Yes (100%) | | 33% |
| Juvenile Justice | Aggression Replacement Training | Yes | | | | | | | | | |
| | Youth in institutions | | No | Yes | -- | No | Yes | – | Yes (94%) | Heterogeneity | 17% |
| | Youth on probation | | No | Yes | -- | No | Yes | – | Yes (96%) | Heterogeneity | 17% |
| | Connections Wraparound | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Coordination of Services | Yes | No | Yes | -- | No | Yes | – | Yes (82%) | Single evaluation | 10% |
| | Dialectical Behavior Therapy | Yes | No | Yes | -- | No | Yes | – | N/A | Single evaluation/Heterogeneity/Program cost | 27% |
| | Drug courts | | Yes | – | -- | Yes | -- | – | Yes (94%) | | 43% |
| | Family Integrated Transitions | Yes | No | Yes | -- | No | Yes | – | Yes (91%) | Single evaluation/Heterogeneity | 30% |
| | Functional Family Parole with high fidelity | Yes | No | Yes | -- | Yes | -- | – | Yes (91%) | | 38% |
| | Functional Family Parole with average implementation | Yes | No | Yes | -- | No | Yes | – | N/A | | 38% |
| | Functional Family Therapy | Yes | | | | | | | | | |
| | Youth in institutions | | No | Yes | -- | No | Yes | – | Yes (100%) | Heterogeneity | 18% |
| | Youth on probation | | No | Yes | -- | No | Yes | – | Yes (100%) | Heterogeneity | 18% |
| | Mentoring | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Multidimensional Family Therapy for substance abusers | Yes | No | Yes | -- | No | Yes | – | Yes (84%) | Single evaluation | 100% |
| | Multidimensional Treatment Foster Care | Yes | No | Yes | -- | No | Yes | – | Yes (85%) | Heterogeneity | 26% |
| | Multisystemic Therapy | Yes | Yes | – | -- | Yes | -- | – | Yes (98%) | | 51% |
| | Scared Straight | Yes | No | No | No | No | No | No | No (0%) | Weight of evidence | N/A |
| | Sex offender treatment | | Yes | – | -- | Yes | -- | – | N/A | Program cost | 43% |
| | Multisystemic Therapy (MST) for juvenile sex offenders | Yes | Yes | – | -- | Yes | -- | – | N/A | | 43% |
| | Other treatment for juvenile sex offenders | | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Therapeutic Communities for substance abusers | | No | Yes | -- | Yes | -- | – | Yes (77%) | | 57% |
| | Victim offender mediation | | Yes | – | -- | Yes | -- | – | Yes (95%) | | 72% |
| | You Are Not Your Past | | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| General Prevention | Communities that Care | Yes | Yes | – | -- | No | Yes | – | N/A | Heterogeneity/Program cost | 11% |
| | Fast Track Prevention Program | Yes | No | Yes | -- | No | Yes | – | No (0%) | Benefit-cost/Single evaluation | 0% |
| | Good Behavior Game | Yes | Yes | – | -- | Yes | -- | – | Yes (100%) | | 49% |
| | Guiding Good Choices | Yes | No | Yes | -- | No | Yes | – | Yes (85%) | Single evaluation/Heterogeneity | 1% |
| | Quantum Opportunities Program | Yes | Yes | – | -- | No | Yes | – | No (60%) | Benefit-cost | N/A |
| | Seattle Social Development Project | Yes | No | Yes | -- | No | Yes | – | No (59%) | Benefit-cost | 56% |
| | Strengthening Families Program | | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Strengthening Multi-Ethnic Families and Communities | | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Youth Mentoring Programs | | Yes | – | -- | No | Yes | – | No (61%) | Benefit-cost | 0% |
| | Big Brothers Big Sisters | Yes | Yes | – | -- | Yes | -- | – | NA | | 60% |
| | Other Mentoring Programs | | No | Yes | -- | No | Yes | – | N/A | Weight of evidence | N/A |
| Substance Abuse | Life Skills Training | | Yes | – | -- | Yes | -- | – | Yes (100%) | | 33% |
| | Multidimensional Family Therapy for substance abusing juvenile offenders | Yes | No | Yes | -- | No | Yes | – | Yes (84%) | Single evaluation | 100% |
| | Multisystemic Therapy (MST) for substance-abusing juvenile offenders | Yes | Yes | – | -- | Yes | -- | – | Yes (85%) | | 63% |
| | Project ALERT | | No | No | No | No | No | No | No (1%) | Weight of evidence/Heterogenity | N/A |
| | Project STAR | | Yes | – | -- | No | Yes | – | No (71%) | Heterogeneity/Benefit-cost | 21% |
| | Project Toward No Drug Abuse | | Yes | – | -- | Yes | -- | – | Yes (76%) | | 69% |
| | Seven Challenges | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Therapeutic Communities for substance abusing juvenile offenders | | No | Yes | -- | Yes | -- | – | Yes (77%) | | 57% |

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| Budget Area | Program/Intervention | Manual | Evidence-Based | Research-Based | Promising Practices | Evidence-Based | Research-Based | Promising Practices | Cost-beneficial | Reason Program Does Not Meet Proposed Evidence-Based Criteria (see full definitions for notes below) | Percent Minority |
| Mental Health | **Anxiety** | | | | | | | | | | |
| | Cognitive Behavioral Therapy (CBT) for Anxious Children (group, individual or remote) | | No | -- | -- | No | Yes | -- | N/A | Heterogeneity | 26% |
| | Cool Kids | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | N/A |
| | Coping Cat | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 26% |
| | Coping Cat/Koala book based model | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 26% |
| | Coping Koala | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 10% |
| | Other Cognitive Behavioral Therapy (CBT) for Anxious Children | | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 23% |
| | Parent Cognitive Behavioral Therapy (CBT) for Anxious Young Children | | No | Yes | -- | No | Yes | -- | Yes (81%) | Heterogeneity | 26% |
| | Theraplay | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | **Attention Deficit Hyperactivity Disorder** | | | | | | | | | | |
| | Cognitive Behavioral Therapy (CBT) for Children with ADHD | | No | No | No | No | No | No | No (3%) | Weight of evidence/Heterogeneity | 7% |
| | Behavioral Parent Training (BPT) for Children with ADHD | | No | Yes | -- | No | Yes | -- | Yes (98%) | Heterogeneity | 26% |
| | Barkley Model | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 26% |
| | New Forest Parenting Programme | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | N/A |
| | Multimodal Therapy (MMT) for Children with ADHD | | No | Yes | -- | No | Yes | -- | No (11%) | Weight of evidence/Heterogeneity | 7% |
| | **Depression** | | | | | | | | | | |
| | Cognitive Behavioral Therapy (CBT) for Depressed Adolescents | | No | Yes | -- | No | Yes | -- | Yes (99%) | Heterogeneity | 19% |
| | Coping with Depression-Adolescents | Yes | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 14% |
| | Treatment for Adolescents with Depression Study | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence/Heterogeneity | 23% |
| | Other Cognitive Behavioral Therapy (CBT) for Depressed Adolescents | | No | Yes | -- | No | Yes | -- | N/A | Heterogeneity | 14% |
| | **Disruptive Behavior (Oppositional Defiant Disorder or Conduct Disorder)** | | | | | | | | | | |
| | Behavioral Parent Training (BPT) for Children with Disruptive Behavior Disorders | | No | Yes | -- | Yes | -- | -- | N/A | | 43% |
| | Incredible Years Parent Training | Yes | Yes | -- | -- | No | Yes | -- | No (61%) | Benefit-cost | 51% |
| | Incredible Years Parent Training + Child Training | Yes | Yes | -- | -- | No | Yes | -- | No (59%) | Benefit-cost | 51% |
| | Parent Child Interaction Therapy (PCIT) for Children with Disruptive Behavior Problems | Yes | Yes | -- | -- | Yes | -- | -- | Yes (100%) | | 64% |
| | Triple-P Level 4, Group | Yes | No | Yes | -- | No | Yes | -- | Yes (100%) | Heterogeneity | 6% |
| | Triple-P Level 4, Individual | Yes | No | Yes | -- | No | Yes | -- | Yes (92%) | Heterogeneity | 6% |
| | Other Behavioral Parent Training | | No | Yes | -- | No | Yes | -- | No (68%) | Heterogeneity | N/A |
| | Brief Strategic Family Therapy (BSFT) | Yes | Yes | -- | -- | No | Yes | -- | No (69%) | Benefit-cost | 100% |
| | Families and Schools Together (FAST) | Yes | Yes | -- | -- | No | Yes | -- | No (52%) | Benefit-cost | 57% |
| | Kids Club and Moms Empowerment support groups | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Multimodal Therapy (MMT) for Children with Disruptive Behavior | | No | No | No | No | No | No | No (42%) | Weight of evidence/Heterogeneity | 7% |
| | **Fetal Alcohol Syndrome** | | | | | | | | | | |
| | Families Moving Forward | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | **Serious Emotional Disturbance** | | | | | | | | | | |
| | Multisystemic Therapy (MST) for Youth with Serious Emotional Disturbance (SED) | Yes | No | Yes | -- | No | Yes | -- | No (68%) | Heterogeneity | 21% |
| | High Fidelity Wraparound for Youth with Serious Emotional Disturbance (SED) | Yes | No | Yes | -- | No | Yes | -- | N/A | Program cost | 61% |
| | **Trauma** | | | | | | | | | | |
| | ADOPTS: therapy to address distress of post traumatic stress in adoptive children | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | Child-Parent Psychotherapy | Yes | No | Yes | -- | No | Yes | -- | N/A | Single evaluation | 9% |
| | Cognitive Behavioral Therapy (CBT)-Based Models for Child Trauma | | Yes | -- | -- | Yes | -- | -- | Yes (100%) | | 47% |
| | Classroom Based Intervention for war-exposed children | Yes | Yes | -- | -- | Yes | -- | -- | N/A | | 100% |
| | Cognitive Behavioral Intervention for Children in Schools | Yes | Yes | -- | -- | Yes | -- | -- | N/A | | 100% |
| | Enhancing Resiliency Among Students Experiencing Stress (ERASE-Stress) | Yes | Yes | -- | -- | Yes | -- | -- | N/A | | 100% |
| | KID-NET Narrative Exposure Therapy for Children | Yes | Yes | -- | -- | Yes | -- | -- | N/A | | 100% |
| | Trauma Focused CBT for Children | Yes | Yes | -- | -- | Yes | -- | -- | N/A | | 42% |
| | Trauma Grief Component Therapy | Yes | No | Yes | -- | No | Yes | -- | N/A | | N/A |
| | Other Cognitive Behavioral Therapy (CBT)-Based Models for Child Trauma | | Yes | -- | -- | Yes | -- | -- | N/A | | 67% |
| | Eye Movement Desensitization and Reprocessing (EMDR) for Child Trauma | Yes | Yes | -- | -- | Yes | -- | -- | Yes (79%) | | 50% |
| | Take 5: Trauma Affects Kids Everywhere - Five Ways to Promote Resilience | Yes | No | No | Yes | No | No | Yes | N/A | Weight of evidence | N/A |
| | **Treatment Organizational Approaches** | | | | | | | | | | |
| | Modularized Approaches to Treatment of Anxiety, Depression and Behavior (MATCH) | | No | Yes | -- | No | Yes | -- | N/A | Program cost | 65% |

**Notes:**

Benefit-cost: The WSIPP benefit-cost model was used to determine whether a program meets this criterion. Programs that do not achieve at least a 75 percent chance of positive net present value do not meet the benefit-cost test.

Heterogeneity: To be designated as evidence-based under current law or the proposed definition, a program must have been tested on a "heterogeneous" population. We operationalized heterogeneity in two ways. First, the proportion of minority program participants must be greater than or equal to the minority proportion of children in Washington State aged 0 to 17. From the 2010 Census, for children aged 0 through 17 in Washington, 68% were white and 32% minority. Thus, if the weighted average of program participants had at least 32% minorities then the program was considered to have been tested on a heterogeneous population.
Second, the heterogeneity criterion can also be achieved if at least one of the studies has been conducted on youth in Washington and a subgroup analysis demonstrates the program is effective for minorities ($p <= .2$).
Programs that do not meet either of these two criteria do not meet the heterogeneity definition.

Mixed results within an outcome: If findings within an outcome area (e.g., crime) have mixed results from different measures, (e.g., undesirable outcomes for felony convictions and desirable outcomes for misdemeanor convictions) the program does not meet evidence-based criteria.

Program cost: A program cost was not available to WSIPP at the time of the inventory. Thus, WSIPP could not conduct a benefit-cost analysis.

Single evaluation: The program does not meet the minimum standard of multiple evaluations or one large multiple-site evaluation contained in the current or proposed definitions.

Weight of evidence: Results from a random effects meta-analysis ($p > .10$) indicate that the weight of the evidence does not support desired outcomes, or results from a single large study indicate the program is not effective.

# Training alone will not suffice

- Chorpita et al. (2011) identified 395 evidence-based protocols of over 750 psychosocial treatments tested in controlled clinical trials
  - Even if a practitioner knew 395 EBTs, it would cover less than half of the children receiving usual care
  - For one agency to train 8 clinicians to use 4 manualized EBPs would cost… $160-$190K

# A new movement in EBP is to focus on Practice Elements of effective interventions

## Behavior Therapy

- token economy (points system)
- time-out
- structure

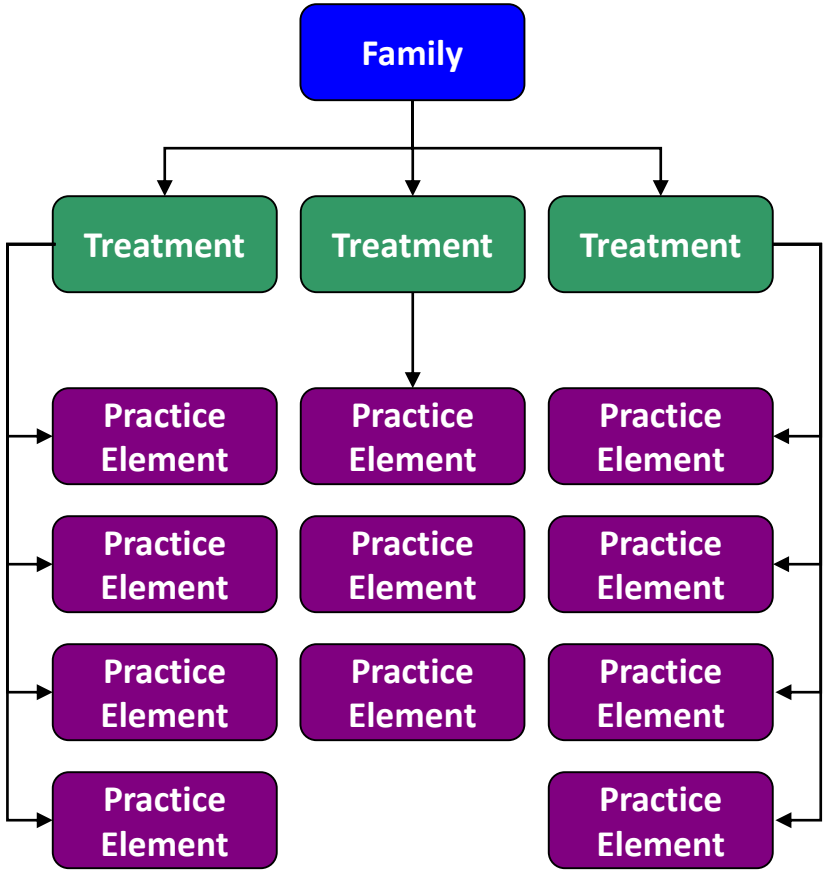
## Cognitive-Behavioral Therapy

- problem-solving skills
- social skills
- changing irrational or very negative thinking
- stress reduction (e.g., relaxation)

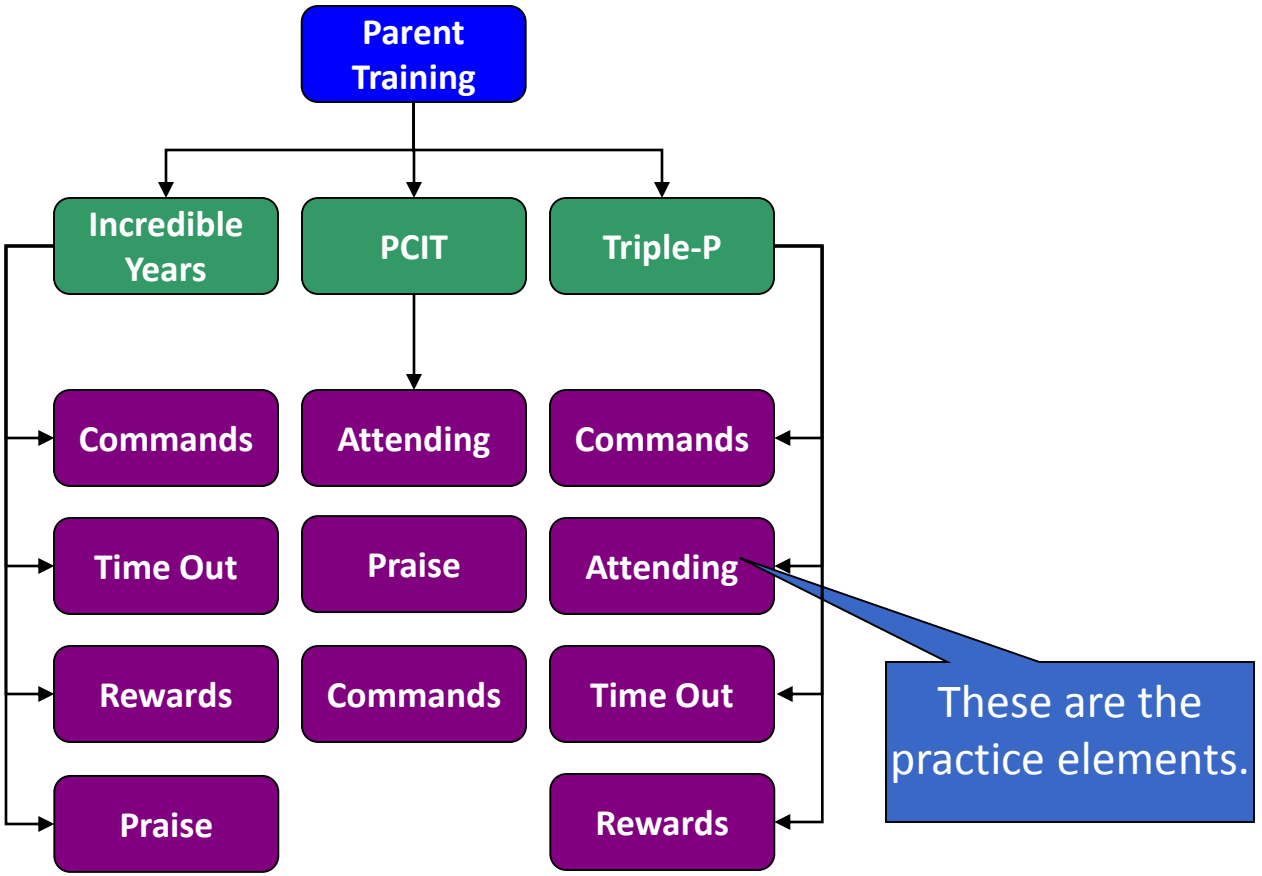
## Parent Skills Training

- Praise, attending
- encourage positive behavior
- track behavior
- establish rules
- interrupt conflict
- implement consequences
- communication
- family fun

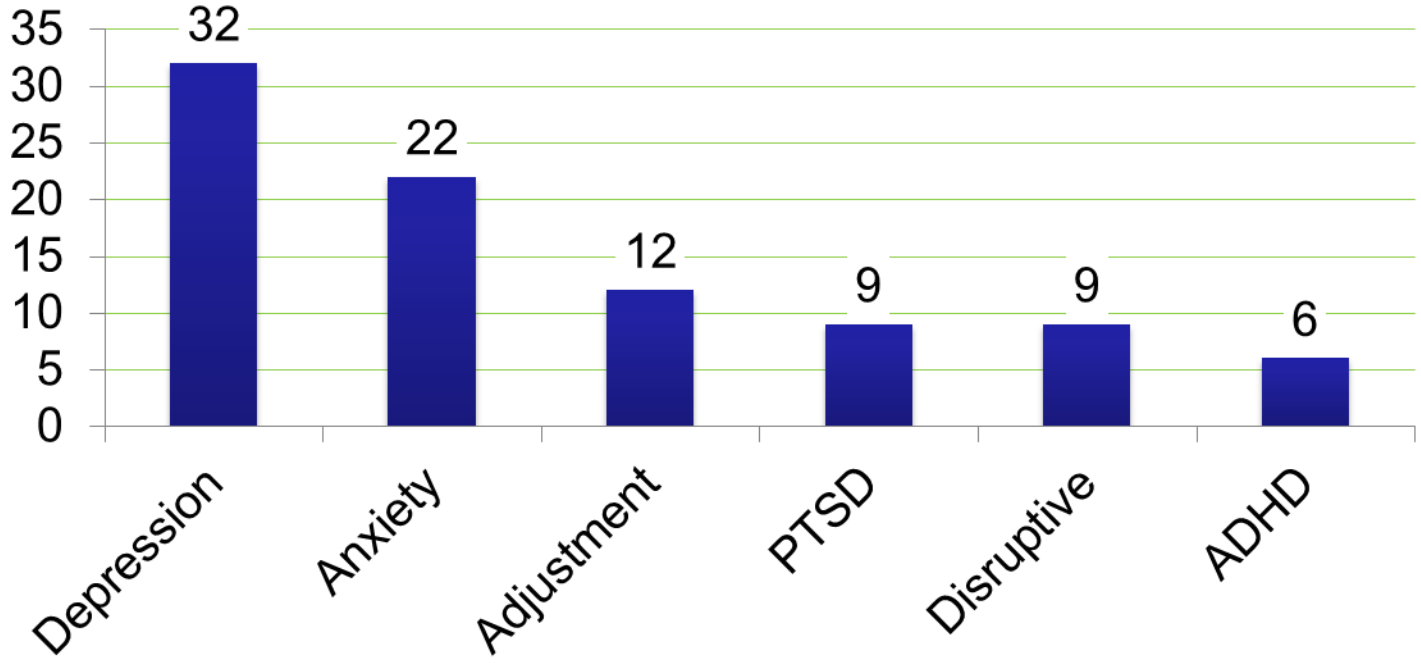
# A new movement in EBP is to focus on Practice Elements of effective interventions




# Practice Elements Are the Parts of Treatments




# WA State Medicaid Billing – Most Common Conditions




# What is CBT+?

Elements of:

- CBT for Anxiety
- CBT for Depression
- TF-CBT for trauma specific impact
- Parent Behavior Management skills for Behavior Problems

# What is CBT+?

- Efficient: training method in 4 EBTs
  - Provides coverage for 80+% of diagnoses given in WA
- Evidence-based models:
  - The 4 EBPs are on the WSIPP Inventory
- Evidence-based training method:
  - In-person + Case Consultation
  - Documentation of delivery of the models
- Cost effective: Uses “common elements” approach
  - No proprietary companies or costs for the models
- Reach: 1500 public mental health providers trained

# What counts as an EBP?

## EBPI Reporting Guides for WA Providers: Minimizing Burden, Reinforcing practice

| Checklist for Determining Whether a Service Encounter is an R/EBP |
| --- |
| ✓ **1. Training:** The provider received training in the R/EBP certified training OR a training that covered essential elements of practice. |
| ✓ **2. Consultation:** The provider completed the consultation requirements of a name brand program (only applicable for name brand R/EBP). |
| ✓ **3. Treatment Plan:** The provider lists at least one essential clinical element in the treatment plan for the indicated client. |
| ✓ **4. Progress Notes:** The provider lists at least one essential or approved clinical element in the progress notes for the indicated client session. |

# WA State Juvenile Rehabilitation Administration

- JRA's Integrated Treatment Model
  - Incorporates **common elements** of cognitive-behavioral and family therapy principles into residential and parole programs in the JRA continuum of care.

# JRA ITM
# Functional Family Parole

- Parole staff work with families to address the role each member has in generating and ultimately resolving "problem behavior”
- Based on *Functional Family Therapy*, a research-based family intervention considered a "Blueprint" model
- Interventions reduce blame and negativity among family members and instill hope for change.
- Families are also referred to needed services in the community that match family interaction styles and provide continued support for the family once the youth is no longer on parole.

# Effects of Functional Family Parole on Re-Arrest and Employment for Youth in Washington State

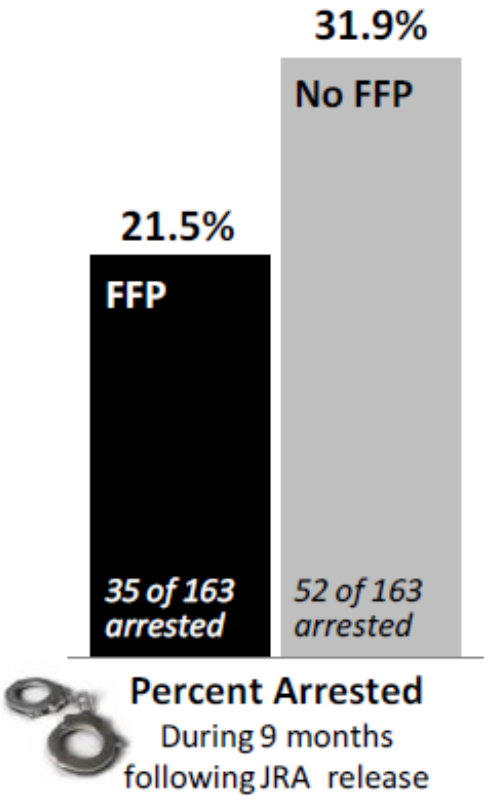
## EXECUTIVE SUMMARY

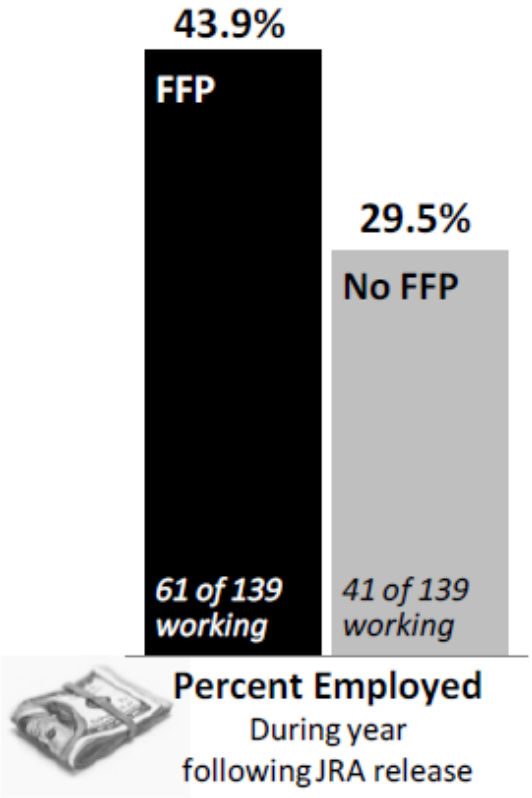
Barbara A. Lucenko, PhD, Lijian He, PhD, David Mancuso, PhD, and Barbara Felver, MES, MPA

*In collaboration with Bob Salsbury, Juvenile Rehabilitation Administration*

***NOTE:*** *See* ***Technical Appendix*** *for Methods and Definitions: http://www.dshs.wa.gov/rda/.*

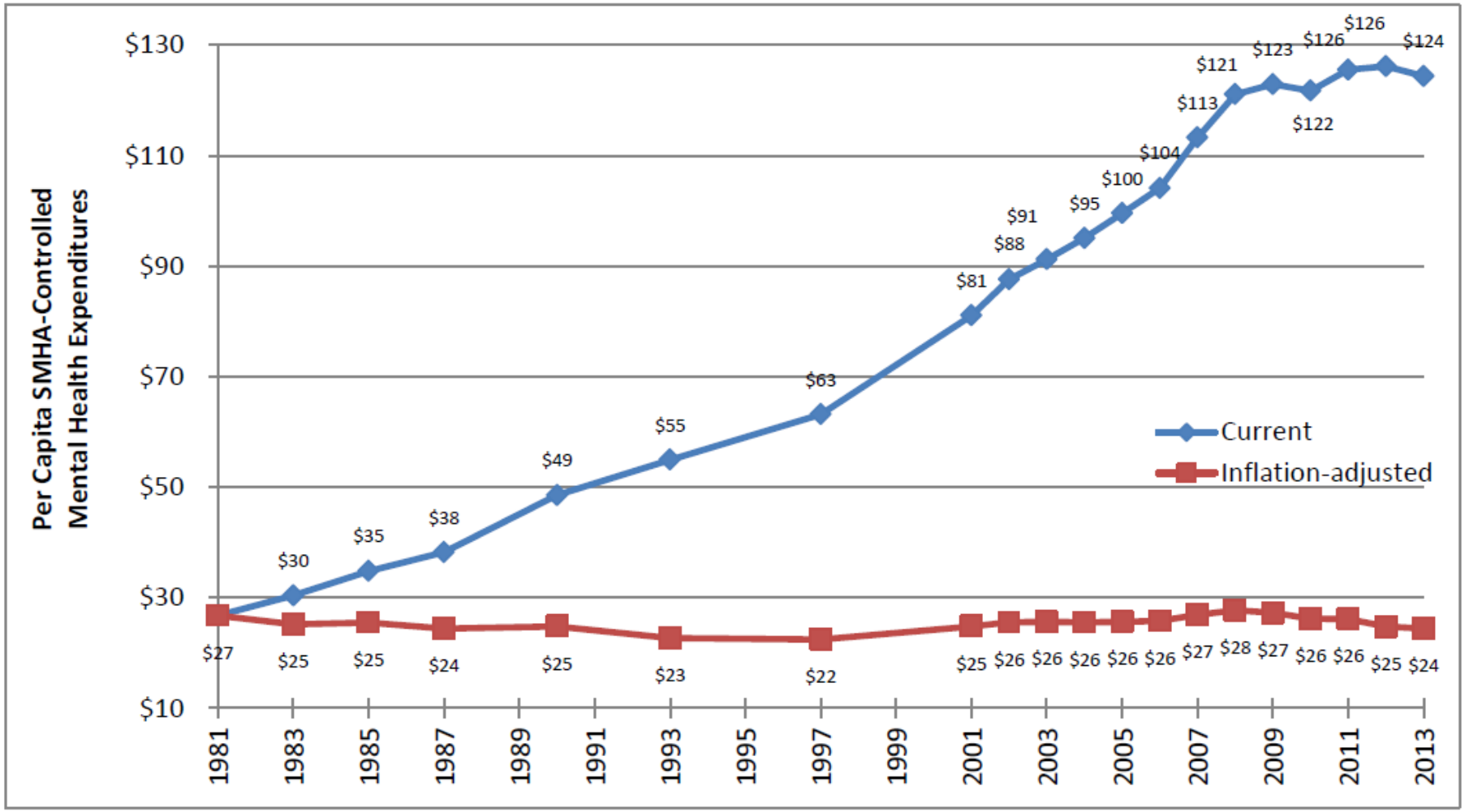
# FFP youth far less likely to be arrested and more likely to be employed 12 months later




Washington State DSHS (2011)

# Trends in state mental health expenditures




Source: NASMHPD Research Institute, 2014

# Summary of main points*

- "Distill": Brief, efficient, non-proprietary approaches that mobilize common elements of EBP for use in the real world
- "De-institutionalize": "Flip the cost triangle" and build integrated, community-based care structures
- "Democratize": Go where the kids are, adopt team-based approaches, and activate indigenous helpers (peers, school staff, parole officers)
- "Deploy": Implement broad policies, not programs
  - Care management entities, MTSS, Common elements
  - Evidence-based parenting, universal pre-school, Income support
- "Drive with data":
  - Use Health Information Technology
  - Study impacts at youth, program, and system levels

*with thanks to Kimberly Hoagwood

# Opportunities abound!

- **HB2536:** Training and consultation on efficient approaches to EBP
- **Medicaid Billable, Cheap, and Effective:** Youth and Parent Peer Support
- **2020 – Integrated Care in WA**: Applying research to outcome monitoring, “intermediate care coordination”
- **ESSA:** 295 School Districts who can get incentives for ISS, MTSS, and SMH
- **HITECH Act:** Health Information Tech. and EHRs
- **Workforce development** – pre- and post-placement training programs
- **Research** on impact of all of the above

# Let's go!

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