Measurement in Children's Behavioral Health

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REC
It's Groundhog Day again.

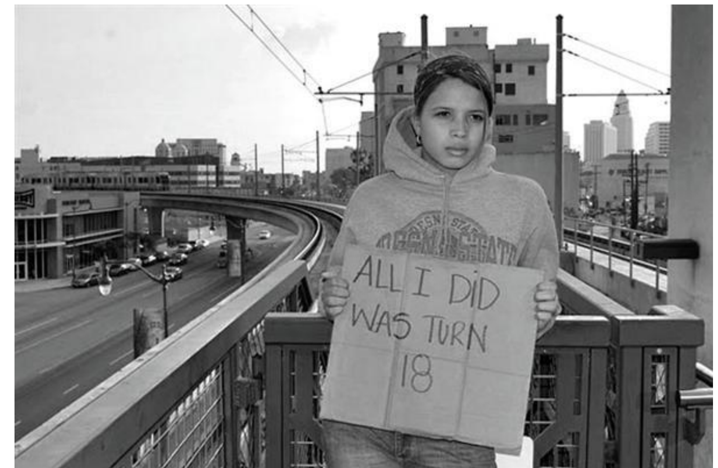
Continuing trends in youth behavioral health

Medicaid: residential treatment spending

- Residential and group home spending increased from $1.5 billion to $2.6 billion from 2005 to 2011 (Pires, 2017)

Child welfare: rates and length of placements

- ACF data shows 56,188 (14%) of all youth in care were in RTCs
- Placements average 8 months
- 34% of all youth spend 9 months or more in facilities
  - (Casey Family Programs, 2016)



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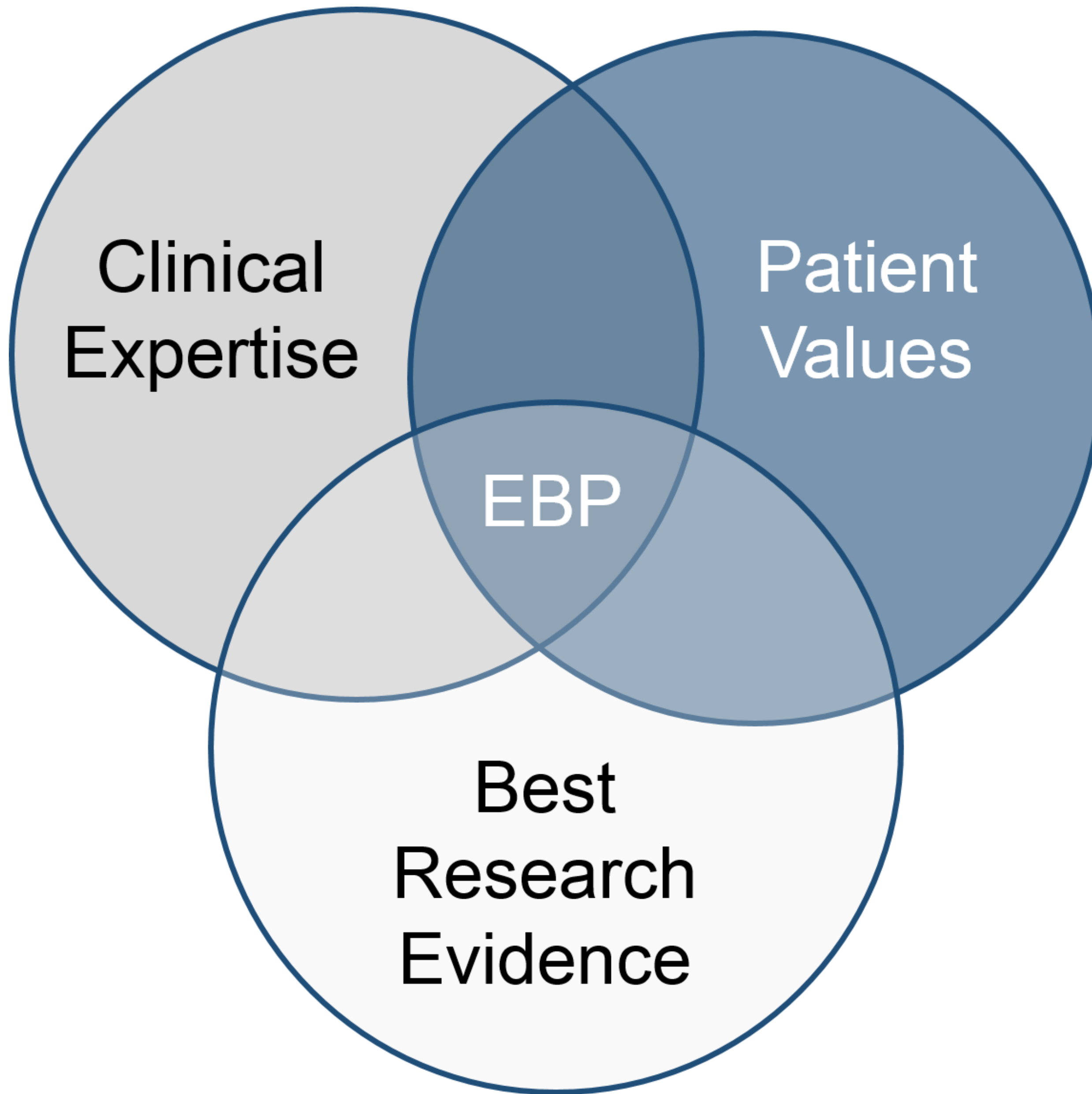
Clinical Expertise
Patient Values
EBP
Best Research Evidence

Common factors of effective care

- Engage and build alliance
- Build skills
- Coordinate across helpers
- **Clear, shared goals**
- **Measure progress**

Adm Policy Ment Health (2016) 43:482–491
DOI 10.1007/s10488-015-0649-6

POINT OF VIEW

The Expanding Relevance of Routinely Collected Outcome Data for Mental Health Care Decision Making

gatti[4] ·

Is It Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis

Michael J. Lambert, Jason L. Whipple, and Eric J. Hawkins, Brigham Young University
David A. Vermeersch, Loma Linda University
Stevan L. Nielsen and David W. Smart, Brigham Young University

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nhancing Treatment Outcome of Patients at Risk of Treatment Failure: Meta-Analytic and Mega-Analytic Review of a Psychotherapy Quality Assurance System

Kenichi Shimokawa, Michael J. Lambert, and David W. Smart
Brigham Young University

Objective: Outcome research has documented worsening among a minority of the patient population (5% to 10%). In this study, we conducted a meta-analytic and mega-analytic review of a psychotherapy quality assurance system intended to enhance outcomes in patients at risk of treatment failure. ***Method:*** Original data from six major studies conducted at a large university counseling center and a hospital outpatient setting (*N* = 6,151, mean age = 23.3 years, female = 63.2%, Caucasian = 85%) were reanalyzed to examine the effects of progress feedback on patient outcome. In this quality assurance

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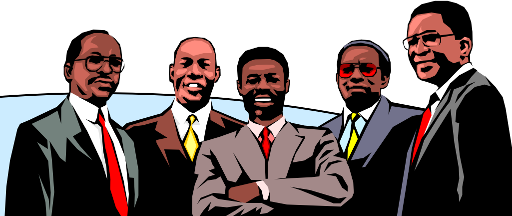
Monitoring: Realizing the Potential of k-Informed Treatment

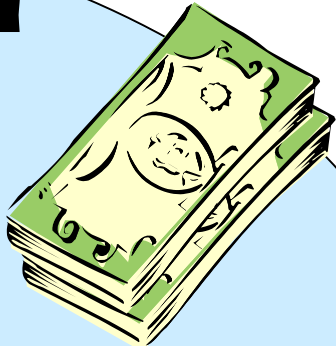
A. Hubble, Daryl Chow, and Jason Seidel
ter for Clinical Excellence, Chicago, Illinois

ntrolled trials and several meta-analyses have provided strong e monitoring (ROM) in clinical practice. Despite current enthusi- d the growing belief among some proponents and policymakers that in the practice of psychotherapy, other research has suggested that nitoring is in danger of missing the point. Any clinical tool or rapist who uses it. Failing to attend to the therapist's contribution, therapy outcome, ensures that efforts to create, research, and refine will inevitably fall short. Research from the field of expertise and expert performance provides guidance for realizing the full potential of ROM.

Keywords: routine outcome measurement, therapist factors, expertise, professional, development

Necessary Community and System Supports for Wraparound





Hospitable System *Funding, Policies

Supportive Organizations

* Training, supervision, interagency coordination and collaboration

Effective Team

* Process + Principles

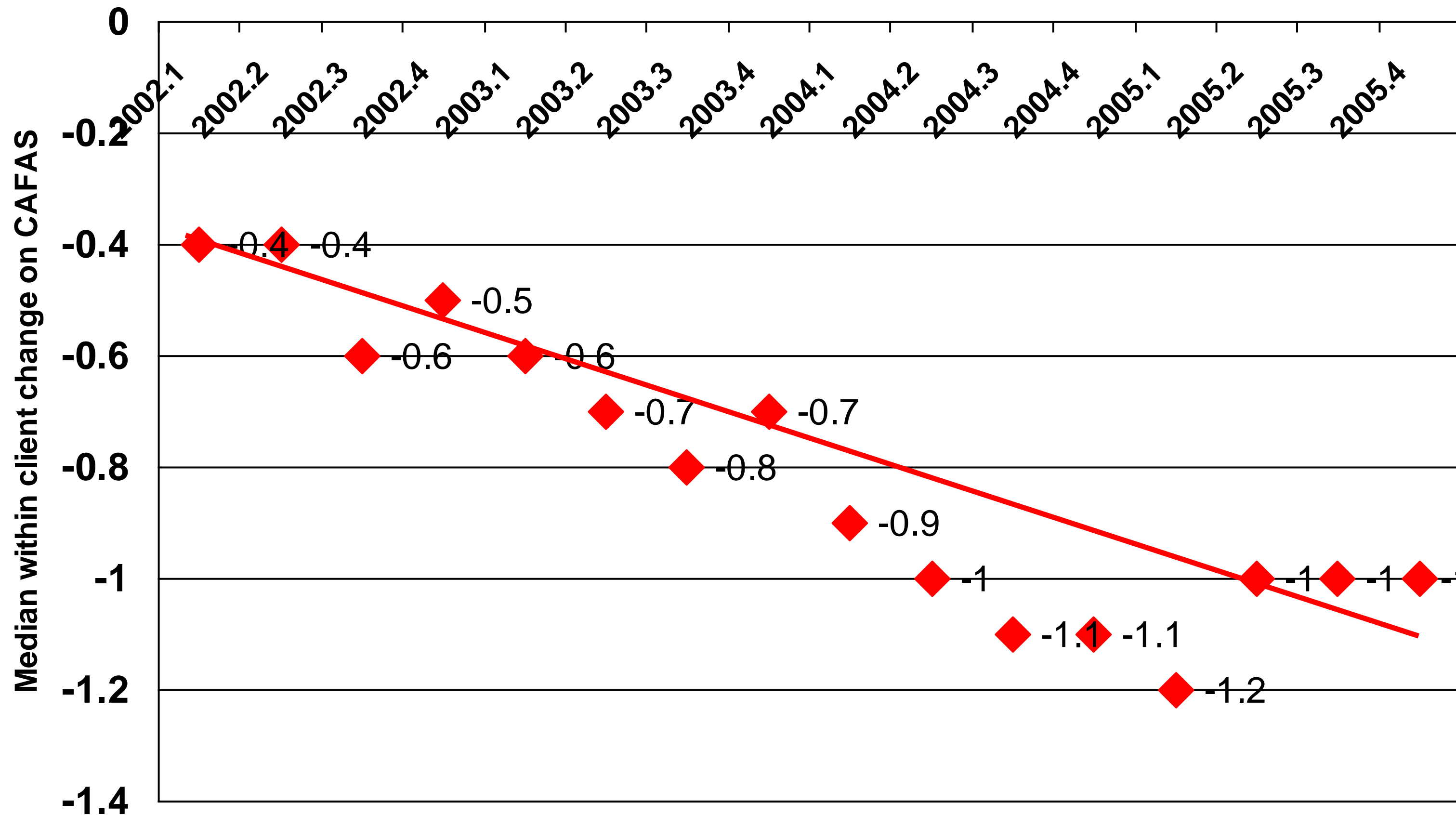
Necessary Community and System Supports for Wraparound

- Partnership
- Service Array
- Fiscal strategies
- Workforce Development
- Accountability

Program and system decision support promoted by TCOM

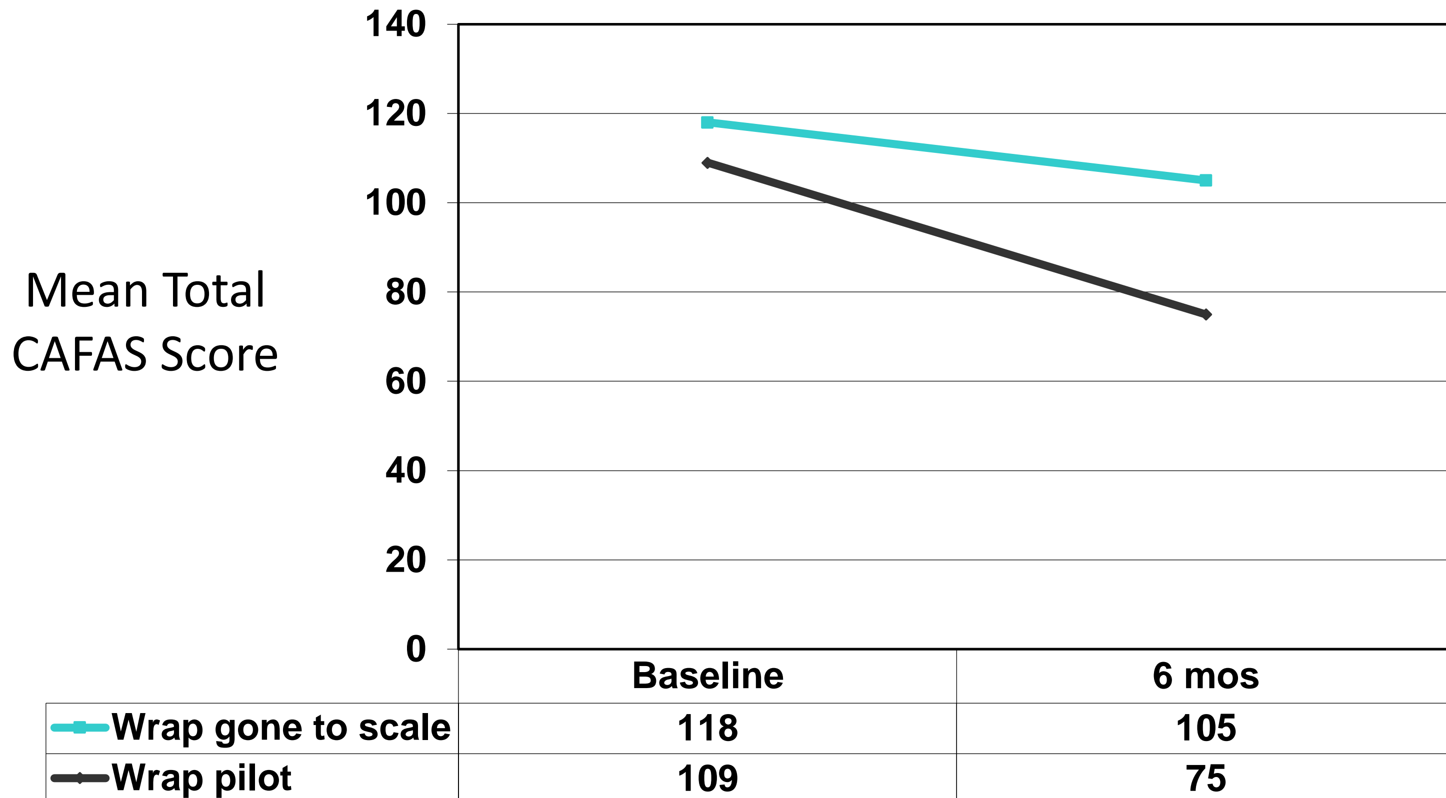
	Family and Youth	Program	System
Decision Support	• Care planning • Effective practices • Selection of EBPs	• Eligibility • Step-down • Transition	• Resource Management • Right-sizing
Outcome Monitoring	• Service transitions • Celebrations • Plan of care revision	• Evaluation of Outcomes	• Evaluation • Provider profiles • Performance contracting
Quality Improvement	• Care management • Supervision	• Continuous quality improvement • Program (re)design	• Transformation • Business model design

Tracking the rate of improvement in child functioning in Hawai'i



Daleiden et al. (2006). Getting better at getting them better: Health outcomes and evidence based practice in a system of care. *Journal of the American Academy of Child and Adolesc. Psychiatry, 45*.

Tracking the rate of child improvement over time after state went to scale



	Baseline	6 mos
Wrap gone to scale	118	105
Wrap pilot	109	75

Bruns, Pullmann, Sather, Brinson, & Ramey, 2014

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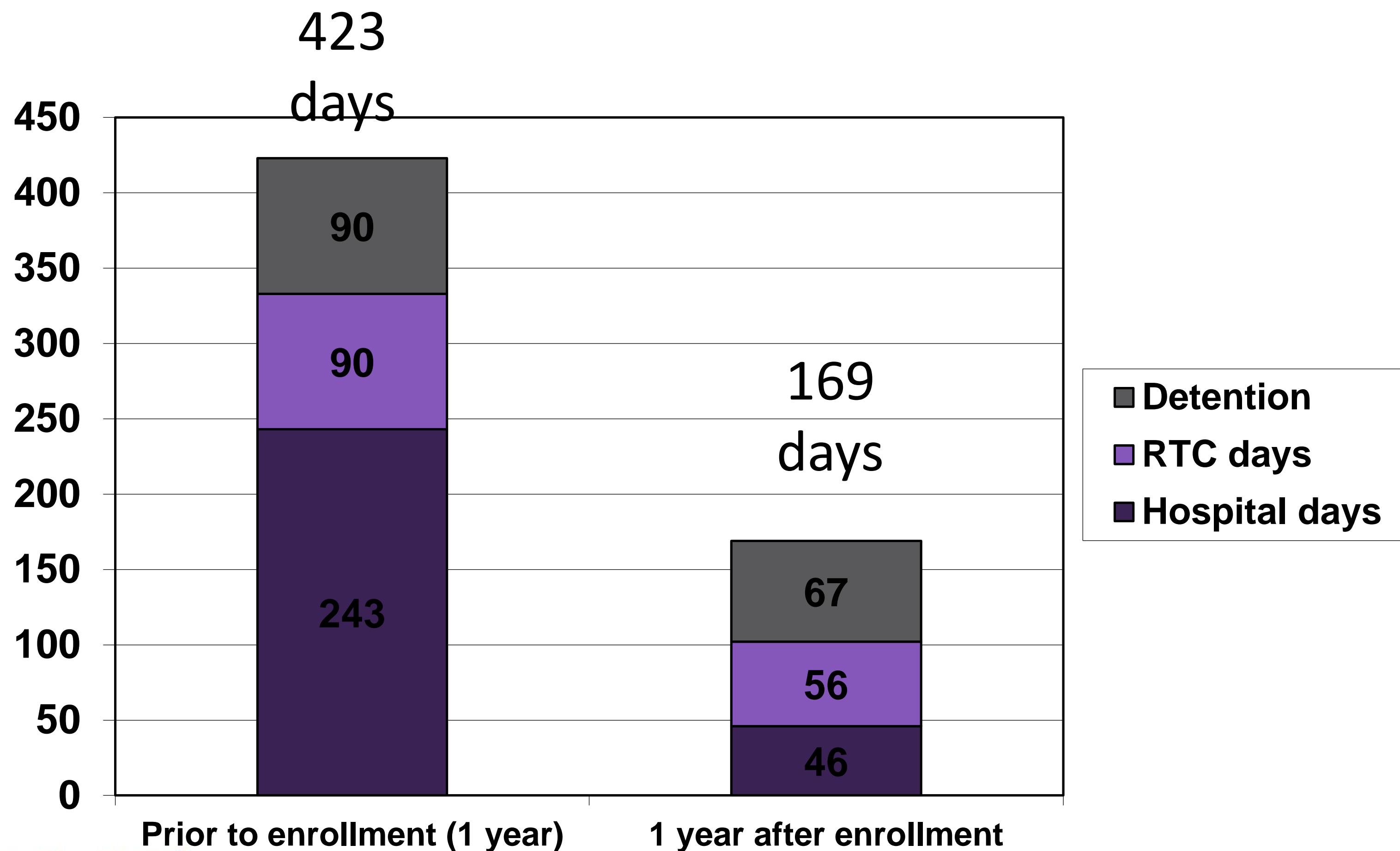
Tracking placement status pre- and post wraparound (n=20 youth)



Translating placement data to cost-effectiveness data for 20 wrap youths

Placement type	Cost per unit	N units		Total cost	
		Pre-wrap	post-wrap	Pre-wrap	post-wrap
Detention	$407/day	90	67	$36,630	$27,269
Resid. Treatment	$450/day	90	56	$40,500	$25,200
Psych Hospital	$3500/day	243	46	$927,630	$161,000
TOTAL out of community care				**$1,004,760**	**$213,269**
Savings on out of community care				**$714,361**	
TOTAL WRAP COSTS	$1,300 pmpm	9 months (average LOS)		**$234,000**	
NET COST SAVINGS				**$480,361 ($24,018 per youth)**	

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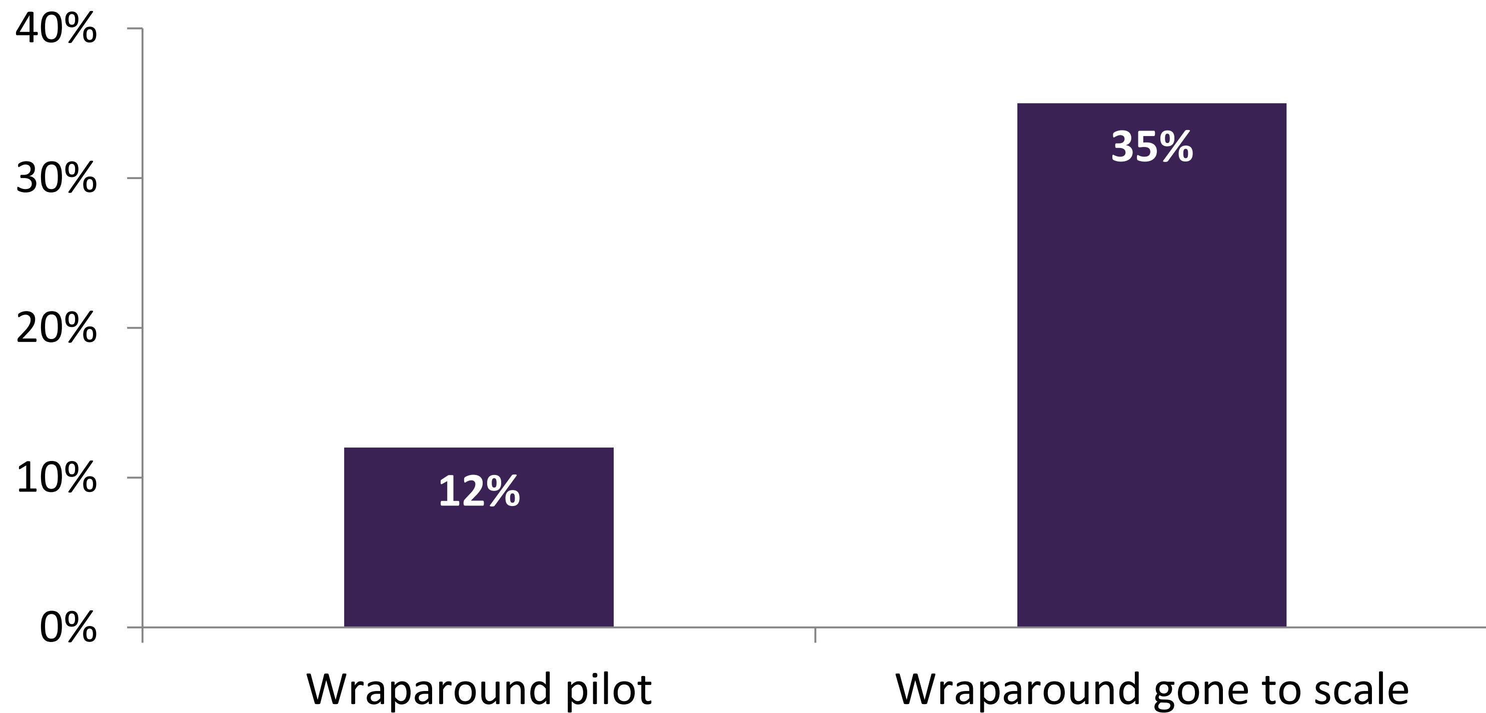
Tracking the change in placement rate over time after state went to scale



National Wraparound Implementation Center (NWIC)

Bruns, Pullmann, Sather, Brinson, & Ramey, 2014

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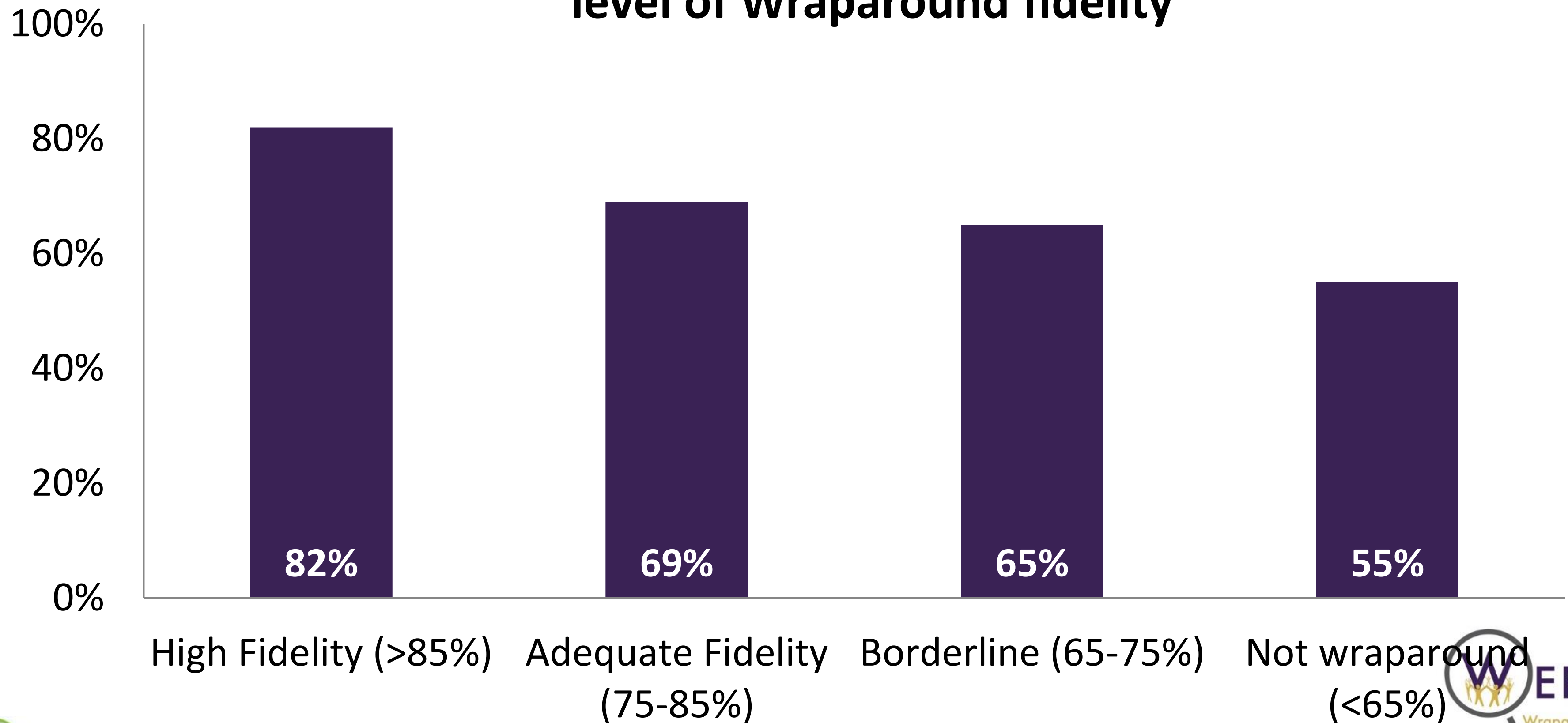
Associating youth outcomes with implementation fidelity



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Effland, McIntyre, & Walton, 2010

We wrote a guide about CANS use in Wraparound at a Program- and System-Level!

This guide is currently under review by SAMHSA. Stay tuned for a finalized version.

A GUIDE FOR SUPERVISORS AND ADMINISTRATORS

Prepared by the University of Washington School of Medicine Wraparound Evaluation and Research Team

Spencer W. Hensley | Jennifer Schurer Coldiron | Ryan Parigoris | Eric J. Bruns

PURPOSE

The simultaneous implementation of Wraparound and the Child and Adolescent Needs and Strengths (CANS) assessment tool is increasingly common across the United States. Current estimates suggest that 44 states with Wraparound initiatives in at least some jurisdictions also require the regular administration of the CANS. We receive frequent requests for guidance about how best to use the CANS tool within the Wraparound process, and it has become clear that many sites have years' worth of historical CANS data, only some of which is being used to inform program and system-level decision making.

This guide is intended to provide suggestions and examples of how Wraparound provider organizations (WPOs) and larger systems can or do make use of CANS data, getting it out of the files and databases and into action.

We are focusing on the CANS not only because of its ubiquity, but also because of its unique measurement approach, which can lead to confusion and less-than-ideal use. This document is not meant as an endorsement of the CANS, or any other specific tool. We suggest programs and systems explore a variety of standardized and ideographic measurement tools, and choose those which best fit with their information needs and the Wraparound approach.

SECTIONS OF THIS GUIDE

CANS developer, John Lyons, suggests that the tool can be used at multiple levels of practice to manage complex systems, such as systems of care where Wraparound is typically implemented. Within his Transformational Collaborative Outcomes Management (TCOMS) framework, Dr. Lyons breaks out three broad applications of CANS data. This guide is organized around those areas:

DECISION SUPPORT: How CANS data has been integrated into decision making about level of care authorization, workforce development, and system planning in some jurisdictions.

OUTCOMES MONITORING: Explores multiple approached to measuring change in youths' CANS scores and how this information can be appropriately used at the program and system level. Provides enrollment to discharge change statistics for a national sample from nine large Wraparound-implementing organizations and states.

QUALITY IMPROVEMENT: Summarizes how and when CANS data can be used to monitor the impact of your decisions.

FOR MORE INFORMATION ABOUT THE CANS

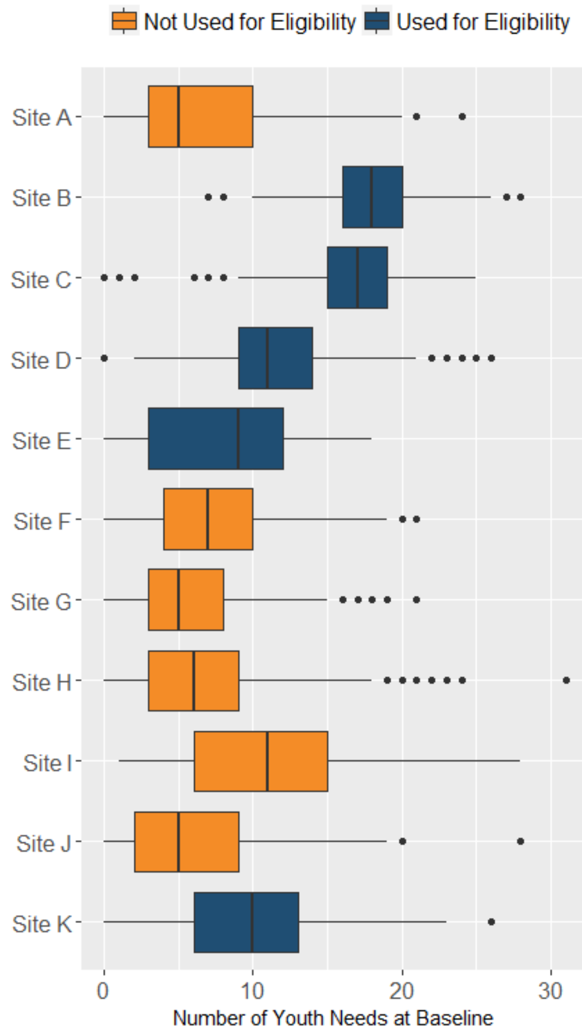
The CANS is a multi-item "communimetrics" tool designed to assess youth and family strengths and needs in relation to the level of action needed to improve functioning in the home and community.

For more information, visit the CANS website at https://praedfoundation.org/

This guide focuses specifically on applications of the CANS at the program and system level. For guidance about how to be more outcomes-based at the level of individual cases and how the CANS fits into this principle, please see our 2016 *Putting the Outcomes-based Principle into Action, Part One: A guide for Wraparound care coordinators.*

And when I say “we,” I mean these folks…

Number of mean actionable needs at baseline among wraparound programs



Mean N of actionable needs at enrollment between sites that use the CANS for eligibility and those that do not.

- Are youth in need of Wraparound being excluded unnecessarily due to eligibility algorithms…
- <u>**or**</u> are non-eligibility sites enrolling youth who would be better and more efficiently served in a lower level of care…
- Or… something else?

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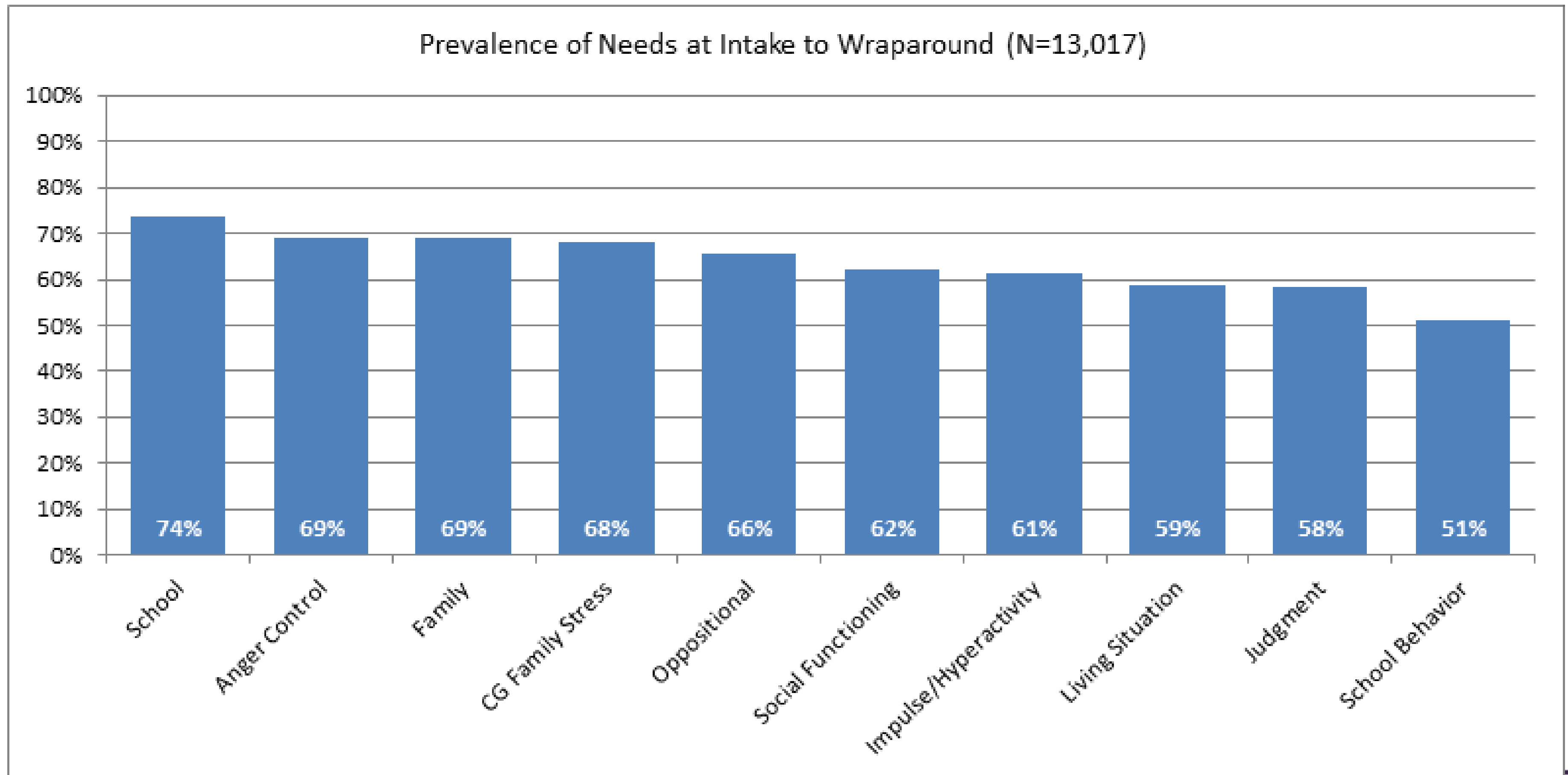
There is a wide range of change experienced by Wraparound youth as measured by the CANS

Most youth started Wraparound with between 6 and 12 actionable needs, and **had 2 or 3 fewer needs at discharge**

- At discharge, Wraparound youth still have "actionable" needs that need supports and services to maintain positive functioning.

	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site I	Site-Level Average
ENROLLMENT: Actionable Items										
Average number of actionable youth needs	6.62	7.90	11.00	6.98	11.76	7.34	7.11	18.73	16.81	10.47
% of total needs items	16%	21%	27%	19%	22%	18%	18%	52%	45%	27%
DISCHARGE: Change in number of actionable items										
Actionable youth needs	-2.58	-0.90	-5.34	-1.81	-3.90	-2.93	-2.03	-4.09	-2.25	-2.87
% of total needs items	-6%	-2%	-13%	-5%	-7%	-7%	-5%	-11%	-6%	-7%

Most common CANS Needs at Intake to Wraparound (N=13,017)



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PHQ-9 for Depression

Date: __ __/__ __/__ __ __ __ Kid ID: _______ Clinician: ____________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	PHQ-9	Not at all	Several days	Over half the days	Nearly every day
1.	Little interest or pleasure in doing things	☐ 0	[X] 1	☐ 2	☐ 3
2.	Feeling down, depressed, or hopeless	☐ 0	[X] 1	☐ 2	☐ 3
3.	Trouble falling/staying asleep, sleeping too much	☐ 0	☐ 1	[X] 2	☐ 3
4.	Feeling tired or having little energy	☐ 0	[X] 1	☐ 2	☐ 3
5.	Poor appetite or overeating	[X] 0	☐ 1	☐ 2	☐ 3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	[X] 0	☐ 1	☐ 2	☐ 3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	[X] 1	☐ 2	☐ 3
8.	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	[X] 0	☐ 1	☐ 2	☐ 3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	[X] 0	☐ 1	☐ 2	☐ 3

10. *If you checked off any problems on this section so far, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?*

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
[X] 0	☐ 1	☐ 2	☐ 3

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Rating engagement, rating progress
(SRS+ORS; Miller, Duncan, & Johnson, 2002)

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience

Relationship:

I did not feel heard, understood, and respected. |-----------------------------------| I felt heard, understood, and respected.

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk about. |-----------------------------------| We worked on and talked about what I wanted to work on and talk about.

Approach or Method:

The therapist's approach is not a good fit for me. |-----------------------------------| The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today. |-----------------------------------| Overall, today's session was right for me.

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Looking back over the last week (or since your last visit), including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually:
(Personal well-being)

|-----------------------------------|

Interpersonally:
(Family, close relationships)

|-----------------------------------|

Socially:
(Work, school, friendships)

|-----------------------------------|

Overall:
(General sense of well-being)

|-----------------------------------|

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Cognitive and Behavioral Practice xx (2014) xxx-xxx

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Free, Brief, and Validated: Standardized Instruments for Low-Resource Mental Health Settings

Rinad S. Beidas, Rebecca E. Stewart, and Lucia Walsh, *University of Pennsylvania Perelman School of Medicine*
Steven Lucas, *University of Pennsylvania Perelman School of Medicine* and *University of Pennsylvania*
Margaret Mary Downey, *University of Pennsylvania Perelman School of Medicine*
Kamilah Jackson, *Department of Behavioral Health and Intellectual DisAbility Services, Philadelphia*
Tara Fernandez and David S. Mandell, *University of Pennsylvania Perelman School of Medicine*

Evidence-based assessment has received little attention despite its critical importance to the evidence-based practice movement. Given the limited resources in the public sector, it is necessary for evidence-based assessment to utilize tools with established reliability and validity metrics that are free, easily accessible, and brief. We review tools that meet these criteria for youth and adult mental health for the most prevalent mental health disorders to provide a clinical guide and reference for the selection of assessment tools for public sector settings.

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0022-006X/11/$12.00 DOI: 10.1037/a0023307

Youth Top Problems: Using Idiographic, Consumer-Guided Assessment to Identify Treatment Needs and to Track Change During Psychotherapy

John R. Weisz
Harvard University and Judge Baker Children's Center

Bruce F. Chorpita
University of California at Los Angeles

Alice Frye
Wellesley Centers for Women

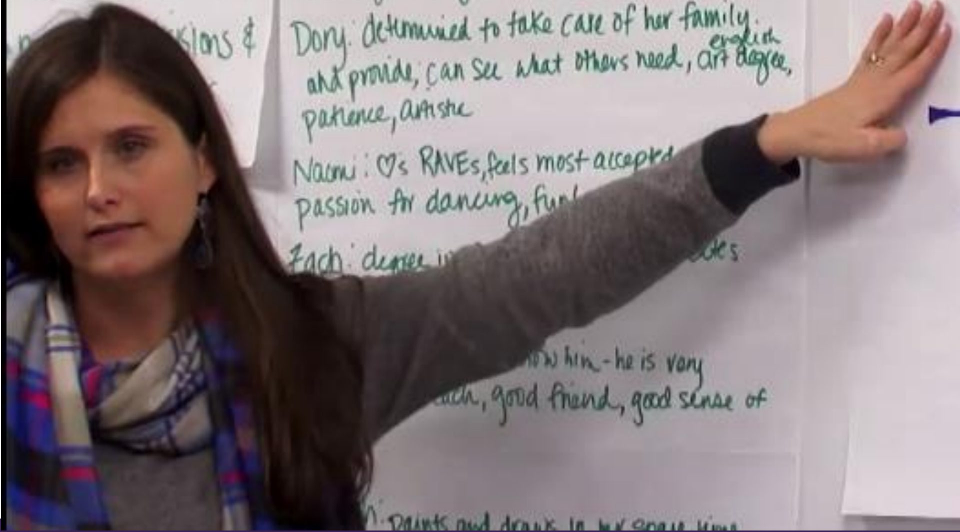
Mei Yi Ng and Nancy Lau
Harvard University

Sarah Kate Bearman, Ana M. Ugueto, and David A. Langer
Judge Baker Children's Center and Harvard University

Kimberly E. Hoagwood
Columbia University

The Research Network on Youth Mental Health

Objective: To complement standardized measurement of symptoms, we developed and tested an efficient strategy for identifying (before treatment) and repeatedly assessing (during treatment) the problems identified as most important by caregivers and youths in psychotherapy. *Method:* A total of 178 outpatient referred



Strengths
Pat: has a goal of opening up a drop in center for kids, passionate about identifying strengths in other
Sara: finds beaches as a happy place, waves crashing - beauty & peace & consistant
Dory: determined to take care of her family and provide, can see what others need, english art degree, patience, artistic
Pitt Family Vision
We will ride off in our VW bus into the sunset owning our weird.
Team Mission
Naomi
I need to know
Sara
NWIC
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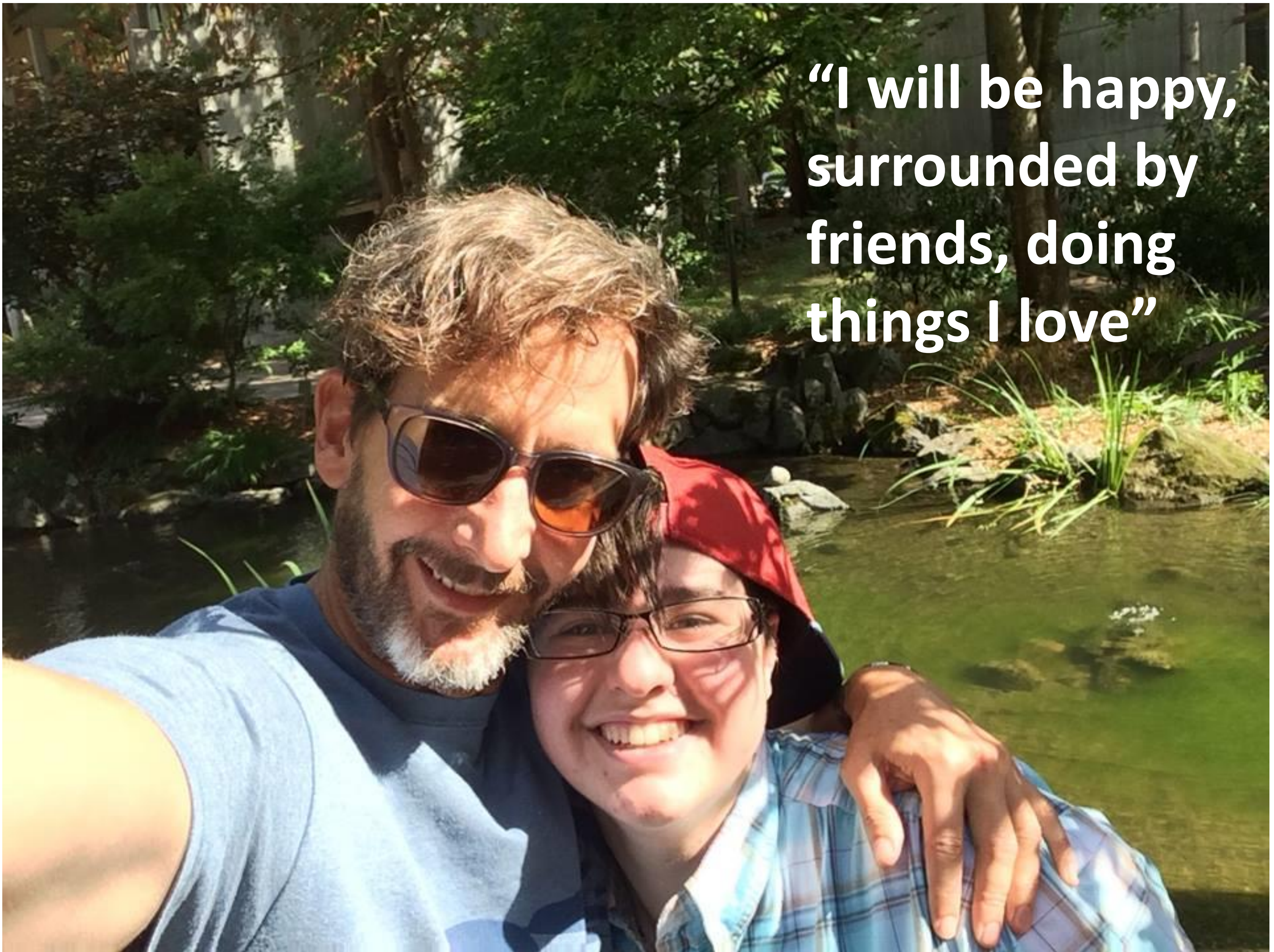

"I will be happy, surrounded by friends, doing things I love"

Welcome to Fairhaven
↑ FAIRHAVEN RESIDENCES
← FAIRHAVEN COLLEGE

CLEVER STORE
BANKERS BOX
upperware

From listing service needs to identifying underlying needs

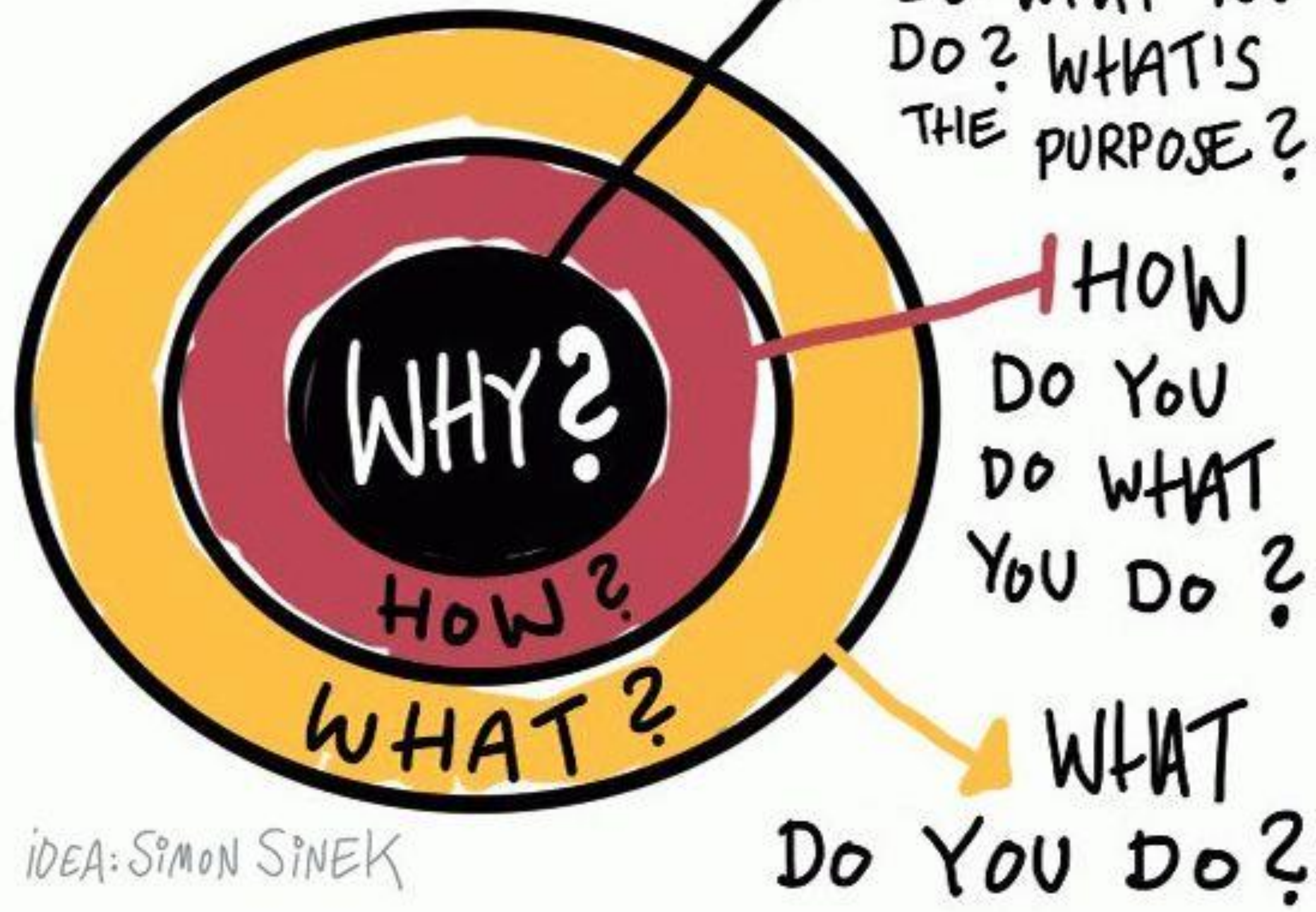
- “Miguel needs anger management classes.”
- “Miguel needs to learn how to control his anger.”
- “Miguel needs to know that to become the man he wants to be he can be strong and peaceful at the same time.”

From listing service needs to identifying underlying needs

- Matthew needs therapy for his past trauma
- Matthew needs to be able to better cope with the traumatic events he has experienced
- Matthew needs to know people can be permanent parts of his life

10 Strategies to meet 1 need

1. John will take Matthew back to his old neighborhood, share stories of how he grew up.
2. Mona will join ancestry.com and show Matthew how he fits in their family tree.
3. Adam (therapist) will work with Matthew, Mona, and John to explain how depression and trauma relate to aggressive behaviors.
4. Adam (therapist) will work with Matthew 1x/week using trauma-focused CBT.
5. Matthew will be Coach Smith's assistant and help out with other sports between football activities.
6. Sue will get tickets to university games that Matthew and Coach Smith will attend
7. Tina (parent partner) will work with Mona and John on a behavior contract with Matthew that includes rewards and consequences.
8. The family will create an 'I liked it when…' box that all family members will put notes in daily about something they liked that another family member did. Notes will be read Wednesday night after dinner and on Fridays before Matthew's games.
9. Michelle and Mona will work out every day during which time Michelle will check in with Mona about Matthew's behavior. She will keep a record of good days and bad days and report it back to the team.
10. Jennifer will check in with the school weekly to find out about office referrals and report it back to the team.


GOLDEN CIRCLE
WHY DO YOU DO WHAT YOU DO? WHAT'S THE PURPOSE?
HOW DO YOU DO WHAT YOU DO?
WHAT DO YOU DO?
WHY?
HOW?
WHAT?
IDEA: SIMON SINEK

START

HOW GREAT LEADERS INSPIRE
EVERYONE TO TAKE ACTION

WITH

SIMON SINEK

WHY

WITH A NEW
PREFACE
AND
AFTERWORD

GETTY IMAGES
MARCH

Thank you for listening

and for all you do.

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