

Overview of Ontario's Screening and Outcome Measurement Initiative in Children's Mental Health

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ABSTRACT

Introduction: Ontario's mental health practitioners strive to provide the best services for the most children and youth in the face of limited resources and increasing demand. **Method:** To do this efficiently and ethically necessitates identifying those at greatest risk, determining which services are most effective for a variety of children, and demonstrating improved functioning post-treatment. Standardized screening can assist in triaging those at greatest risk and outcome measurement can demonstrate improvement and treatment effectiveness. **Results:** To this end, Ontario has initiated systematic screening and outcome measurement for children ages 6 to 17 years receiving mental health services in selected hospital-based and community organizations. **Conclusion:** Standardized screening and outcome tools are key building blocks for improving the quality of service and promoting the use of evidence-based practices across the system. The lessons learned to date suggest there is a need to build individual and organizational readiness for change, to improve the state of technological literacy and infrastructure across the sector, and to improve the exchange of knowledge among stakeholders regarding the clinical benefits of the tools and the data they will produce regarding the state of children and youth receiving mental health service in Ontario.

Key words: children's mental health, outcome measurement, mental health screening, evidence-based practice

RÉSUMÉ

Introduction: Les intervenants en santé mentale de l'Ontario cherchent à procurer les meilleurs services au plus grand nombre possible d'enfants et de jeunes tout en tenant compte des effectifs limités et de l'accroissement de la demande. **Méthodologie:** Afin de rencontrer cet objectif de façon éthique, nous devons d'abord identifier les personnes les plus à risques, déterminer quels sont les services les plus efficaces et ce, pour le plus grand nombre, et également démontrer en postcure qu'il y a eu amélioration. L'évaluation standardisée est utile pour le triage et l'identification des personnes plus à risques alors que certains instruments de mesure peuvent servir à démontrer que le traitement a été efficace et qu'il y a eu amélioration. **Résultats:** La province de l'Ontario a entrepris d'évaluer et de mesurer systématiquement les résultats des interventions auprès d'enfants de 6 à 17 ans qui reçoivent des soins de santé mentale dans un certain nombre d'hôpitaux et d'organisations communautaires. **Conclusion:** L'évaluation standardisée et les outils de mesure de l'intervention sont les éléments-clés d'un processus d'amélioration de la qualité et de promotion d'un système de soins reposant sur des données probantes. À date, les données recueillies suggèrent qu'il faut d'abord préparer les changements organisationnels au niveau des individus et des structures, améliorer les compétences et le substratum technologiques, et favoriser les échanges de connaissances parmi tous les intervenants, particulièrement en ce qui a trait aux avantages cliniques liés l'utilisation de tels outils et données.

Mots-clés: santé mentale chez les enfants, mesure des résultats, évaluation en santé mentale, pratique basée sur des données probantes.

Ontario's mental health practitioners strive to provide the best services for the most children in the face of limited resources and increasing demand. To do this efficiently and ethically requires that we establish service effectiveness for children with diverse problems and determine how the sector can provide for a greater proportion of children in need given the resources at hand. Standardized screening practices can help us to manage long waiting lists by identifying children at greatest risk. Outcome measurement can demonstrate which treatments are effective and for whom, and the proportion of children who improve as a result of service. To this end, Ontario initiated systematic screening and outcome measurement in 1999 as part of a four-point plan for children's mental health that also saw

development of intensive child and family services, mobile crisis services, and telepsychiatry. An overview of the initiative and the tools being implemented is provided.

EARLY HISTORY AND GOALS

With few evidence-based treatments in use in clinical practice, little data regarding the types of disorders with which children present for service, and no systematic evidence of outcome, the system is hard-pressed to move forward in a rational way. In response, Ontario commissioned a review of outcome measurement tools for children's mental health (Raphael, Weir, Weston, Lines & Pettingill, 1999). Based on report recommendations, service provider interviews, and results of a feasibility study (Boydell, Barwick, Ferguson & Haines, in

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press) two instruments were selected for implementation: 1) a standardized intake instrument to screen morbidity (Brief Child and Family Phone Interview / BCFPI; Cunningham, Pettingill & Boyle, 2000), and 2) a standardized outcome instrument to assess level of functioning and monitor the effectiveness of treatment (Child and Adolescent Functional Assessment Scale / CAFAS; Hodges, 2003). Children's Mental Health Ontario, an advocacy organization that promotes the well-being of children, youth, and their families, oversees BCFPI training and implementation with support from BCFPI Incorporated and the Offord Centre for Child Studies at McMaster University. CAFAS training and implementation is provided by professionals from the Community Health Systems Resource Group at The Hospital for Sick Children, in consultation with an advisory group of service providers.

SCREENING: THE BRIEF CHILD AND FAMILY PHONE INTERVIEW

Screening can assist in identifying a client's need for service and the likely presence of particular disorders. Its value lies in enabling clinicians to efficiently identify, with a fairly high degree of confidence, areas of disturbance and severity of risk (Maruish, 1999). Over time, use of the BCFPI will allow us to determine shifts in referral trends, providing objective evidence that, as many clinicians suspect, we are seeing more children with mood management problems and severe impairments. Various organizations in Ontario are using the BCFPI to assist in making triage decisions, to connect families to interim services (e.g., readings, videos, groups), to formulate assessment plans, to obtain standardized measures of treatment outcome for comparison to "benchmarks" in the clinical literature, to support strategic organizational and regional planning, to determine whether children most in need are receiving service, and to examine the distribution of child problems for which services must be developed.

The BCFPI is a structured computerized interview administered to the parents (or teachers) of 3 to 18 year olds at the first point of intake, prior to clinical assessment and treatment. An adolescent self-report form is available. The instrument is also used in Sweden, British Columbia, and Alberta, and is available in French, English, and Swedish. Administration takes 30 to 45 minutes and begins with a narrative overview of client concerns. Given the instrument's ability to capture both narrative and more structured interview data, it is designed to replace rather than add to the traditional intake interview. The instrument gathers standardized information on demographics, common behavioral and emotional problems, impacts on child and family functioning, risk and protective factors, family readiness for service, and potential barriers to service utilization. Online data entry, scoring, and report generation create efficiencies for wait list management and triage (Cunningham, Pettingill & Boyle, 2001).

The BCFPI's standardized questions were derived from the survey measurement tools of the Ontario Child Health Survey (Boyle, Offord, Racine, Sanford, et al, 1993). Subscale scores are based on normative data from the Revised-Ontario Child Health Study Scales (Boyle, Offord, Racine, Fleming, Szatmari & Sanford, 1993a) for boys and girls aged 6-12 years or 13-18

years in both population and clinical samples. Seven subscales measure common childhood problems and aggregate to form composite scales: (1) Externalizing Behaviour (Regulating Attention, Impulsiveness and Activity Level, Cooperativeness, and Conduct); (2) Internalizing Behaviour (Separation from Adults, Managing Anxiety, Managing Moods). A Total Problems scale is derived from the 36 items comprised in the Externalizing and Internalizing scales.

The extent to which problems have adversely affected the child's social participation, quality of social relationships, and school participation and achievement are captured in subscales that combine to inform Impact on Child Functioning. Family Functioning is measured by a Family Activities subscale (the extent to which the child's problems have influenced the family's relationships with friends and family and/or mobility in the community); a Family Comfort subscale (the extent to which the child's problems are a source of conflict and anxiety within the family); and a Global Family Situation composite scale (combined items from the Family Activities and Family Comfort subscales). A Barriers to Service Utilization scale determines whether work schedules, transportation difficulties, or language barriers limit the family's ability to participate in treatment. A Readiness for Change scale determines parental interest in a list of potential service options, such as topical literature or video programs, parenting skill building groups, or support groups. New versions of the tool include brief, standardized measures of parental mood and a checklist of concerns such as specific phobias, fire setting, and thought problems.

The psychometric properties of the BCFPI have been evaluated with a community sample of 1,741 children and a clinic referred sample of 1,727 (Cunningham et al, 2001). The factor structure derived from the Ontario Child Health Study Scales – Revised for population and mental health clinic samples was replicated in a large field trial involving 10,916 6 to 18 year old children referred to 74 children's mental health organizations in Ontario. With the exception of Conduct problems (.68), reliability coefficients for subscales in field trials ranged from .75 to .85 for Problem Behaviour scales and .75 to .77 for Functional Impact scales. The instrument has adequate test-retest reliability, good evidence of sensitivity to change, and good concurrent validity, with correlations between the BCFPI's subscales and the extended scales from the Ontario Child Health Study's (OCHS-R) survey diagnostic instrument ranging from .88 to .96. Discriminant validity is evident on comparison of the means of clinic and non-clinic samples that yielded significant differences on all BCFPI subscales.

OUTCOME MEASUREMENT: THE CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE

Outcome measurement leads to improved treatment, enhances clinical science, provides accountability, and maintains the ethical responsibility of practitioners to examine service quality (Barlow, Hayes & Nelson 1984; Ogles, Lambert & Masters, 1996). All too frequently, children receive care that is based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes (Huang, Hepburn & Espiritu, 2003).

The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes (Busch 2002; Dishion, McCord & Poulin, 1999) despite evidence that most children who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Chambliss & Ollendick, 2001; JCCP 1998).

Global outcome measures, such as the CAFAS, help to standardize the measurement of quality and provide a common language and metric for comparison across programs, regions, and client populations (Busch 2002). This makes them particularly relevant for system-wide application. Global outcomes provide an index of overall severity that is easier to aggregate than specific measures. They also put into practice NIMH criteria regarding the importance of measuring the impact of interventions on day-to-day functioning in the client's real life (Newman, Ciarlo & Carpenter, 1999).

The CAFAS (Hodges 2003) is designed to rate impairment in children and youth who have or may have emotional, behavioral, substance use, psychiatric, or psychological problems. It consists of behavioral descriptions, (e.g., expelled from school) arranged into four levels of impairment - severe, moderate, mild, and no or minimal impairment - across eight domains of functioning (subscales): school or work, home, community, behavior towards others, moods and emotions, self-harmful behavior, substance use, and thinking. The rater reads the items in each subscale, beginning with the severe items, until a description of the client's functioning is found. The score on each subscale is determined by the level of impairment under which the item appears: severe, 30; moderate, 20; mild, 10; no or minimal, 0. Subscale scores are combined to form a total score. Each subscale has an accompanying list of strengths and goals. Available in both paper and electronic form, raters familiar with the software take about 10 minutes to complete the scale. Work burden is not increased as the clinician uses information typically collected in clinical service as the basis for rating the CAFAS, and the software produces information required for practice (e.g., assessment and outcome reports, treatment plan).

Training can be accomplished independently by rating 10 reliability vignettes from the CAFAS Self-Training Manual (Hodges, 2003). This ensures that all raters use the same "rules" and definitions of terms. In Ontario, reliability training takes place in 2-day training workshops. Software and train-the-trainer workshops are also provided. To guard against "rater drift," booster exercises are completed annually. In a study of rater drift among Ontario users interrater reliabilities for 315 raters proved to be in the moderate to high range (.848 to .995). Booster reliability training conducted one year later showed interrater reliabilities improved statistically on 3 subscales and drifted on 4 subscales but remained in the moderate to high range (.82 to .99). The feasibility of a train-the-trainer approach for establishing interrater reliability among practitioners new to the field demonstrated high correlations for 140 practitioners trained by on-site practitioner-trainers (.84 to .99) (Barwick, Omrin & Basnett, under review).

Knowing something about the client's initial level of disturbance and early response to treatment helps clinicians to identify potential treatment failures, to improve outcomes,

and reduce deterioration in the client (Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001). As such, best practice in Ontario involves rating CAFAS (1) periodically to manage outcome and assess progress; (2) to assist with assessment, formulation, and planning, and (3) to measure overall outcome. As a multi-dimensional measure of global functioning the CAFAS demonstrates better reliability in the field than unilateral measures, such as the GAF and CGAS that are prone to rater bias (Herman, 1990). Previous research has demonstrated the reliability of the CAFAS (Hodges & Wong, 1996) as well as its' concurrent and predictive validity. High interrater reliability has been reported across different sites and with both layperson and clinician raters (Barwick et al, under review; Hodges & Wong, 1996). Studies of concurrent validity have found greater impairment on the CAFAS to be associated with: more intensive level of care, more restrictive or therapeutic placement, more serious psychiatric disorders, more problems in social relationships, involvement with juvenile justice, school related problems, and child and family risk factors (Hodges & Wong, 1996; Hodges, Doucette-Gates & Liao, 1999; Manteuffel, Stephens & Santiago, 2002). Studies of the CAFAS' predictive validity has demonstrated that CAFAS score at intake predicted: cost of services, service utilization, contact with law, poor school attendance, and recidivism at either 6 or 12 months post intake, depending on the study (Hodges et al 1999; Hodges, Doucette-Gates & Kim, 2000; Hodges & Kim, 2000; Hodges & Wong, 1997; Quist & Matshazi, 2000). The CAFAS has been successfully used to assess outcome for youths varying in degree of impairment, referral source, and diagnosis (Manteuffel et al 2002; Duchnowski, Hall, Kutash & Friedman, 1998; Rosenblatt & Furlong, 1998 Walrath, Mandell & Leaf, 2001). No differences have been observed for the total CAFAS score on gender, race/ethnic group (i.e., comparing Caucasians, African-Americans, and Hispanics), or caregivers' education level (Hodges & Wong, 1997).

In Ontario, a supplemental rating guideline has been developed for rating CAFAS with Aboriginal children and youth (Barwick, Ojibway Child and Youth Services, Hodges 2004). Hodges has recently published a compilation of resources and guide for matching CAFAS profiles to evidence-based treatments (Hodges, 2004). There is also a screening interview (15 minutes) that inquires about the youth's functioning and is administered to a caregiver (or other adult informant). A newly developed CAFAS Advanced Child Management Scale examines caregiver functioning in the areas of: providing directions and follow-up; encouraging good behavior; discouraging undesirable behavior; monitoring activities; connecting positively with youth; and problem solving orientation. Lastly, both paper and software versions of the CAFAS scale are available in French.

IMPLEMENTATION

Initially conceptualized as a training endeavor, Ontario's measurement initiative involves substantial organizational and practice change. Changing practice is a formidable task that occurs slowly, often requiring changes in clinician behavior, program restructuring, and an infusion of resources (Huang et al., 2003). To support the use of the tools, computer hardware is provided to service providers along with ongoing support.

Organizations have incurred costs and disruptions related to substantial technological upgrading, while seeing a rise in computer literacy skills among clinicians and improvements in triaging, assessment, and monitoring of treatment response. Implementation of new practices is especially difficult in an environment of shrinking budgets and competing priorities. The simultaneous implementation of CAFAS and BCFPI, although aimed at different functions of the organizations, has been challenging, particularly for those faced with accreditation, amalgamation, staff turnover, and rising demand for service. In recognition of these challenges, CAFAS and BCFPI teams have provided support through consultation, regional community of practice meetings, clinical guidelines and manuals, web site support, and sustainability and capacity building activities (Barwick, Boydell & Omrin, 2002).

As we approach the middle of the fifth year, over 600 intake workers and administrative personnel in 114 organizations have been trained in the reliable administration of the BCFPI, and 98% have implemented this instrument. Over 3000 child and youth workers, social workers, psychologists, and psychiatrists have been trained to reliably rate CAFAS. As of last spring, 102 of 110 eligible organizations (98%) reported "using" the CAFAS, yet an estimated 70% reported using the software version of the tool as mandated. The 2004-2005 fiscal year marks the first time the data from both tools will be analyzed in an aggregate report for the Ministry of Children and Youth Services. Challenges for the year ahead include achieving full implementation for both instruments, continued training and support regarding the clinical utility of the tools through community of practice meetings held quarterly in each of the province's nine regions, and working with government and service provider organizations to develop policies and procedures for the collection, analysis, and reporting of aggregate level data.

CONCLUSION

There is much to be learned here beyond the mental health status of Ontario's children. We hope to learn how best to bring evidence-based practices to the field and how to support the adoption of new and innovative approaches to mental health care for children. The lessons learned to date suggest there is a need to build individual and organizational readiness for change, to improve the state of technological literacy and infrastructure across the sector, and to improve the exchange of knowledge among stakeholders regarding the clinical benefits of the tools and the data they will produce regarding the state of children receiving mental health service in Ontario. Anecdotal reports suggest appreciation for what the tools contribute clinically is growing with practitioner experience, yet real and imagined barriers remain to be dealt with. Whether we are successful in developing a culture that is receptive to evidence-based practice and service delivery innovations remains to be seen; the journey continues.

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First Nations children and youth were not included in the OCH study and, thus, there are no norms for this population. The current measurement initiative will provide the first ever aggregate data on the mental health well-being of First Nations children in Ontario.