

Revising California's Children and Youth Performance Outcome System

Synopsis of a Two-Day Meeting of the Task Force for Developing/Selecting New Children's Instruments

July 8-9 1999

Revisiting The Need For Modifications in The Current Children And Youth Performance Outcome System

Background

The current Children's Performance Outcome System was implemented statewide in April 1998. Its design was based around what was understood to be the evaluative component of California's grant funded children's system of care. As the system was implemented, many complaints were raised, the most frequent of which was that it required too much effort to collect the data. To ease concerns that the State was implementing a flawed and labor intensive system that counties and county staff would have to live with for years to come, the California Mental Health Directors Association (CMHDA), California Mental Health Planning Council (CMHPC) and the Department of Mental Health (DMH) agreed that implementation of the system should proceed with the stipulation that the system be re-evaluated within 2 years. And, if alternatives to the current system were found that could measure the required domains, provide appropriate outcomes data to the state and quality improvement data to the counties, while minimizing the associated costs and time impacts on county staff, that appropriate modifications would be made. The extent of the changes in the system would be related to the extent of the problems that were identified and the available options that were available.

After almost one year of implementation, a group was convened to discuss the problems and issues related to the current system, including its strengths and weaknesses, as well as possible modifications that should be considered. The initial consensus of the group was that we should develop instruments specific to California's needs. Specifically, the goal was to develop instruments that were short, public domain, addressed the specific questions that were important to California, have an interagency flavor, be more strengths-based, and maintain our commitment to collecting data from parents, children, and clinicians.

As staff from the DMH were visiting counties providing training for the Adult Performance Outcome System which is soon to be implemented, they informed attendees that the state-of-the-art in measuring outcomes in mental health is not particularly advanced. Therefore, all of the public mental health system constituencies need to be committed to continually evolving our outcome systems as better approaches are identified. Staff further explained that this is the reason that a group is meeting to begin the process of making recommendations for changing the Children's Performance Outcome System.

As training for the Adult Performance Outcome System progressed, DMH staff occasionally heard comments from county staff that they did not want the Children's Performance Outcome System changed. This is surprising given the amount of resistance there was to its initial implementation. Such comments were also brought to the attention of Ann Arneill-Py of the CMHPC. She recommended that the entire prospect of revising the Children's Performance Outcome System be reconsidered. This recommendation

was presented to DMH staff several days prior to the two-day meeting that was intended to make significant progress toward the system redesign. Ms. Arneill-Py recommended that the meeting proceed, but that we also need to make sure that there is still a consensus that the Children's Performance Outcome System needs to be changed.

Pros and Cons of Changing the Children's Performance Outcome System

Jim Higgins, State DMH, began the two-day meeting by informing the attendees that some are expressing the opinion that the Children's Performance Outcome System should not be changed—or at least that there needs to be a careful consideration of whether it should be changed and, if so, to what extent. Several members of the group, which included clinical staff, quality managers, children's program coordinators, children's evaluators, researchers, and child psychiatrists, noted that, now that the system was implemented, it must be recognized that any change will have repercussions and could actually lead to an increased burden on clinical staff.

Next, several members agreed that they would like to step back and review the strengths and weaknesses of the current system again. The group discussion included the following as pros and cons of the current system:

Pros

- ?? The system is already implemented—which is a monumental accomplishment in itself;
- ?? Relatively uniform and systematically collected data are being reported to DMH which is allowing, for the first time in a quantifiable way, that California's public mental health system is contributing to children getting better;
- ?? The CAFAS, especially, is providing data that is usable, easily interpretable, and makes good sense to policy makers interested in the broad impacts of mental health service provision. In addition, the CAFAS is relatively quick for clinicians to complete;
- ?? Several of the tools that are being used, especially the Child Behavior Check List (CBCL) and the Youth Self-Report (YSR), are industry standards and can be considered very high quality. These instruments are widely recognized as being valid and reliable and have developed norms.
- ?? The multi-axial approach has been helpful to provide a more comprehensive assessment with increased awareness of each respondent's perspective.

Cons

- ?? The primary problems with the current system involve the amount of staff time associated with collecting the data. In the most ideal case, the CBCL is completed by the parent and the YSR is completed by the child. If parent/child are able to complete these assessment instruments without assistance, a tremendous amount of clinical data is generated with minimal clinician effort.

However, it has been found that with our target population clients and their families, more often than not assistance in completing the forms must be supplied. DMH staff have been informed by clinicians from a wide variety of counties that completing the CBCL and YSR can take up to four hours of a clinician's time. Clinicians report that they feel this is an inappropriate use of their time. The main issue related to this is that, the information from the CBCL and YSR may have some marginal usefulness, however, when viewed in terms of the time required to complete them, they do not provide sufficient added value.

- ?? Concerns have been raised regarding the appropriateness of the CBCL and YSR tests to such a large target population. While extremely clinically useful in specific cases, some clinicians have expressed they would prefer more flexibility to select the appropriate assessment tool based on the situational context.
- ?? The CBCL and YSR generate a tremendous amount of clinical data that can be used in a clinical setting. However this information is questionable for outcomes purposes. The state level data collected is at a very generalized level (total problems, total competencies) and does not appear to be very sensitive to change over time. There is a high local cost with a minimal return on data utility.
- ?? The CBCL, YSR, and CAFAS are copyrighted instruments and must be purchased from the authors on a form-by-form basis. This makes it very difficult for counties to reformat the instruments to meet their local needs. For example, a county is not permitted to computerize the instruments to aid in data collection. Additionally, counties are not permitted to develop scannable forms that integrate with their data entry systems. Several counties have received letters from lawyers representing instrument authors for taking actions that would make the instruments easier to use in their county.
- ?? The CBCL and YSR require that counties purchase a proprietary scoring software package. This package is written in DOS and cannot be automated to facilitate scoring. Since it does not integrate readily with other information systems, this creates additional manual work hours for county staff to score the data and get the data into their data management system.
- ?? The report generated by the CBCL and YSR are difficult to read and most clinicians report that they are not particularly useful. In addition, some clinicians have expressed concern regarding the cultural competence of these instruments.
- ?? Many clinicians have expressed that they do not actually use the data generated from the instruments. One of the group members who is a clinician in a county mental health program, informed the group that during a poll of his fellow staff, only 50% said that they actually used any of the information collected from the performance outcome instruments.
- ?? The psychometrics of the CAFAS, which is arguably the best outcome instrument in the current system, is increasingly being questioned. For example, the Substance Use Scale on the CAFAS indicates that there is little or no substance abuse among our target population clients. This is completely unbelievable given the prevalence of drug use in the target population's age group as well as research evidence that suggests that there are a large number of individuals who have dual diagnoses of substance abuse and mental illness.

- ?? It is difficult to corroborate the clinician's view of the client's functioning by relying on the parent's and youth's responses on the CBCL and YSR because the CBCL and YSR do not have scales that are comparable to those on the CAFAS. Therefore, simply relying on the clinician's rating is fraught with the possibility that scores are being deflated at intake and inflated at periodic and discharge administrations.
- ?? There have been complaints that the CSQ-8 is not especially informative and has a relatively high cost.
- ?? There have been difficulties associated with the availability of the instruments in the necessary languages, especially in combination with the desired technological format due to copyright issues and contractual issues with technology vendors.
- ?? There have been complaints regarding the lack of flexibility of the current system to accommodate changes in the format and to address other issues for coordinating with local needs and technological constraints.

After a discussion of the pros and cons of the current system, each attendee was asked to give their opinion about how we should proceed. Should we a) leave the system as it is, b) examine alternative instruments for the parent, child, and clinical perspectives, or c) only examine alternative instruments for a portion of the current system.

The group unanimously expressed the opinion that, at a minimum the CBCL and YSR should be replaced. Regarding the CAFAS, the group expressed that they could live with it, but that if something better could be found, it should also be replaced with an instrument that allows greater flexibility.

It must be noted, however, that the group was unanimous that any transition between the current system and a new system must only take place after a well designed pilot test of the new instruments. Additionally, implementation of the new system must be flexible and well planned so as not to adversely impact county programs. It was also noted that many of the fears regarding changing the existing children's system are based upon concerns with the types of changes that might occur and with the implementation process itself rather than upon the premise that the current system is working well and should not be changed.

Ideals of a New Children's Performance Outcome System

Criteria for selection of new instruments for the Children's Performance Outcome System were discussed and rated in order of priority. The attendees unanimously agreed that any system that is eventually adopted should have as many of the following characteristics as possible:

- ?? #1) Measures the domains specified by the CMHPC
- ?? #2) Collects information from multiple informants (ideally it would have scales that are directly comparable between clinician, client, and parent)
- ?? #3) Valid and Reliable

- ?? #4) Sensitive to change
- ?? #5) Short and relatively easy to administer;
- ?? #6) Provides added value, has profiles that are easy to read and generates information that is useful to clinicians in a cost and time effective manner
- ?? #7) Include strengths as well as functioning
- ?? #8) Public domain preferable but, if not, is inexpensive
- ?? #9) Flexible (Counties can reformat, automate, and add questions as necessary)
- ?? #10) Provide information on the family
- ?? #11) Applicable to broad age range
- ?? #12) Includes risk factors/context
- ?? #13) Is culturally neutral and psychometrically unbiased
- ?? #14) Data can be useful to multiple agencies

The Instruments That Were Reviewed

The group reviewed the instruments that were provided in a compendium by UCSF staff using the above rating criteria. There were a number of instruments that the task force reviewed in depth including the Ohio Scales, the Behavioral and Emotional Rating Scale (BERS), the VFI, the Columbia Impairment Scale (CIS), and the Behavior Assessment System for Children (BASC). UCSF will also follow up in procuring copies and gaining information regarding other instruments that should be included in our review, such as the CCAR. Additional instruments in the compendium provide examples of the types of questions being used for more in-depth assessments of various domains such as physical health, depression, client satisfaction, substance abuse, and family functioning. As we proceed, these may provide guidance in developing specific questions to gather any required/recommended data that is not covered by the core instruments that are selected for further evaluation.

Evaluation of the Instruments

The following pages provide a summary of the results/comments on the instruments reviewed. Attachment A summarizes how each instrument did or did not appear to meet the evaluation criteria with the exception of the CMHPC domains that are addressed in Attachment B. The summary also indicates where further information is required, especially related to costs and flexibility with formatting and technology issues.

At the next task force meeting, DMH and UCSF staff will present a comprehensive overview of how each instrument addresses the CMHPC domains and the evaluation criteria. The group will then determine which instruments would be viable options and discuss the future direction. Ideally, there would be a number of potential instruments that could be pilot tested in volunteer counties for further analysis and comparison with the existing system.