the EVALUATION CENTER @ HSRI

TECScript 4

Outcome Measures for Children and Adolescents

Messages from 23 October 2001 – 13 November 2001

An Unedited Compilation of Email Messages from the Outcomes Evaluation Topical Evaluation Network (OUTCMTEN) at outcmten@world.std.com

Human Services Research Institute
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

This **TEC*Script*** was compiled by *the Evaluation Center*@HSRI. The Center is funded through a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The mission of the Evaluation Center is to provide technical assistance to the evaluation of adult mental health system change.

TEC*Scripts* are one component of the **Topical Evaluations Networks (TENs) Program**. The purpose of this program is to provide mental health system stakeholders (consumers, providers, researchers and families) with the opportunity to communicate directly with each other, and with Evaluation Center associates about topics of specific interest in adult mental health system change evaluation. The Networks Program makes use of electronic mailing lists to allow subscribers who have access to the Internet to participate in ongoing discourse about the specific topics listed below.

The **TEC*Scripts*** are designed to provide interested persons with unedited compilations of email messages from the various mental health electronic mailing lists that the Evaluation Center operates. The only changes that have been made to the original messages are to correct for misspelled words. Messages are in chronological order. Time stamps are Eastern Standard Time. If the message being replied to is not the original message but is still in the same topic thread, this message is in italics and precedes the response, which is in plain text.

The Center operates four electronic mailing lists that deal with different aspects of mental health evaluation. Following are descriptions and subscribing instructions for the four lists:

- **Legal and Forensic Issues in Mental Health Topical Evaluation Network (LEGALTEN)** The purpose of the LEGALTEN list is to facilitate the implementation and use of rigorous evaluations at the interface of the mental health system, the criminal justice system, and the courts.

- **Managed Behavioral Health Care Evaluation (MBHEVAL)** The purpose of the MBHEVAL list is to discuss the evaluation of managed care as it affects the delivery, outcomes and costs of mental health care and substance abuse treatment services at the state, local, program, or consumer level.

- **Multicultural Mental Health Evaluation (MCMHEVAL)** The purpose of the MCMHEVAL list is to foster discussion of issues related to the evaluation of mental health services for diverse cultural, racial and ethnic populations. Potential issues for discussion include measuring ethnocultural identity, cultural competence, and access to mental health services for diverse groups.

- **Outcomes Evaluation Topical Evaluation Network (OUTCMTEN)** The purpose of the OUTCMTEN list is to develop a broad collective expertise with respect to problems of assessing and analyzing outcomes of interventions aimed at improving mental health systems. The list also serves to provide assistance, information, and contacts regarding (1) issues in evaluation, (2) experimental and quasi-experimental design, (3) instrument and survey development, and (4) statistical analysis for mental health.

If you would like to subscribe to LEGALTEN, MBHEVAL, MCMHEVAL or OUTCMTEN visit the list subscription page of our web site at http://tecathsri.org/lists-form.asp or send an email message to:

imailsrv@tecathsri2.org

containing only the following words (leaving the subject line blank):

subscribe list name email address

For example:

subscribe legalten jones@yahoo.com

Transcripts of on-line discussions, as well as printed copies of archived documents are made available in TECScripts by email or mail to interested stakeholders; especially those who do not have Internet access. Visit the publications section of our web site at http://www.tecathsri.org/pubs.asp to view available TECScripts. For more information contact Clifton Chow at the Evaluation Center@HSRI by phone (617) 876-0426 x 2510 or by email chow@hsri.org.

H. Stephen Leff, Ph.D.
Director & Principal Investigator

Clifton Chow
Program Manager

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Tue, 23 Oct 2001 4:43PM
From: Catherine Panzarella, PhD <catherine.panzarella@phila.gov>

Hi Everyone,
We are looking for a tool to assess children's behavioral needs and measure change for outcomes in the child welfare system. We are considering the Achenbach but have concerns given publisher cautions about having baccalaureate level child welfare workers administer this instrument. Has anyone successfully used the Achenbach with baccalaureate level administrators? Would anyone recommend alternatives that we consider?

Catherine

Catherine Panzarella, PhD
The Philadelphia Behavioral Health System
714 Market Street, 5th Floor
Philadelphia, PA 19106
215.413.7697
fax 215.413.7111

Date: Tue, 23 Oct 2001 7:17PM
From: G. Lawrence Farmer, MSW, PhD <glfarmer@rci.rutgers.edu>

In general I believe that you should not be concerned regarding using BA level individuals to administer the measure. In general the Achenbach behavior checklist measures are easy to use. Classroom teachers around the country regularly use the teacher rating scale with little problems. You can take a look at Achenbach's web site (http://www.aseba.org/index.html) and the extensive reference list provided for more information.

Larry

****

G. Lawrence Farmer, MSW, Ph.D.
Rutgers, The State University of NJ
School of Social Work
536 George Str.
New Brunswick, NJ 08901
732/932-7672 (voice)
732/932-8181 (Fax)

Date: Tue, 23 Oct 2001 8:17PM
From: Robin Jenkins <rjenkins@cccommunicare.org>

It's not the b.a./b.s. level of administration that's of concern, as it is that level of training in the scoring and interpretation of the instrument. The Achenbach-Edelbrock taxonomy is well documented and described. Interpretation requires grounding in behavioral assessments at the graduate level including an understanding of cross-classification statistics (correlation), and a detailed understanding of the psychological constructs underlying the factors included in the instrument. Re: other instruments, I've struggled with this for several years personally. I have not found a global, comprehensive tool that can be administered, scored and interpreted well by b.a./b.s. level staff. There are great rating tools for specific behavioral problems and conditions (e.g., stress, depression, anxiety, risk assessment, lack of social support, etc.) but not -- at least that I've found -- one that includes social, emotional, academic, behavioral, ecological (family, school, community) dimensions appropriate for the Bachelor's level folk. If you or someone else turns one up, please post to the list. Good luck.

BTW, if you go w/masters prepared staff to do the assessments, the BASC (AGS publishers) is a wonderful tool.

Date: Tue, 23 Oct 2001 9:28PM
From: Cynthia Patton, PhD <cpatton412@aol.com>
Catherine-
I like the CBCL because the information I need is very clinical. We have master's level and above staff interpret the information due to the issues stated in a previous post. You might want to look at some of the functional assessment tools if your need is not so clinical. The CAFAS (Child & Adolescent Functional Assessment Scale is, I think, the correct name) by Kay Hodges is widely used. Also the Vanderbilt Functional Inventory by Len Bickman and his group at Vanderbilt has shown good results when compared with both the CBCL and the CAFAS and the Ohio group (sorry no reference, Dee somebody-help out there) has done good work in this area. Because of the focus of these, I do not believe the training requirements for staff are quite as rigorous in interpreting the data. Good luck.

Cynthia Patton, Ph. D.
Outpatient Child Program Coordinator
Ozark Guidance Center
PO Box 6430
Springdale, AR 72766

Date: Wed, 24 Oct 2001 8:13AM
From: John E Myers, Jr, PhD <Evalu8orJM@aol.com>

As a possible alternative, you might want to have a look at the Ohio Youth Scales at http://www.mh.state.oh.us/initiatives/outcomes/outcomes.html

John E Myers, Jr, PhD
Administrator, Mental Health Planning & Evaluation
Trumbull LIFELINES (ADAMHS Board)
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330-675-2765, ext. 110
330-675-2772 Fax
Evalu8orJM@aol.com
or jemyersjr@mac.com

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Wed, 24 Oct 2001 8:41AM
From: Donna Podrazik <dpodraz@epix.net>

Catherine,

Our county has recently initiated an outcome assessment research pilot for outpatient psychotherapy services in our children's mental health system. It seemed as if we reviewed every known instrument and finally selected the Ohio Scales for our pilot. While not meant to be diagnostic, the scales offer very relevant information for treatment planning. The scales are brief, very easy to use and unbelievably inexpensive. The assessments are completed by the child (ages 12 to 18), the parent and the worker -- BA/BS child welfare workers should have no problems completing it.

The scales include problem severity measures and levels of functioning, hopefulness, and service satisfaction measures. The worker scales also include the ROLES (instead of hopefulness and satisfaction). We have elected not to use this portion of the scales as variations of that data can be found in Pennsylvania's Mental Health POMS (performance outcomes measures system).

You can download the Ohio Scales and the user and tech manuals from the Ohio MH web site if you wanted to take a look at them -- http://www.mh.state.oh.us/initiatives/outcomes/outcomes.html

Dr. Ogles, the scales lead researcher/creator, has also been very response to all my questions about using the instrument. We've just begun our pilot and have no solid data at this point, but feedback about the ease of using the instruments has been positive so far.

Regards,

Donna

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Wed, 24 Oct 2001 9:08AM
From: Marcella A. Maguire, PhD <marcella.maguire@phila.gov>

Catherine,

We used the Achenbach with bachelor's level research folks at NIMH in the late 80s on a study of children of mothers with affective disorders. Children over time ranged in age from 3 -15. We did use bachelor's level raters (including me at the time) and would often check them against the research fellows who were much more experienced. We found little to no differences, as long as the rating group, including those with more or less experience met frequently and could discuss pertinent issues before we did a reliability check. Hope that helps.

Marcella A. Maguire, Ph.D.
Behavioral Health Liaison
Coordinating Office for Drug and Alcohol Abuse Programs
Philadelphia Behavioral Health System

Date: Wed, 24 Oct 2001 10:00AM
From: Dave Colton <dcolton@ccca.state.va.us>

We're also considering use of a functional assessment instrument for an inpatient (acute evaluation and stabilization) setting. Does anyone have a reference for the Vanderbilt Functional Inventory (Bickman) that Cynthia Patton referred to?

David Colton, Ph.D.
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144

Date: Wed, 24 Oct 2001 10:21AM
From: Sylvia Perlman <sperlman@mhsacm.org>

As I understand it (although I have not used the CBCL myself), the biggest problem in using it for the purposes you mention is that it does not measure change well. Has anyone used it successfully to measure change?

Sylvia B. Perlman, Ph.D.
Mental Health & Substance Abuse Corporations of MA
251 W. Central Street, Suite 21, Natick, MA 01760
(508) 647-8385, x 16
(508) 647-8311 Fax
sperlman@mhsacm.org

Date: Wed, 24 Oct 2001 1:01PM
From: Debra Srebnik <srebnik@u.washington.edu>

On Wed, 24 Oct 2001 8:41AM Donna Podrazik <dpodraz@epix.net> wrote:

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Regards,
Donna

I'll chime in too - our county system also recently chose the Ohio youth scales after reviewing many, many other instruments.

Date: Wed, 24 Oct 2001 1:32PM
From: Geoffrey Gray <ggray@oqsystems.com>

The Y-OQ is widely used nationally, has strong psychometrics, is easy to administer and interpret clinically, has a Spanish version, and is inexpensive. Computer versions allow data entry via Palm Pilot or IVR. There is a parent/clinician version and a self-report version (for kids over 11). You can check www.oqfamily.com or www.oqsystems.com

Geof Gray

Date: Wed, 24 Oct 2001 1:41PM
From: Gary Spicer <spicer@bhcs.mail.co.alameda.ca.us>

On Wed, 24 Oct 2001 1:01PM Debra Srebnik <srebnik@u.washington.edu> wrote:

I'll chime in too - our county system also recently chose the Ohio youth scales after reviewing many, many other instruments.

Interesting that several have chosen the Ohio Scales.... My curiosity is piqued. How did you get around basic concerns about the questions:

The 'cultural competency' problem of concepts such as 'Hobbies' in minority communities.
The 'cultural competency/stages of development' problem of references to 'girlfriends' or 'boyfriends'.
The 'double barreled' aspect of questions that ask about 'following rules' and 'breaking the law', which are totally different issues.
What about the single question that asks about 'attending school' and 'getting passing grades'? Very different items!

It seems that the Ohio Scales have a lot of what we might consider very generalized questions that reflect broad mental health capacities:

Getting along with friends
Getting along with adults outside the family.
Feeling good about self.
Accepting responsibility for actions
etc. etc..

The point is that the respondent is asked to 'score' each of these as if it were a category of problem or strength. None of these 'scores' is anchored to a specific behavior or documentable indicator. How will you measure change over time? How will you validate any change measurement as reflecting anything more that the respondent's 'state of mind' at the time the form is completed?

Finally, how will you use the Ohio Scales as a means of collecting clinical data that might be useful in developing treatment plans, identifying therapeutic goals or issues? Certainly, the question arises as to how one would use the Ohio Scales to answer the basic questions that you want to answer about the client's functional status.

I don't want to make an argument against the Ohio Scales. We are also considering them. I am interested, however, in how to address these issues? Are these issues less important than they seem at this point?

I'm assuming that those of you who have already adopted the Ohio Scales have already raised these questions.

I'll be happy for any guidance.

TEC*Script* 4: Outcome Measures for Children and Adolescents
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Date: Wed, 24 Oct 2001 3:38PM
From: Bill Berman <wberman@echoman.com>

Our experience with outcomes has led us to lots of alternatives. You need to make the decision as to whether the primary choice is one of diagnosis/assessment or outcomes. The Achenbach, Devereux, and to a lesser extent the Conner's are all primarily diagnosis tools, not outcomes. They are very good at that, but tend to be too long and cumbersome for repeated measures. The best outcomes tools we have found for outcomes for children are (in no particular order):

CAFAS (liked for its ease of use for clinicians and use in treatment planning);
Child Well-Being Scale (very good for Child Welfare, as the scope of dysfunction is quite broad;
Vanderbilt Functioning Index; quick and easy, with good outpatient reference data;
Ohio Scales (Self-report, parent and caseworker forms). Very widely used, with different versions for different data sources, easy to apply and score;
CFARS. Used in several states, also particularly good for children who have the most challenges and sources of difficulty.

All but the first are public domain, so the cost is much better as well. I would be happy to provide information about how to get these via back channel, or on the list if people want it.

William H. Berman, Ph.D.
Chief Clinical Officer, The Echo Group
wberman@echoman.com

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Wed, 24 Oct 2001 4:01PM
From: Dee Roth <rothd@mhmail.mh.state.oh.us>

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For more information about specifics and psychometrics, I'd invite you to visit our web site—both the Ohio Scales Users Manual and the Technical Manual are on there and can be downloaded. The address: www.mh.state.oh.us/initiatives/outcomes/outcomes.html

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Dr. Ben Ogles and his research team are in the middle of a very interesting research project at the moment that is testing the effect of the case manager and the family and other members of the treatment team having regular Ohio Scales feedback within wraparound services, versus a group just getting wraparound services and not the regular outcomes feedback. Preliminary results are showing that having the outcomes feedback is improving kids' outcomes! (A few months from now we will have a chapter out on that study in the upcoming volume of our biennial publication, New Research in Mental Health, and, as always, I'll advertise the volume's availability on this listserv when it is published. In the meantime, if you would like more information on the research or the Ohio Scales, I suggest you get in touch with Dr, Ben Ogles at Ohio University.

Dee Roth, MA, Chief
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OPER site: www.mh.state.oh.us/oper.html
Outcomes site: www.mh.state.oh.us/initiatives/outcomes/outcomes.html

Date: Wed, 24 Oct 2001 4:26PM
From: Rich N Deliberty <rdeliberty@fssa.state.in.us>

On Wed, 24 Oct 2001 3:38PM Bill Berman <wberman@echoman.com> wrote:

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William H. Berman, Ph.D.
Chief Clinical Officer, The Echo Group
wberman@echoman.com

Indiana, with Fred Newman's help, developed the Hapi-A a few years ago. That has proven to be an excellent instrument that predicts costs and is also useful for outcome measurement for adults with mental illness or addictions. We tried a version of the CAFAS for children, and found it to be unreliable.

Last year we developed (again under Fred's leadership) the Hapi-C for children. It seems to be psychometrically very strong, and borrowed a lot from the Ohio scales. We've been using it for a year now, with positive reports from clinicians and trainers. Within a few months we'll have some information on its usefulness for risk adjustment.

Just to let you know that there is another option.

Richard DeLiberty
Deputy Director
Indiana Division of Mental Health and Addiction

Date: Wed, 24 Oct 2001 4:45PM
From: Frederick L Newman, PhD <newmanf@fiu.edu>

On Wed, 24 Oct 2001 4:26PM Rich N Deliberty <rdeliberty@fssa.state.in.us> wrote:

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Richard DeLiberty
Deputy Director
Indiana Division of Mental Health and Addiction

We will have a paper ready on the HAPI-Children's measure ready by December. It is a public domain measure and has very strong psychometrics. The ratings are based upon information collected via a structure clinical interview and other information available to the clinical assessor. The strong psychometrics in Indiana are probably due to the fact that assessors are required to be trained to a criteria in its use. Moreover, a random audit is performed on the clinical information sited to support the ratings. The auditors are RNs specifically trained to review charts and the clinical information used to support the ratings.

We will let folks know when the paper is ready and probably have it mounted on a web site available through the Indiana Division of Mental Health.

Fred

Date: Wed, 24 Oct 2001 4:57PM
From: Scott Hickey, PhD <5hickeys@pdq.net>

On Tue, 23 Oct 2001 8:17PM Robin Jenkins <rjenkins@cccommunicare.org> wrote:

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BTW, if you go w/masters prepared staff to do the assessments, the BASC (AGS publishers) is a wonderful tool.

We can narrow the problem down to an interpretive problem if your organization can spring for the scoring software. Clerical staff can score the scale accurately with this software. Interpretation is another matter. Our professional staff were reluctant to embrace this tool, perhaps because it was required paperwork imposed from the state level. Although I think it is a useful assessment tool, I found that professional staff members needed special training sessions before they began to use the scale clinically. We were able to do a little bit of outcome work using CBCL scores and found some sensitivity to change. The problem for us was one of building a large enough sample size. Our consumers tended to stay for briefer durations than the required re-test intervals. Ooops.

Good luck with your endeavor.

Date: Wed, 24 Oct 2001 4:59PM
From: Geoffrey Gray <ggray@oqsystems.com>

On Wed, 24 Oct 2001 4:01PM Dee Roth <rothd@mhmail.mh.state.oh.us> wrote:

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Dee Roth, MA, Chief
Office of Program Evaluation & Research
Ohio Department of Mental Health

You mention studying the impact of feedback on psychotherapy outcomes with children. I call your attention to two recent controlled studies of adults by Lambert et al that show that when therapists are told which patients are responding poorly during the course of therapy, they are able to significantly enhance the outcomes of those patients. Lamberts major finding was that the use of feedback provides information that gives the clinician a perspective on change that cannot be derived from clinical intuition alone, and that this feedback enhances outcomes with at-risk clients. The effect size of that enhancement is estimated to be .40, a moderate-range effect size that compares to a .10 to .20 effect size differential in studies that compare alternative forms of treatment such as cbt or interpersonal therapies. My guess is that you will find that outcomes monitoring with feedback has a measurable impact on the quality of psychotherapeutic care with children as clinicians use the data to recalibrate treatment.

Date: Wed, 24 Oct 2001 5:21PM
From: Bill Berman <wberman@echoman.com>

On Wed, 24 Oct 2001 4:01PM Dee Roth <rothd@mhmail.mh.state.oh.us> wrote:

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Office of Program Evaluation & Research
Ohio Department of Mental Health

I would venture to say that none of the instruments that are available are "perfect". I believe there is a dialectic between the psychometric capabilities and the usability of an instrument, and that one of our jobs as health services researchers is to acknowledge those difficulties, admit to our selection criteria and move forward. Gary's questions are good ones, and do present problems in assessing multicultural populations. The solution to that may be to have versions that are conceptually and psychometrically equivalent but do not ask the exact same questions, since the questions have different meanings and values in different cultures. But the cost of designing such a set of scales would be prohibitive, and take years in development. Dee's comments are accurate as well, but belie the fact that there are a number of problems with the Ohio Scales. In addition to Gary's points, the short-form Ohio scales are based on a change model (hopefulness, symptom improvement, and role improvement) rather than a diagnostic model, which makes them less useful to people who are accustomed to having the latter. In addition, interpretation of the Ohio scales is made

difficult by the fact that there is no single direction for health or difficulty. Diagnostic assessments are much too long for most of us to do repeatedly.

I raise these not as a criticism or endorsement of any scale in particular, but to acknowledge that there are pros and cons to every one, and we should acknowledge that we are only at the first stage of measurement technology. To paraphrase a recent commercial for insurance, "The greatest risk of all is doing nothing."

Bill Berman

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Thu, 25 Oct 2001 8:23AM
From: Bill Berman <wberman@echoman.com>

On Wed, 24 Oct 2001 4:45PM Frederick L Newman, PhD <newmanf@fiu.edu> wrote:

We will have a paper ready on the HAPI-Children's measure ready by December. It is a public domain measure and has very strong psychometrics. The ratings are based upon information collected via a structure clinical interview and other information available to the clinical assessor. The strong psychometrics in Indiana are probably due to the fact that assessors are required to be trained to a criteria in its use. Moreover, a random audit is performed on the clinical information sited to support the ratings. The auditors are RNs specifically trained to review charts and the clinical information used to support the ratings.

We will let folks know when the paper is ready and probably have it mounted on a website available through the Indiana Division of Mental Health.

Fred

Are the HAPI-A and the HAPI-C public domain, or proprietary?

Bill Berman

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Thu, 25 Oct 2001 8:58AM
From: Molly Brunk <mbrunk@hsc.vcu.edu>

On Wed, 24 Oct 2001 4:59PM Geoffrey Gray <ggray@oqsystems.com> wrote:

You mention studying the impact of feedback on psychotherapy outcomes with children. I call your attention to two recent controlled studies of adults by Lambert et al that show that when therapists are told which patients are responding poorly during the course of therapy, they are able to significantly enhance the outcomes of those patients. Lamberts major finding was that the use of feedback provides information that gives the clinician a perspective on change that cannot be derived from clinical intuition alone, and that this feedback enhances outcomes with at-risk clients. The effect size of that enhancement is estimated to be .40, a moderate-range effect size that compares to a .10 to .20 effect size differential in studies that compare alternative forms of treatment such as cbt or interpersonal therapies. My guess is that you will find that outcomes monitoring with feedback has a measurable impact on the quality of psychotherapeutic care with children as clinicians use the data to recalibrate treatment.

Do you have the references for these studies?

Date: Thu, 25 Oct 2001 9:04AM
From: Gene Lyle <gene.lyle@co.ramsey.mn.us>

On Wed, 24 Oct 2001 4:26PM Rich N Deliberty <rdeliberty@fssa.state.in.us> wrote:

Indiana, with Fred Newman's help, developed the Hapi-A a few years ago. That has proven to be an excellent instrument that predicts costs and is also useful for outcome measurement for adults with mental illness or addictions. We tried a version of the CAFAS for children, and found it to be unreliable.

Last year we developed (again under Fred's leadership) the Hapi-C for children. It seems to be psychometrically very strong, and borrowed a lot from the Ohio scales. We've been using it for a year now, with positive reports from clinicians and trainers. Within a few months we'll have some information on its usefulness for risk adjustment.

Just to let you know that there is another option.

Richard DeLiberty
Deputy Director
Indiana Division of Mental Health and Addiction

Richard,

If you wouldn't mind, could you expand a bit on your comments re: the unreliability of the CAFAS? Do you mean reliability in the statistical sense or are you using a more generic meaning?

Gene Lyle
Office of Performance Measurement & Evaluation
RCCHSD
St. Paul, MN

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

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References:

Lambert MJ, Whipple, JL, Smart DW, Vermeersch DA, Nielsen SL, Hawkings EJ. The Effects of Providing Therapists with Feedback on patient Progress During Psychotherapy: Are Outcomes Enhanced? Psychotherapy Research 11(1) 49-68, 2001.

Lambert MJ, et al. Patient-Focused research: Using patient outcome data to enhance treatment effects. Journal of Consulting and Clinical Psychology, 2001 (April), Vol 69 (2), 159-172.

Lambert, et al. Enhancing Psychotherapy Outcomes via Providing Feedback on Client Progress: A replication. Journal of Consulting and Clinical Psychology, in press.

Gray, GV and Lambert, MJ. Feedback: A Key to Improving Therapy Outcomes. Behavioral Healthcare Tomorrow, October (2001).

Date: Thu, 25 Oct 2001 10:02AM
From: Dave Colton <dcolton@ccca.state.va.us>

The other day I asked if there was any information about the instruments developed by Len Bickman at Vanderbilt. A little searching on the Internet found the web site for the Child/Adolescent Measurement System (CAMS) at:
http://www.vanderbilt.edu/VIPPS/CMHP/measurementsys.html

The primary instruments under discussion appear to be the Achenbach scales, the Ohio Youth Problem, Functioning, and Satisfaction Scales, the Child/Adolescent Measurement System (CAMS), the Child and Adolescent Functional Assessment Scale (CAFAS), and the Acuity and Psychiatric Illness Scale - Child and Adolescent Version. There is also a Brief Psychiatric Rating Scale for Children (Overall and Pfefferbaum). If you're aware of any others, I'd appreciate your sharing with the list.

Each instrument has its pluses and minuses, including cost, ease of administration and scoring, and most importantly 'pertinence'. For example, after reviewing all of these instruments I am not sure that any would meet our needs for longitudinal assessment of behavioral functioning in an inpatient acute care setting.

David Colton, Ph.D.
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144
dcolton@ccca.state.va.us

Date: Thu, 25 Oct 2001 10:38AM
From: Frederick L Newman, PhD <newmanf@fiu.edu>

On Thu, 25 Oct 2001 8:23AM Bill Berman <wberman@echoman.com> wrote:

Are the HAPI-A and the HAPI-C public domain, or proprietary?

Bill Berman

Both are owned by Indiana and are considered Public Domain. There is a paper by Deliberty, Newman, and Ward in J of Behavioral Health Services (2001) that describes the basic psychometrics of HAPI-A and the data as to why the Indiana Version of the CAFAS (an adapted version titled the Mini-CAFAS) was not seen as reliable given its use in Indiana. The usual tests of reliability and validity in a controlled field study indicated that it was reliable and valid. However, when put out in the field it was not stable over time (even though we had annual training and random audits).

That paper also describes how the HAPI-A did hold up under all circumstances.

The programs and the State Office of MH then approached me and John McGrew to create a Child/Adolescent version of the HAPI. As with the Adult version -- the underlying theme is to assess the child's (and parent's) ability to self-manage day to day functioning several areas. So the construct of "self-management" was a basic ingredient for both instruments. This was seen by several consumer groups (some of whom participated in the development of the HAPI-A) as representing a concept of "recovery" rather than impairment and illness. By bring the "self management" concept over to the HAPI-Children scale -- it was hoped that we were moving toward a "recovery model" here as well. However, this is a statement of theory and we have not actually empirical evidence that it does represent "recovery."

Again, please be patient while my colleagues and I attempt to put the finishing touches on the formal papers on both the HAPI-C and the HAPI-A.

Fred

Date: Thu, 25 Oct 2001 11:07AM
From: John Ward <ward@fmhi.usf.edu>

On Thu, 25 Oct 2001 10:02AM Dave Colton <dcolton@ccca.state.va.us> wrote:

The other day I asked if there was any information about the instruments developed by Len Bickman at Vanderbilt. A little searching on the Internet found the web site for the Child/Adolescent Measurement System (CAMS) at: http://www.vanderbilt.edu/VIPPS/CMHP/measurementsys.html

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David Colton, Ph.D.
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144
dcolton@ccca.state.va.us

Bill Berman mentioned the CFARS in a note to the list yesterday as one of the better instruments for tracking outcomes for kids. There is actually an instrument for Adults (Functional Assessment Rating Scale) and one for kids (Children's Functional Assessment Rating Scale) available for free on the web at: http://outcomes.fmhi.usf.edu

The FARS and CFARS were derived, modified and ultimately evaluated and implemented in Florida after creating them from early versions of the Colorado Client Assessment Record (CCAR). As with the CCAR, the FARS and CFARS are clinician completed instruments that can be (and are in practice and research) completed by bachelor's level or higher staff. Both scales have good interrater reliability and validity research support, including use of BA level raters in both mental health and substance abuse settings. Free interactive web training to criterion and certification is also available linked to the above web site for the CFARS. Software, manuals and forms are also available for free download on the web site for both scales. The software downloads can be used on stand alone PC computers or linked in networks to permit data entry and menu driven printouts of individual clinical or aggregate quality assurance/outcome reports based on that data. As Bill Berman mentioned re: the CFARS, these scales are in use in Florida and several other states or sites. Both the FARS and CFARS are in use in Florida, Wyoming and other sites like counties in other states or individual mental health centers. The CFARS is also being used statewide in Illinois, New Mexico and several other large sites as well...including some SAMHSA funded research. The FARS and CFARS are also included in an ORYX vendor system operated by my agency. As I understand it, as of the October release of the CMHC Systems, Inc. software, both the

FARS and CFARS are included with input screens. If you want more information than is on the web address for download, give me a call or email me.

John C. Ward, Jr., Ph.D.
Associate Professor
Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida
813-974-1929

Date: Thu, 25 Oct 2001 11:11AM
From: Rich N Deliberty <rdeliberty@fssa.state.in.us>

On Thu, 25 Oct 2001 9:04AM Gene Lyle <gene.lyle@co.ramsey.mn.us> wrote:

Richard,

If you wouldn't mind, could you expand a bit on your comments re: the unreliability of the CAFAS? Do you mean reliability in the statistical sense or are you using a more generic meaning?

Gene Lyle
Office of Performance Measurement & Evaluation
RCCHSD
St. Paul, MN

First, I'm not speaking specifically of the CAFAS. Indiana worked with Fred Newman and Kay Hodges to create an Indiana specific version of the CAFAS the CAFAS MINISCALE VERSION. This effectively divided the CAFAS scales into a series of subscales. The psychologists involved tell me that this is psychometrically more sound.

For a discussion of our initial issues and statistics I'd refer you to:

DeLiberty, Newman, & Ward. (2001). "Risk Adjustment in the Hoosier Assurance Plan: Impact on Providers" The Journal of Behavioral Health Services & Research, 2001, 2(3), 1-20.

Working with an advisory group and doing some qualitative work we found a few things relevant to the problem for us. Staff new to the instrument seemed to work very well with it. Because the CAFAS MINISCALE is so behavior specific, though, over time raters tended to rely on their clinical judgment more than on the behavioral markers. Training had a huge impact on new raters but minimal or no impact on experienced ones.

The biggest problems seemed to be with kids in and out of residential care, or foster care. There was a lot of confusion among raters about who should be rated as family. If the child is in inpatient, waiting to return to foster care, do I rate the inpatient staff, foster family, or biological family?

Richard N DeLiberty
Deputy Director
(317) 233-4319

Date: Thu, 25 Oct 2001 12:21PM
From: Paul Cook <pcook@scriptassistllc.com>

On Thu, 25 Oct 2001 11:11AM Rich N Deliberty <rdeliberty@fssa.state.in.us> wrote:

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Richard N DeLiberty
Deputy Director
(317) 233-4319

I feel the need to chime in with an "end-user" perspective on the CAFAS Miniscale Version, having done my psychology internship in Indiana a couple of years ago when the scale was being used. At the community mental health center where I was working, the major problem in achieving consistent ratings had to do with the behavioral anchors themselves. In some cases, these seemed too specific (a child would present with difficulties that were similar, but didn't exactly match any of the categories), or else seemed open to various interpretations. This might help to explain the rater drift--in the absence of clear criteria, raters seemed to develop their own idiosyncratic system for making ratings, and stayed with what they had "figured out," even in the face of feedback that someone else (including the trainer) was using a different system for making these judgments. Another problem was that CAFAS scales were defined in terms of specific behaviors that were different for each problem category--it was like trying to achieve inter-rater reliability on 20 different rating scales, rather than one. The HAPI-A was much easier to use: For each problem category, it relied on a consistent 1-7 rating scale with anchors defined in terms of the severity of functional impairment.

Paul Cook, Ph.D., Director of Research
PRO Behavioral Health/ScriptAssist
Denver, CO

Date: Thu, 25 Oct 2001 1:03PM
From: Rich N Deliberty <rdeliberty@fssa.state.in.us>

On Thu, 25 Oct 2001 12:21PM Paul Cook <pcook@scriptassistllc.com> wrote:

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Paul Cook, Ph.D., Director of Research
PRO Behavioral Health/ScriptAssist
Denver, CO

Thanks. The behavioral anchors on the CAFAS Miniscale Version had very few adjustments from the original CAFAS.

Richard N DeLiberty
Deputy Director, DMHA
(317) 233-4319

Date: Thu, 25 Oct 2001 3:14PM
From: Tuan Nguyen <tuan.nguyen@mhmraharris.org>

On Wed, 24 Oct 2001 5:21PM Bill Berman <wberman@echoman.com> wrote:

I would venture to say that none of the instruments that are available are "perfect". I believe there is a dialectic between the psychometric capabilities and the usability of an instrument, and that one of our jobs as health services researchers is to acknowledge those difficulties, admit to our selection criteria and move forward. Gary's questions are good ones, and do present problems in assessing multicultural populations. The solution to that may be to have versions that are conceptually and psychometrically equivalent but do not ask the exact same questions, since the questions have different meanings and values in different cultures. But the cost of designing such a set of scales would be prohibitive, and take years in development. Dee's comments are accurate as well, but belie the fact that there are a number of problems with the Ohio Scales. In addition to Gary's points, the short-form Ohio scales are based on a change model (hopefulness, symptom improvement, and role improvement) rather than a diagnostic model, which makes them less useful to people who are accustomed to having the latter. In addition, interpretation of the Ohio scales is made difficult by the fact that there is no single direction for health or difficulty. Diagnostic assessments are much too long for most of us to do repeatedly.

I raise these not as a criticism or endorsement of any scale in particular, but to acknowledge that there are pros and cons to every one, and we should acknowledge that we are only at the first stage of measurement technology. To paraphrase a recent commercial for insurance, "The greatest risk of all is doing nothing."

Bill Berman

I would agree with many statements that Bill Berman made, including the fact that some measurement NOW is better than none. However, I would seriously take him to task for glibly sweeping away efforts to address cultural appropriateness of assessment instruments on the ground that it would be too costly and takes too long. Misdiagnosing and missassessment of minority groups create personal and group burdens, stigma, costs, and pains, as well as societal costs that must not be ignored.

I would venture to argue (not being a clinician myself) that a treatment plan designed on the basis of the scores or information derived from questions that a child (and his/her family) does not understand would be inappropriate for the child and the family. As a consequent, there would ensue either a waste of treatment resources (because of misapplication of intervention to inaccurately defined goals), or a rejection of treatment by the child or family (for lack of cultural congruence), or (and often concurrently) social and clinical labeling of the minority persons as treatment resistant or recalcitrant, which then casts many minority children, adults, and families outside the network of services. Good intervention and good treatment begins with an accurate identification of problems, objectives, and goals. The best solutions when applied on the basis of the wrong diagnosis or problem formulation constitute in effect a resource squander that we can ill afford given the current paucity of resources. Use of instruments that exclude de facto, albeit unintentionally, minority persons from the service delivery system is unfair since it continues to perpetrate racial and ethnic inequality.

From a process perspective, I find it revealing that Gary who is from Alameda County, California was sensitized to the multicultural issue and raised it. Perhaps the OYQ fits and is useful in environments that are culturally homogeneous, but should be less readily embraced (or should be modified) when the target population is multicultural, as is the case in many parts of California, New York, Texas, and many other parts of the US. Ibid for many other instruments that have not been subjected to examination for cultural biases.

Tuan D. Nguyen, Ph.D
Director, Research, Evaluation, & Planning
MHMR Authority of Harris County
1502 Taub Loop
PO Box 25381
Houston, TX 77265-5381
713-970-7161 (Voice)
713-970-7106 (Fax)
tuan.nguyen@mhmraharris.org

Date: Fri, 26 Oct 2001 9:34AM
From: William Berman <wberman@echoman.com>

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tuan.nguyen@mhmraharris.org

Mea culpa, mea culpa. I did not intend to glibly sweep away cultural sensitivity. Having spent 10 years in the Bronx, I am well aware of the clinical and human issues involved. And I agree with what Dr. Nguyen has said about the waste of resources. My point was in no way to dismiss this issue, but rather to identify it as a pervasive limitation of outcomes measurement. I am struck that, despite years of discussion of the need for culturally sensitive outcome measures, I do not believe there are any that are in use for either children or adults. For example, the SF12/SF-36 uses the term "Full of pep" which I am told does not translate well into other cultures. Translations of the BASIS-32 are available, but I don't

believe they have been tested for cultural equivalency. I am unaware of any cultural equivalency validations of any of the children's assessment tools. Is anyone using any acculturation measures as a control variable for outcomes? Are there standards for determining cultural equivalency validity, not just language translations?

William H. Berman, Ph.D.
Chief Clinical Officer, The Echo Group
wberman@echoman.com

Date: Fri, 26 Oct 2001 8:26PM
From: Linda Toche-Manley <linda@acrx.com>

Yet, another option:

CAMHOMS (which has had extensive NIHM review/funding) is designed to be a clinical decision support system in support of adolescent treatment. CAMHOMS is unique since it embeds strength-based content and functions as a "learning system" that progressively gets better at predicting service need/improvement using data mining and other mathematical modeling.

CAMHOMS is also designed to reduce respondent and administrative burden and produces individual and clinical reports in real-time to help clinicians plan and monitor treatment. There are countless systems out there for kids now, and most do a good job if your goal is group-level analysis. However, if you are interested in building evidence-based treatment for individual kids, you may want to take a look at the system.

You can find out more about the CAMHOMS system at www.psybermetrics.com

Linda Toche-Manley

TEC*Script* 4: Outcome Measures for Children and Adolescents
23 October 2001 – 13 November 2001

Date: Fri, 26 Oct 2001 8:29PM
From: Ivan Williams <isw@pvi.org>

On Thursday, October 25, 2001 10:38AM Frederick L Newman, PhD <newmanf@fiu.edu> wrote:

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Again, please be patient while my colleagues and I attempt to put the finishing touches on the formal papers on both the HAPI-C and the HAPI-A.

Fred

Fred - Could you elaborate on the question of stability over time for the HAPI, and for outcomes measures general, in a field setting? If these folks were receiving treatment and the measure is sensitive to changes due to that treatment you would expect different results over time as a result of differences in the magnitude of the treatment effect. Maybe I'm missing
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be this way and much of the "unreliability of treatment" is beyond our control. So maybe the question is: Is this measure reliable and valid enough to help us improve the reliability of and provide validation for the treatment we provide?

Ivan Williams
Outcomes/PI Coordinator, Prairie View, Inc.

Date: Sat, 27 Oct 2001 8:55AM
From: Frederick L Newman, PhD <newmanf@fiu.edu>

On Fri, 26 Oct 2001 8:29PM Ivan Williams <isw@pvi.org> wrote:

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Ivan Williams
Outcomes/PI Coordinator
Prairie View, Inc.
williamsis@pvi.org

Ivan (and interested others)

We fully agree that sensitivity to change is of primary importance and the HAPI-A is. The empirical evidence that the HAPI-Adult is shown the published paper. Moreover, Indiana does use change scores within risk adjusted groups as part of the Annual Report Card on MH and SA Service Providers. (I think that Indiana is a leader in the publication of such a report card on publishing change scores by risk adjusted groups).

The concept of stability may be best described as "Does the profile on the HAPI-A and the risk adjusted grouping remain stable for a Service Provider from year." Recall that in estimating reliability one can have change over time, and the correlations among consumers can remain stable over time.

Are there some consumers who do not demonstrate change over time on the HAPI-A? Sure, but this needs to be understood in terms of what is being measured: Ability to self-manage their day to day functioning. The view is that if the service providers are doing their job, they could be working with the consumers to have them achieve and maintain a satisfactory level of self-management. This does not mean that services stop - - - Within the HAPI-Adult, there is a rating of the consumers need for services to maintain their self-management of their community functioning.

Thus, we are often interested in finding stability of self management of community functioning for some consumers who are sustain high scores on the HAPI-A profile across the psycho social factors and the reliance on community services.

Having said all of this, I still hope that folks will go to the full paper to get the details.

Fred

Date: Sat, 27 Oct 2001 5:20PM
From: Frederick L Newman, PhD <newmanf@FIU.EDU>

In re-reading my email I think that there were sufficient typos to warrant my making a few corrections. See below:

Ivan (and interested others)

We fully agree that sensitivity to change is of primary importance and the HAPI-A is sensitive to change, and the time 2 scores show reliability and the same factor structure. The empirical evidence that the HAPI-Adult is shown in the published paper. Moreover, Indiana does use change scores within risk adjusted groups as part of the Annual Report Card on MH and SA Service Providers. (I think that Indiana is a leader in the publication of such a report card on publishing change scores by risk adjusted groups).

The concept of stability may be best described as addressing the question: "Does the profile on the HAPI-A and the risk adjusted grouping remain stable for a Service Provider from year to year?" Recall that in estimating reliability one can have change over time and still have the correlations (ICCs) among consumers to remain stable over time. If the correlations of the profile within a program changes from year to year to year are very low, then one wonders about either the program's stability or the measure's stability. We looked at these correlations over a three year period. For the adult population, we did see high year to year correlations on the HAPI-A (even though there were changes within consumers), but for the CAFAS Mini-Scale these same correlations were quite low. Yes, the CAFAS Mini-Scale did show good coefficients of reliability and validity in the controlled study, but as our colleagues has said in other emails on this server, it was not as easy to use as the HAPI-A. That is why we sought to create a children's version (HAPI-C). Again the psychometrics within a controlled study were outstanding (in fact a bit better than the CAFAS Mini-Scale). But in the next year or so, we will see if it holds up as the adult scale has.

Another issues is whether we would expect that there are some consumers who do not demonstrate change over time on the HAPI-A? Sure, but this needs to be understood in terms of what is being measured: Ability to self-manage their day to day functioning. The view is that if the service providers are doing their job, they could be working with the consumers to have them achieve and maintain a satisfactory level of self-management. This does not mean that services stop - - -Within the HAPI-Adult, there is a rating of the consumers need for services to maintain their self-management of their community functioning.

Thus, we are often interested in finding stability of self management of community functioning for some consumers who are sustain high scores on the HAPI-A profile across the psycho social factors and the reliance on community services.

Having said all of this, I still hope that folks will go to the full paper to get the details.

Fred

Date: Mon, 29 Oct 2001 3:30PM
From: Dave Colton <dcolton@ccca.state.va.us>

In the discussion of the HAPI-C instrument, is there a web site where more information and perhaps examples of items can be found?

David Colton, Ph.D.
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144
dcolton@ccca.state.va.us

Date: Mon, 29 Oct 2001 4:24PM
From: Frederick L Newman, PhD <newmanf@fiu.edu>

On Mon, 29 Oct 2001 3:30PM Dave Colton <dcolton@ccca.state.va.us> wrote:

In the discussion of the HAPI-C instrument, is there a web site where more information and perhaps examples of items can be found?

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Dave,

It is possible that the Indiana Office of MH would distribute a copy, however, if you are willing to wait about a month, we will have a copy of the instrument and a report on the psychometrics ready in about a month. We have all of the data complete, but a bunch of other things are competing with the time to write the report.

Fred

Date: Mon, 29 Oct 2001 5:11PM
From: Rich N Deliberty <rdeliberty@fssa.state.in.us>

On Mon, 29 Oct 2001 3:30PM Dave Colton <dcolton@ccca.state.va.us> wrote:

In the discussion of the HAPI-C instrument, is there a web site where more information and perhaps examples of items can be found?

David Colton, Ph.D.
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Telephone: 540-332-2144
dcolton@ccca.state.va.us

I will attempt to have the instrument and manual put on an accessible web site. Currently they are available on a web site that only our providers can reach.

Richard N DeLiberty
Deputy Director, DMHA
(317) 233-4319

Date: Tue, 13 Nov 2001 3:12PM
From: Rich N Deliberty <rdeliberty@fssa.state.in.us>

As promised, the HAPI-A (Hoosier Assurance Plan Instrument - Adults) and HAPI - C (ditto, children) is now available on the IDMHA web site:
http://www.in.gov/fssa/servicemental/hap/assess.html

The scoring manual for the HAPI-C is on the same site. The scoring manual for the HAPI-A will be there as soon as the most recent revisions are complete.

Richard N DeLiberty
Deputy Director
(317) 233-4319