

## PART II

### **The Children's Resource Center: Using outcomes in practice**

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#### **The Children's Resource Center: An early player in community-based care**

**T**he Children's Resource Center (CRC) has provided mental health services to children, adolescents, and their families in Wood County, Ohio for 30 years. Founded in 1976, the Center's original board had a vision of community-based care. It was a pioneering approach for the time and the board pushed to convince the state legislature to shift funding toward community mental health for children. The prevention of hospitalization for children was among CRC's initial goals, and one that lasts to this day.

Reflecting many of the principles previously highlighted, CRC focuses on evidence-based practices and the use of outcomes in conjunction with the Ohio Mental Health Consumer Outcomes System. Family involvement in decision making is a key tenet of the organization's philosophy. Thus, impact on the family is an upfront consideration when it comes to assessment, treatment, and evaluation of the treatment.

While CRC and ODMH have a collaborative and mutually respectful relationship, this required work and commitment from both given that CRC has frequently forged new ground ahead of the rest of the state. State and local policymakers have learned from CRC's efforts and experience and have considered those lessons as they make mental health policy and funding decisions. An example of this stemmed from a low-cost yet significant research project concerning assessment. ODMH funded research of CRC's structured assessment of family aggression during client intake assessments. This had implications for practice and led to new aspects of coordination across CRC, Bowling Green State University (BGSU), and ODMH. At the same time, the focus of Ohio's policymakers on the importance of research evidence and outcomes has contributed to CRC's refinement and improvement of its practices. North Carolina policymakers at the state and local level can learn from CRC's work with state and university partners.

#### **The Children's Resource Center**

##### Mission and services

CRC is a private, not-for-profit agency with a behavioral health focus. Staff members provide evaluation, treatment and guidance to families of children with behavioral and emotional problems, including children with SED. The range of services include outpatient therapy, psychiatric services, intensive home-based services, residential services, partial hospitalization, treatment foster care, parenting education, school-based, early child, and prevention services. CRC is a leader in the region in raising public awareness of and advocating for the broad range of health, social, and psychological problems of children and adolescents.

The CRC's mission is to provide child-centered, family-focused mental health services to families in Wood County and nearby communities. In pursuing this goal, CRC is guided by the philosophy that:

- Mental health needs of children cannot be isolated or treated apart from other needs or problems of a child, such as educational or language challenges;
- The recognition that agencies addressing children's varying problems must unify their efforts into a coordinated, multi-disciplinary team to effectively serve the child and the family; and
- Children's problems must be recognized and addressed as early in life as possible to prevent minor problems from becoming major in later years.

CRC's funding comes from state and local sources, individuals, and other interested parties. It is increasingly seeking funding and developing partnerships with other children's mental health stakeholders.

### Meaningful Partnerships

CRC partnerships with local stakeholders include:

#### *Wood County Family and Children First Council (WCFandCFC)*

The WCFandCFC brings together local leaders in political and administrative positions who value families and are committed to community services that raise the general health and well-being of children. The Council includes key decision makers and constituents whose collective action sets community policy for multi-agency youth. Membership includes representatives from public agencies, including mental health, health, human services, education, substance abuse and juvenile justice; early childhood representatives; county and city elected officials; consumers, family members; relevant state agency regional office representatives; medical providers and child abuse prevention representatives. The WCFandCFC model is in place across Ohio's local mental health systems.

#### *Strategic Alliance Partnership*

This community-wide collaborative planning process was developed within the Family and Children First Council structure to improve the lives of children and families in Wood County. The effort was recently funded by a community foundation to assist the partners with their efforts at collaboration and joint problem solving. Partners cover the range of potential stakeholders and include the local United Way, after-school programs, non-profits that address child abuse prevention and substance abuse prevention, the CRC, and BGSU. A primary focus of the partnership is to figure out how best to improve data collection and pool data for collaborative needs assessment and monitoring. Partners intend to use the data to assess and address child health and mental health needs, child abuse rates, education challenges, and other aspects of child and family well-being. BGSU's role is significant, with faculty and students focusing on research and analysis and incorporating the university's commitment to service learning for students. Another promising aspect of the Strategic Alliance Partnership is its potential for positioning the partners for future state and federal grant opportunities.

#### *Wood County Cluster*

The Wood County Cluster's mission is to assure that multi-need youth receive the services necessary to meet their needs. Over the years, the Cluster has provided multi-disciplinary planning on behalf of children with extensive needs. For the great majority of these children, out-of-home placements were avoided. Two core values support the Cluster's mission:

- Community-based, with the focus of services, as well as management of these services and decision-making responsibilities, resting at the community level; and
- Child-centered, with children's and families' needs dictating the types and mix of services provided.

These and other local and state partnerships contribute significantly to CRC's ability to stay on the cutting edge of research and services related to children's mental health. Data use is another means by which the agency continuously seeks to enhance and improve its work.

### **Using Data and Outcomes in Practice**

The ODMH surveys mental health service providers across the state as part of a recertification process required for providers to be eligible for Medicaid reimbursement. One component of the questionnaire addresses consumer outcomes. Among other purposes, ODMH uses the responses to monitor providers' use of outcomes and to identify opportunities for improvement in the state's Consumer Outcomes System. The CRC's responses to the December 2005 survey reflect its continuous use of data to guide its work. CRC reports that 83.7 percent of its clients are included in the Outcomes System. Some providers in the state boast an even higher percentage. This demonstrates the extent to which the Outcomes System captures information about children and families across the state who receive mental health services.

A further example of data use involves the Ohio Scales instrument, a component of the Outcomes System, which measures four domains: problem severity, functioning, hopefulness, and satisfaction. Importantly, youth, parents, and agency workers all complete the Ohio Scales forms as part of the measurement effort. CRC was instrumental in encouraging ODMH to allow child agencies to collect not only one parent's report but to collect as many forms as possible from parents and extended family members. CRC advocated for this enhanced data collection in part to promote parental and family involvement. In proposing that more parent forms be completed, CRC also worked with ODMH to ensure that the electronic forms were easy to track, otherwise even the initial level of data collection would have seen far less use for policy and practice. CRC found ODMH responsive and understanding of the importance of the increased parental and family involvement through data collection.

The outcomes efforts through Scales is also critical for the CRC because of the Center's conviction that outcomes data helps identify issues for treatment planning. As it collects Ohio Scales at various intervals, CRC encourages clinicians to look at patterns of change to assess progress toward client goals and to assist with ongoing treatment planning. Consistent with a System of Care approach, CRC involves family members in all aspects of treatment. CRC encourages clinicians to discuss the results of ratings with family members, and to consider whether specific items should be included as part of treatment plans. As this demonstrates, CRC stresses meaningful integration of the Ohio Scales for performance improvement, with implications for:

- Incorporating outcome measures into clinical practice;
- Assessment, treatment planning, and treatment review activities;
- Utilization and level of care decisions;
- Combining Ohio Scales data with other data, such as individual provider data and type of service; and
- Comparing client treatment plan goals and objectives with findings from Ohio Scales.

Using the data in conjunction with performance improvement efforts led CRC to:

- Identify needs for additional staff training about use of Ohio Scales and for greater and broader involvement of clinical leaders in Ohio Scales performance improvement activities;
- Encourage increased discussion of Ohio Scales results as part of clinical supervision, including discussion of whether level of care is consistent with client need as measured on Ohio Scales;
- Add an item about Ohio Scales to the annual staff performance appraisal process;
- Begin more frequent presentations about Ohio Scale results and issues to staff; and
- Become one of the first providers to conduct aggregate data analysis about client change over time.

The attention given to performance improvement with regard to the role of data by the Ohio mental health system goes beyond CRC. An example is the Southern Consortium for Children's development of a 2004 training video conference on the use and relevance of Scales and the data it generates. The conference was broadcast live to training sites around the state, providing an opportunity to use collaborative training to generate partnerships between the developers of Scales, policymakers, and practitioners.

CRC has been deliberate about sharing data analysis results with policymakers not only for the sake of information sharing but to demonstrate how providers use data. CRC is also willing to point out limitations of the system. For example, it is not possible to link individual client outcomes data with other client-level demographic or service history data reported to the state through the MACSIS system. While this is deliberate and with consumer protection in mind, it limits how confidently and with what level of specificity the state or providers can draw conclusions from data analysis and program evaluation. The reality that clients simultaneously may receive multiple services from multiple programs makes it virtually impossible to isolate the effects of one program from another without much more data sharing across and among service domains.

Finally, how CRC uses data and incorporates it into decision-making processes is closely linked to its emphasis on evidence-based practices.

### **A Key Ingredient: Evidence-based practices**

The CRC uses evidence-based practice for both assessment and treatment. Evidence-based programs or practices have consistent scientific evidence showing improved outcomes for clients, participants, or communities.

For assessment, CRC uses a multi-informant, multi-measure protocol for diagnostic assessment intake that integrates the use of semi-structured clinical interviews and structured questionnaires that assess child behavior problems and functioning, family relationships, family physical and verbal conflict. This approach was initially developed at CRC as part of a CRC-BGSU clinical and research collaboration, was evaluated with the support of an ODMH grant, and was recognized by ODMH in its *Top Ten Mental Health Research Findings, Volume 3, 1999-2000*. This approach has been modified to incorporate the Ohio Mental Health Outcomes System.

With regard to treatment, CRC promotes the use of best practice, research-supported interventions in its clinical service delivery to youth and families. Three broad examples of empirically-supported approaches in use at CRC are:

- Behaviorally-oriented treatment programs for families of children with disruptive behavior disorders. The key component of this model is training parents in specialized behavioral interventions so they can help their children.
- Cognitive behavior therapy (CBT) for children and adolescents suffering from internalizing disorders such as anxiety and depression. CBT helps clients learn to identify and assess the negative and self-defeating thinking patterns associated with their emotional distress and replace those with more realistic and adaptive thoughts. Additionally, clients learn to use healthy problem-solving and coping strategies that help them manage emotional distress.
- Social and emotional competence development for children whose emotional disturbance interferes with the development of appropriate and positive relationships with peers. Using a mixture of behavioral and cognitive-behavioral approaches, therapists help children learn and practice social skills in a peer group context. Typical skills taught include identification and communication of feelings, learning to understand and respect others, social problem solving, and self-regulation in a group setting.

These approaches have accompanying treatment manuals which identify principles, strategies, and sequences for intervention, and are supported as evidence-based practices by scientific professional literature.

The challenge for clinical practice settings such as CRC is to apply evidence-based programs developed in narrower research settings to the more complex environments that clinical practitioners face. That requires a commitment to training, as well as to ongoing monitoring and supervision of implementation. CRC sponsors an annual conference, the Douglas G. Ullman Conference on Children's Mental Health, which hosts national speakers on evidence-based practices who train CRC staff, supervisors, and practitioners in Ohio. Additionally, CRC has partnered with The Cullen Center, a Toledo, Ohio site of the National Child Traumatic Stress Network (NCTSN), for networking and training designed to support evidence-based practice in child traumatic stress. Such partnerships often lead to other benefits. In the past two years the Cullen Center has linked with ODMH in a statewide initiative to help providers improve their recognition of trauma on youth, including youth in juvenile justice and educational settings. The Cullen Center has sponsored learning communities to help Ohio mental health providers learn and implement an empirically-supported model of trauma-focused treatment. This development is applicable to North Carolina, whose Duke University's NCTSN program is one of the flagship sites of the national network.

Two additional illustrations of CRC's evidence-based program implementation are related to ODMH initiatives. CRC is a member of the ODMH-promoted Ohio Mental Health Network for School Success, a statewide group that promotes the use of empirically-supported mental health programs in schools. CRC has received staff training and program financial support, provided through ODMH, to help deliver *The Incredible Years* program, an evidence-based program that includes behaviorally-based parent training and child social skills training.

The CRC provides many examples of how and why mental health providers would use data in practice. A close look at the Outcomes Initiative and CRC identify implications for policy that are relevant for North Carolina.

## CONSIDERATIONS FOR NORTH CAROLINA POLICYMAKERS

Creating a way to measure outcomes was an essential element of Ohio's mental health reform efforts. Developing a set of common outcomes has allowed Ohio to establish a continuous improvement process to ensure that the system meets the needs of consumers and providers. By providing timely and meaningful information, policymakers in Ohio can use this system to reallocate resources, respond quickly to problems and effectively guide decisions about the use of scarce resources.

Like North Carolina, mental health reform in Ohio involved moving from hospital-based to community-based services, encouraging the use of evidence-based practices and increasing consumer satisfaction. Ohio began its reform efforts in 1988. By 1995, a basic level of community services had been established in nearly every county. The next challenge was to ensure the quality of those services. Key to Ohio's success was the understanding that a successful system required an accountability plan that could measure the quality of services and provide timely feedback to policymakers, practitioners, and consumers. This was especially important if Ohio was going to encourage the use of evidence-based practices. Getting practitioners to use new therapies, getting consumers to accept new treatments, and making sure program developers knew what was and was not working involved providing information about how programs worked in real-world settings.

Generating meaningful information that is useful for local and state planning is challenging. Ohio recognized that if this information was going to be useful it would have to meet the needs of a broad cross section of constituents. It had to be a collaborative process involving representatives from the state's community mental health boards, service agencies, advocacy organizations, and professional associations.

While a challenging process, convening stakeholders to reach consensus about how to measure the system's work created a strong foundation for interagency collaboration, which is essential. This also helped develop a policy infrastructure to support OTF.

Defining goals is an important first step to creating an information system. These goals should guide the selection of the indicators to be monitored. In creating the new information system Ohio decision makers had to agree on concepts that would be used to develop and evaluate policy options. Ohio chose "recovery" for adults and "resilience" for youth and families as the organizing principles for its accountability system.

The new accountability system has helped shape policies and priorities at the department and local service provider levels. Following are ways that the Outcomes Initiative and the work of the CRC have had relevance for policymaking:

- Ohio's Quality Agenda helped shaped policy activity through its focus on consistently applying evidence-based clinical practices, moving from quality assurance to continuous quality improvement techniques, and measuring consumer outcomes for quality improvement;
- State-level policy development and implementation consistently stem from a broad cross section of constituents;
- ODMH's predisposition is now to bring more people, especially consumers and families, into the policymaking process;
- The existence of a policy infrastructure affected the success of the OTF;
- Determining values and assumptions up front provided guidance for selecting among policy

- options;
- The Outcomes Initiative identified filters for developing and evaluating policy options - “recovery” for adults and “resiliency” for children;
  - The OTF’s recommendations regarding data use affected future policy development; and
  - The focus of Ohio’s policymakers on the importance of evidence and outcomes has contributed to providers’ ability to refine and improve their practices.

For several years, North Carolina has been in the midst of long-term significant changes to its mental health system. Ohio, too, has taken on major changes in this area. The reforms were not immediate nor were they immediately successful. Both the ODMH and local providers, such as the CRC, highlight the importance of identifying clear values and goals at the outset and involving a wide range of stakeholders throughout the change period. Moreover, funding concerns notwithstanding, it is important to recognize that aspects of Ohio’s Outcomes Initiative involve new ways of thinking as well as new and different approaches to funding. Neither Ohio’s nor North Carolina’s work is done. In terms of using data to learn about and assess mental health outcomes for children, however, Ohio has much to offer policymakers in North Carolina and beyond.

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