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Using Brief Screeners, Let Me Count the Ways

Using the care continuum to differentiate measurement in youth mental health



Written By: **Amber W. Childs, PhD**

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Letter from Amber W. Childs, PhD

Raise your hand if your eyes have started to glaze over when you hear anything related to data-driven, measurement-focused, measurement-informed, measurement-based (trails off into oblivion) care? Same.

And you're not wrong. Evidence-based practices for measurement have been dominating the chat in mental and behavioral healthcare broadly, and in innovation corners specifically. And, (minus the marketing frenzy), we've argued for good reason. When used effectively, measurement scores major points for helping to improve youth treatment and care outcomes. Plain and simple.

There is a storehouse of research, from screening to measurement-based care (MBC), that underscores just how essential measurement is to delivering high-quality mental healthcare for youth. Albeit slightly chaotic and painfully slow-moving, we have managed to make some major strides in systematic measurement in behavioral health, but still have a ways to go to reap all of the gains. There are measurement consensus, implementation, policy, and funding (yeah, we haven't forgotten about the cheddar) challenges and considerations galore. That's part of what our Measurement Collections are being built to discuss. So stay locked in!

But, if we're going to truly unlock the value and potential for measurement to improve mental health care outcomes for youth, we've got to cut through the noise and get back to basics. Not only should we be able to distinguish between different measurement practices and their functions, but we also need to understand the unique opportunities that they serve for youth throughout the care process.

Also, we're used to hearing about measurement practices from the service provider and system perspective. Unfortunately, that means we're often leaving valuable perspectives on how measurement can support key issues like engagement, collaboration, decision- making, and long-term "living your best life" types of outcomes for youth on the table. Couldn't be us!

Don't worry. We've got you on both fronts.



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Speed Run: Measurement Practices



This piece is designed as a mini-starter guide to help you get your arms around a few distinct, but related measurement practices within behavioral healthcare for youth. Because measurement is so complex, we're going to focus here on speed running you through measurement practices that use **brief instruments to support needs identification, treatment planning, monitoring, and clinical outcomes assessment.**

In our examples, we'll demonstrate how a single instrument can serve different functions depending on where the measurement is located along the prevention and treatment phases of the care continuum. Additionally, we'll highlight how the measurement practice can support engagement, collaboration, and shared decision-making for youth.

If that last sentence had you thinking you're about to read a dictionary style document about MBC within each individual level of care (e.g., outpatient, inpatient, IOP/PHP), fear not! We're keeping the discussion to the broad strokes.

Keep in Mind

1. We're zeroing in on brief, standardized instruments because they have broader applicability, are used more often, and will keep this scope organized.
2. Psychological and neuropsychological assessments are their own rodeo, and we can go there later. Just say the word.
3. This is not an exhaustive catalogue of every possible instrument (e.g, PHQ-9, GAD-7, PROMIS, etc.) or every single measurement practice. We're going high-level.
4. We're not covering every domain of youth mental health. (you can find them here)
5. The PHQ-9 is not ragebait. We aren't advocating for the "symptom only" approach (trust, we've got critiques). It helps us illustrate how brief standardized tools function differently depending on where they show up in the care pathway.

The good news for you is that after reading, you'll be able to clock when a screening practice is being marketed as MBC in a heartbeat! You're welcome.



About the Care Continuum

Let's do a quick level set on the care continuum before moving forward. We're focused narrowly on prevention and treatment phases, but with this full framework in mind, you'll be better oriented to where these measurement practices live within the broader care landscape. We'll use the phases laid out by the Institute of Medicine (IOM):

Promotion: Individual and/or system-level strategies that boost overall mental and physical wellbeing (e.g., after-school programs)

Prevention:

- Interventions to support mental and behavioral health through resources and education
- University (SEL curriculum in schools) or targeted (for at-risk youth) enabled by screening and related methods

Treatment:

- Multi-tiered service system addressing increasing levels of acuity ("levels of care")
- Outpatient, intermediate (e.g., IOP, PHP, EDT), and acute/crisis care (e.g., emergency services, inpatient, residential)

Recovery:

- Follow-up and maintenance stage of care focused on sustaining wellness long-term (cycling back to earlier phases where needed)
- Monitors long-term outcomes such as quality of life and life satisfaction

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Measuring to Identify: Early Engagement Galore

Measurement practices designed to help identify potential mental health concerns, guide decisions about next steps in care (e.g., assessment/diagnosis, monitoring, further intervention, etc.), including care transitions, are an incredible opportunity for early youth engagement. Ideally, youth are engaged earlier in the care continuum through promotion and prevention efforts (i.e., after-school programs; social and emotional learning curricula), but we can't sleep on the opportunity to engage youth up front during the screening and triage processes.

Screening and Triage

First stop: screening. Without a doubt, screening is one of the most common places where brief, standardized measurement tools are used. As you know, screening is designed to help identify any new cases of illness or concerns within a population to help figure out who needs further evaluation. We're not typically making formal diagnoses based on screening, but instead we're identifying whether there is a need for further evaluation and follow-up. In other words, which youth need a second or closer look into what might be happening with their mental health and wellbeing.

Triage typically follows, and is the process of using clinical judgment *alongside* information from the screening data (i.e., PHQ-9), to make a decision about the next most appropriate steps for a behavioral health intervention. Those next steps include preventative practices such as psychoeducation and/or coaching or peer support, treatment interventions like therapy, medication management, or crisis intervention, and safety planning.

You can think of screening as "catching" and triage as "sorting". In other words, based on the youth we've identified as having a need, what then are the next most appropriate steps to take based on level of severity, risk, youth preference, and available resources?

For youth, common screening and triage settings include primary care, school-based mental health clinics, and integrated care settings. Youth may also elect to use online self-screening tools in the public domain (e.g., online quizzes or screeners), though these tools are obviously not set up to then make clinical recommendations, or triage the young person.

What's Being Measured

Naturally, psychological symptoms are one aspect of what is being measured. But that's not new to you. Critically, screening and triage rely on more than symptom-focused assessment and include standardized assessments of factors such as social determinants of health (SDoH), including basic needs, caregiving and parenting behaviors, exposure to adverse events in childhood, and more. Presence of symptoms and their acuity (how strong they are), safety risk, SDoH, and youth preference are all taken into consideration when making a determination about next steps for the young person in the care continuum. Check out our Intro Guide to SDoH that walks you through how to assess, address, and communicate about SDoH in youth, and if you're looking for measures that fit the bill, head over to our SDoH screening tools resource that includes a list of standardized screening tools that are in the public domain!

All so important. Right? There's more. Measurement used within the screening phase is an essential opportunity to engage youth within the mental healthcare process.

Case Example

Emmett is a 15-year-old high-school student who is given a PHQ-9 at his yearly well-visit with his pediatrician. The results came back with scores in the mild range for depressive symptoms. His pediatrician invites him to look at the items together during the appointment, and asks whether these scores match how he's been feeling lately. Emmett shares that he had been feeling "a little stressed" about school, and noticed that he felt more tired lately and less up to hanging out with friends since breaking up with his girlfriend. He shared that he hadn't planned to bring it up because he "didn't want to make a big deal out of it." The pediatrician assesses for any potential safety concerns and supportive/protective factors for Emmett. Finding no additional safety concerns, the pediatrician provides Emmett and his parents with psychoeducation about depressive symptoms for youth, and discusses options including therapy and/or other supports for youth, such as coaching or peer-support. Emmett decides that he'd like to give coaching a try, especially because he is concerned about whether a weekly therapy session will interfere with soccer practice. When taken together with his preferences and the data about his presentation, the pediatrician shares recommended services to help Emmett plug into coaching and lets him know that a Care Navigator will also be notified through their insurance to keep an eye on his treatment and offer support and resources. The pediatrician is a total boss and documents the PHQ-9 score, the clinical interview, psychoeducation, and the recommended next steps.



Measurement During Treatment: Collaboration City

Surprising no one, we've arrived at MBC, which let's be honest is a bit of a celebrity because it works to improve outcomes **and** is famously kind of a pain to implement. That said, it's one of the most powerful measurement practices we have in mental healthcare, fits the broadest bill and you'll absolutely need to be doing MBC if you have a service-delivery solution. Let's get into it.

Measurement Based Care

Simply put, MBC is "Collect, Share, Act". You collect youth (and caregiver, teacher)- reported data throughout care, share it back, and get curious together about the findings, and act collaboratively to adjust treatment. MBC is used within active care, not just one-and-done during screening or pre-post for treatment.

Sure, you can use a PHQ-9 to screen and combine with clinical judgment to make initial decisions, but MBC is going to use that same measure to monitor progress, refine treatment (including care transitions), with the added benefit of boosting collaboration and service engagement.

MBC is flexible, especially on measurement tools, diagnosis (can be used with almost all treatment presentations), level of care (with a few exceptions), and evidence-based practice (meaning it works with CBT, DBT, ACT, etc.).There are some level of care/intervention limitations like MBC is not best for crisis situations/triage, care coordination/navigation, or single session interventions. But that doesn't mean that measurement isn't happening in those care settings (quite the contrary!).

MBC should go beyond just symptoms, but must measure what is relevant to the youth's concerns, the immediate focus of treatment, and the things that are most likely to change over the course of care. Individualized measures can be used in combination with standardized or alone, and clinicians tend to prefer them. Check out this free resource compiled by the amazing Dr. Elizabeth Connors for a list of both types of measures! (a youth MBC expert and fellow co-founder of the Yale Measurement-Based Care Collaborative). Also, recall that we've outlined all of the relevant youth domains, which should also get you percolating on what can show up in MBC.

Pop Quiz

- MBC or Screening: A once a year PHQ-9 during your pediatrician appointment
  (If you answered 'screening', please know that I'm beaming with pride).
- MBC or Screening: A PHQ-9 once every 4 weeks as part of a routine treatment visit to check on treatment progress and make adjustments as needed
  (Yep, this one is MBC. See? Same measure, different measurement practice.)

Where does all the collaboration come in?

The best news about MBC is that it's an absolute powerhouse in terms of opportunity for shared decision-making, collaboration, and support of the therapeutic alliance between youth and clinicians or other care professionals. Youth and their care professional can use the data to make sure they're on the same page with treatment goals, check-in, manage any ruptures in the therapeutic alliance, detect any new problems that require more intensive or different intervention, or if treatment is coming to a successful end. Research even shows that youth feel that their therapists are more tuned into their specific problems, needs, and are better aligned.

MBC data, when used in youth populations, can include data from caregivers, teachers and other people involved in the care for the young person, which has added benefits for understanding functioning in different settings, and for identifying discrepancies in youth and parent perspective that could be addressed within treatment.

Case Example

Emmett enrolls in a digital teen coaching program. He and his coach use the PHQ-9 every other week to monitor his symptoms of depression. He makes use of the sessions to learn coping skills to reduce stressors related to school and academic performance and regaining confidence after his recent break-up. Reviewing the data, as well as different resources Emmett was using during the program, helped Emmett and his coach keep a close eye on his progress, and initially, he saw a dip in his depressive symptoms. He was attending school without feeling like a "bundle of nerves" and had started to take his friends up on their offers to hang out on the weekends. But, when his girlfriend started dating someone new, and his best friend didn't make the soccer team (and was angry that Emmett had), Emmett's PHQ-9 scores increased. Emmett wasn't quite ready to make any big changes in his treatment plan, because he was still concerned it might interfere with soccer. Because there were no safety concerns, and they understood that these recent events were the likely culprits explaining his increased symptoms, Emmett and his coach decided to carefully monitor and made some tweaks to their usual sessions to focus his skill-building. After several weeks and a pattern of worsening PHQ-9 scores, Emmett and his coach worked to explore next steps, and decided to add outpatient psychotherapy to his care plan. They book an appointment with his care navigator (who?! See below) who helps to facilitate the transition.

Measurement to Communicate, Coordinate and Transition

Since the mental healthcare system is giving patchwork quilt, youth and families need all the help they can get navigating it, and it only makes sense to talk about how measurement enables movement along the care continuum. This brings us to care navigation.

Care Navigation

Care navigation is essentially the process of 'quarterbacking' care services for a youth and family. A care navigator serves as an essential point of contact between youth and families plugging into and initiating any recommended services, including problem solving common barriers that may arise (scheduling, transportation, therapeutic alliance with providers), collaborating with the many individuals involved in youth systems of care (schools, parents, primary care teams), monitoring progress over time, and helping with transitions between levels of care. And of course, care navigators can track youth treatment progress over time using brief measures that evaluate symptoms and other key factors like SDoH. Care navigators can be clinicians or other administrators or professionals trained to aid clinicians performing their work. They can also support post-treatment follow-up to help youth maintain ongoing wellness (think recovery on the care continuum). As per the sneak preview below, care navigators are also carefully evaluating youth and family satisfaction and experience, so that they can ensure ongoing engagement with care and problem-solve any barriers that may undermine plugging into recommended services.

Note: For the sake of clarity, you'll notice that we laid these measurement practices out in a way that makes it seem like the measurement sequence from screening and triage, to MBC, to care navigation happens linearly (it doesn't). Care navigation is often happening alongside treatment and follows identification.



Emmett's Story Continues



Back to Emmett. Imagine that Emmett wasn't feeling that initial recommendation from his pediatrician when his PHQ-9 score showed mild symptoms of depression. A conversation with a care navigator could have used those PHQ-9 data to help Emmett and his family understand additional options that may be available to him and could continue to monitor his symptoms using the PHQ-9 (or other instruments where appropriate; Pediatric Symptom Checklist-17, PROMIS pediatric measures, Columbia Suicide Severity Rating Scale, etc.) to help guide any future decision making, around follow-up or recommendations. In another scenario, imagine that Emmett was reluctant to pursue stepping up to outpatient therapy as recommended by his coach, but in discussing with a care navigator, they were able to find an option that accepted his insurance and had availability that would not interfere with soccer practice.

Do you see here how the same measure is being used to serve different functions? Yes? Wonderful! Alright, that was a lot, but it was not even close to everything that needs to be covered in the brief, standardized assessment world for youth. If screening and triage help us identify needs and make decisions while engaging youth, MBC helps us to collaborate, and care navigation helps us to coordinate and transition, we also need to understand the process that helps us to use measurement data to evaluate and improve programs, outcomes, and care quality. In other words, what are the next steps in bringing these data together to repair, rebuild, and improve the roads that youth and families are traveling on? Hint: It's quality improvement.

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Next Steps: Measuring to Improve Care

As much as these measurement data should guide and improve care and intervention at the individual level for youth, the utility of the data cannot and should not stop there. Data gleaned from each step in the care sequence can and should be brought together to be used to evaluate overall treatment outcomes and effectiveness (i.e., program evaluation) as well as youth and family satisfaction and experience, and to drive quality improvement initiatives. So yes, there are more measurement practices that rely on data from brief standardized assessments for us to discuss.

Stay tuned for a follow-up piece within the measurement collection focused on using brief, standardized assessment data to support key quality improvement practices. In addition to improving your solution, we'll discuss how youth should be informed about how their data are being used to shape and inform meaningful changes in care beyond the care that they're receiving at an individual level.



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