Implementation of Evidence-Based Mental Health Practices in Seattle's School-Based Health Centers

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Overview

- Intro & Background
- History of QI Collaboration
- Recent Efforts
- Future Plans
- Conclusions

Introduction

Mental health service accessibility

- Only a fraction of youth who require mental health services receive them (Kataoka et al., 2002)
- This problem is even more pronounced for low-income and ethnic minority youth (US DHHS, 2001; Zimmerman, 2005)
- Underserved youth are less likely to access services in settings that commonly provide EBP (Takeuchi et al. 1993; Weersing & Weisz, 2002; Weisz et al. 1997)

Introduction

School mental health

- Schools more effectively provide access for underserved youth (Kataoka et al., 2007)
  - “de facto” service setting for all youth, accounting for >70% of all MH services (Burns et al., 1995)
- School services unlikely to be evidence-based (Evans & Weist, 2004; Rones & Hoagwood, 2000)

Introduction

School-based health centers (SBHCs)

- Operate in nearly 2,000 schools in the US (NASBH, 2008)
- Typically provide primary care and mental health services (Brown & Bolen, 2003)
- Well-substantiated as a mechanism to increase service accessibility to undersserved and uninsured (Gance-Cleveland & Yousey, 2005; Kaplan et al., 1999; Wade et al., 2008)
- Studies indicate improvements in emotional and behavioral functioning, health-promoting behaviors, decreased substance use, and improved educational indicators (Kerns et al., in press; McNall et al., 2010; Nabors & Prodente, 2002; Robinson et al., 2006; Walker et al., 2010)

Introduction

School-based health centers (SBHCs)

- Funded largely by the *Seattle Families and Education Levy*
- Seattle SBHCs, by the numbers:
  - 10 high schools & 4 middle schools have SBHCs
  - In 2008-09 SBHCs served 5,329 students across 31,155 visits.
    - Nearly half (47%) were mental health visits

SBHC Sponsors & Sites

Sponsor: Group Health Cooperative

- **Aki Kurose MS**
- **Franklin HS**
- **Nathan Hale HS**
- **Washington MS**

Sponsor: Neighborcare Health

- **Denny MS**
- **Madison MS**
- **Roosevelt HS**
- **Sealth HS**
- **West Seattle HS**

Sponsor: Public Health Seattle & King County

- **Cleveland HS**
- **Ingraham HS**
- **Rainier Beach HS**

Sponsor: Swedish Medical Center

- **Ballard HS**

Sponsor: SCH Odessa Brown Children's Clinic

- **Garfield HS**

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Academic-Community Partnerships

"The process is a fluid and collaborative exchange in which researchers both influence and are influenced by the perspectives of the service providers who conduct this work on a daily basis."

Frazier, Formoso, Birman & Atkins (2008)

An Iterative QI Process

- Since 2006, SCH/UW researchers have had an ongoing training relationship with SBHC mental health providers
  - Iterative quality improvement process
  - Multiple case study, A-B methodology
  - Focused on addressing barriers to implementation and enhancing the EBP-context “fit”
  - Provide CE credits, case consultation, ongoing support

An Iterative QI Process

SBHC service provision issues to consider in implementation (Lyon et al., 2011)

- Inconsistent training background and experience
  - Turnover
- Variable/inconsistent support from sponsor agencies
- Significant service flexibility (timing, content)
- Time, practice, and caseload size parameters
  - Many school personnel not educated about providers' roles
- Intervention is short-term for many youth and attendance unpredictable
  - Avg. number of MH therapy sessions = 4.6 / semester
- Ability to provide intensive services to high-need youth may be limited

Recent Efforts

QI initiatives have included…

1. Training practitioners in CBT
2. Pilot implementation of modular psychotherapy
3. Increasing use of standardized assessment tools

CBT Training

- 2005-2007 Broad introduction to multiple treatment approaches (CBT, IPT, DBT, MI, BA, relaxation)
- 2008 focused on training and supervision in CBT for students with depression/anxiety
  - Hard to select and deliver an appropriate, lengthy treatment
  - Recognition that systematic implementation of small repertoire of simple skills would be advantageous

Modular Psychotherapy Pilot

- Modular psychotherapies are more flexible than traditional manuals with regard to treatment timing (McHugh et al., 2009)
- Flexibility facilitates the dissemination of the model to school settings (Weist et al., 2009)
- Have the potential to be tailored in order to be maximally effective in the limited number of sessions available to SBHC providers

Modular Psychotherapy Pilot

- Informed by modular therapy tools available from PracticeWise (Chorpita et al., 2009)
- 12 modules introduced
  - Corresponded to the most common presenting problems in our SBHCs (depression and anxiety)
- Counselors tracked module implementation and outcome monitoring using Excel “dashboard”

Modular Psychotherapy Pilot

- 7 SBHC counselors selected 66 students for tracking
- Primary presenting problem:
  - Depression – 75%; Anxiety – 14%; Mixed Dep. & Anx. – 11%
- 487 Total sessions across 66 students
  - Mean # sessions per student = 7.4 (range: 1-24, median: 6, **mode: 3**)
- In **94%** of sessions, students received at least one standardized assessment measure
  - Most common measure: *Short Mood & Feelings Questionnaire (SMFQ; Angold et al., 1995)*

SA Utilization

Focus on incorporating initial assessment and progress monitoring into school-based practice.

- Rating scales can increase the ease and accuracy of clinical diagnosis (e.g., Youngstrom et al., 2004; 2005)
- Clinicians are often not able to detect client deterioration (Hannan et al., 2005)
- Administering SA measures and providing the results to clinicians can result in improved in outcome (Lambert et al., 2003)

SA Utilization

Rationale – Pre-training SA use:

Percent of Caseload:	0%	1-39%	40-60%	61-100%
Gave a SA measure in initial 1-2 meetings	47%	27%	27%	--
Gave a SA measure at termination	63%	36%	--	--
Gave a SA measure	38%	44%	19%	--
Gave a SA measure to a teacher	81%	19%	--	--
Gave feedback about a SA measure	50%	31%	13%	6%
Changed Tx plan based on SA data	69%	31%	--	--
Changed indiv. session plan based on SA	56%	38%	6%	--

SA Utilization

- Focus on training to incorporate initial assessments (using SA tools) into practice
- Assess feasibility of providing SA-based feedback to students
- Project is ongoing – currently piloting anxiety and depression measures with all SBHC cases

SA Utilization

Percent of Caseload:	0%	1-39%	40-60%	61-100%
Gave a SA measure in initial 1-2 meetings (*SPRING 2011*)	17%	**67%**	17%	0%
Gave a SA measure in initial 1-2 meetings (*SUMMER 2011*)	8%	33%	8%	**50%**

Collaboration and QI: Future Directions

1. Development of a measurement feedback system (MFS) to support sustained standardized assessment and progress monitoring

2. Development of a brief, modularized intervention framework within a stepped care treatment model

MFS Development

- MFS provide computerized infrastructure to deliver SA tools and monitor intervention targets over time (Bickman, 2008)
- Planned MFS development
  - Adapt an existing MFS for use by school mental health providers
  - Convene a committee of local SBHC stakeholders to inform fist steps of the adaptation process
    - *Supported by the Gates Foundation*
  - Explore incorporating *academic data* (e.g., attendance) into the MFS for progress monitoring

Brief Intervention

- Development of a brief intervention model (3-4 sessions) to maximize *intervention-setting fit*
  - During 2009 pilot, many youth attended only a few (3-4) sessions (Lyon et al., in press)
    - Large caseloads, sole practitioner
    - Frequent disruptions
    - Engagement difficulties
  - Some students with subclinical presentations
  - Some clinicians struggled to determine which modules to select/prioritize

Brief Intervention

Identified intervention model requirements necessary for a “good fit” with the SBHC context

- Systematic intervention approach
- Adaptable/flexible intervention delivery
- Efficiency (short-term for those who don’t need more)
- Engagement enhancement
- Specific identification and tracking intervention targets

Brief Intervention: Preliminary Components

Model Requirements

Systematic / structured intervention	→ Problem Solving Orientation
Adaptable/flexible (but evidence-based) intervention delivery	→ Modularized Approach
Efficiency	→ Stepped Care / Brief Treatment Structure
Engagement	→ Motivation Enhancement Strategies
Specific treatment target identification	→ Assessment and Monitoring