Child Health and Development Institute

ISSUE BRIEF

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Moving Measures to Conversations

Engaging Youth, Families, and Clinicians in Measurement-Based Care

Children and adolescents are experiencing increasing rates of anxiety, depression, and behavior problems.[1] Accessing behavioral health treatment can be a challenge, and when children do receive treatment, outcomes are generally modest.[2] Efforts to disseminate evidence-based practices (EBPs), or those that have been shown to be more effective than usual care, are increasing and help improve the quality and outcomes of behavioral health services.

Measurement-based care (MBC) is the process of routinely administering and discussing results of assessment measures with youth and their caregivers and using this information to help guide treatment towards achieving youth and family goals.[3,4] MBC is an EBP that can be applied to a range of treatment approaches, types, and settings to improve the quality of care for youth, regardless of presenting concern. A key component of MBC is engaging youth and families in using outcome measures to inform treatment and decision-making. However, while providers are increasingly implementing MBC and becoming more comfortable using standardized measures to track treatment progress, they may struggle to fully engage youth and families in this process.

This Issue Brief highlights strategies for fully engaging youth and families in MBC in ways that are feasible and helpful for both clinicians and families.

Family-Centered MBC Helps Strengthen Care and Reduce Ethnic and Racial Disparities

Children show greater improvement when their clinician regularly administers measures and shares the results with them, compared to children whose clinicians do not.[5,6] Despite the evidence, MBC is less consistently used with racial or ethnic minorities or families who experience socioeconomic strain.[7] This suggests that MBC may not be reaching families equitably and that there are opportunities to improve how MBC is implemented so that youth and caregiver perspectives are consistently represented when evaluating treatment progress and making treatment decisions. Additionally, even when measures are used, they may be selected, administered, and interpreted with little input from youth and families. By ensuring youth and caregiver involvement throughout the MBC process, clinicians can help promote family-centered care, strengthen therapeutic relationships, and reduce disparities in children's behavioral health access, quality, and outcomes (see Figure 1 on page 2).

Figure 1. Best Practices for Engaging Youth and Families in MBC

Family Engagement	Measure Selection	Administration to Youth and Caregiver	Scoring and Feedback	Treatment and Monitoring
High	Individualized, aligned with youth and caregiver goals	Routine (every 1-2 sessions)	Clinician, caregiver(s), and youth review results together	Clinician, caregiver(s), and youth reference results regularly when making treatment decisions
Minimal	Selected by clinician without family input	Infrequently repeated (e.g., less than monthly)	Results viewed by clinician only	Clinician references during ongoing treatment planning
None	Pre-determined. May or may not align with youth/caregiver goals	Intake and/or discharge only	Scored without review	Not referenced when making treatment plan

Challenges to Family-Centered MBC

There are two common systemic challenges that can limit true youth- and family-centered MBC in children's behavioral health:

1. Tendency to default to selecting symptom-focused vs. individualized measures
2. Inconsistent administration of, and feedback about, measures and their scores

There are many different types of measures that can be used with youth and their caregivers. However, problematic behaviors and symptoms are among the most common domains assessed in children's behavioral health, while individualized (or patient-generated) measures are among the least common domains assessed.[8,9] Symptom-specific measures are helpful for some families and for giving a system-level, birds-eye view of how well treatments work for common concerns for which youth present to treatment, but they may or may not align with what many families consider their main concerns and treatment goals. In fact, youth tend to identify therapy goals that fall into categories of relationships, coping, and personal growth more often than goals related to specific symptoms.[10] While we don't yet know how individualized measures may help reduce disparities in treatment engagement and outcomes for diverse families in particular, increasing their use has been recommended as one way to improve the fit of MBC with diverse cultural perspectives and to make outcomes more equitable.[4]

Engaging youth and families in MBC is also naturally tied to how frequently measures are administered and how consistently the results are jointly discussed and interpreted with youth and families. Nationally, only about 5% of clinicians use measures every 1-2 sessions, and fewer than 10% use measures monthly.[11] To achieve the best outcomes, measures should be collected and discussed with youth and families during each treatment session.[3] National research has also shown that feedback about the results of measures is shared with fewer than half of clients.[12] **In a recent survey of Connecticut providers, clinicians reported administering standardized measures and discussing outcomes with fewer than 40% of the clients they served in the prior week.** Without collaborative, routine progress monitoring, it is harder to assess how well behavioral health services are working for youth and where changes are needed to ensure families receive care that aligns with their values and reasons for seeking treatment.

Addressing Barriers to Collaborative MBC

Many youth-serving clinicians report positive attitudes about the utility and benefit of regularly using measures.[13] However, having positive attitudes towards MBC does not necessarily predict its use in practice. Instead, clinicians tend to regularly use measures when they believe 1) doing so is practical in their clinical work and 2) that their organizations support the use of evidence-based practices, including MBC.[11,13]

In a survey of Connecticut providers, clinicians expressed difficulty using measures due to a range of factors, including:

- Not enough time during sessions, particularly when treatment plans are due or when multiple measures need to be completed
- Limited time between sessions for documentation due to high caseloads
- Lack of engagement and/or availability of caregivers to complete measures
- Wariness among families about personal data being collected
- Concerns about the accessibility of the measures and language barriers

Efforts to increase youth, family, and clinician engagement with MBC should address these practical barriers for clinicians and families. It is also important to improve our understanding of youth and caregiver preferences in the MBC process and increase transparency with families about why and how measures are used in their child's treatment.

A recently proposed and promising framework, the Strategic Treatment Assessment with Youth (STAY) model,[4] offers guidance for using MBC to help address these barriers, improve collaboration, and reduce disparities in youth behavioral health. STAY may be particularly important for children and families whose perspectives about treatment needs and outcomes have been historically minimized and who have experienced concerns related to confidentiality and mistrust in the American health system. For example, the STAY model emphasizes transparency, therapeutic alliance, acknowledgments of discrimination, and patient-generated measures to promote treatment that is truly youth and family-centered.

Strategies to Ensure MBC is Relevant for Youth, Families, and Clinicians

MBC that is youth and family-centered must be relevant to youth and family concerns, relevant to treatment, and feasible to implement within the ongoing demands of behavioral health practice.

Clinicians serve a major role in making MBC youth and family–centered. They are best positioned to explain a measure's purpose, interpret scores with youth and families, and facilitate discussions about preferences for types of progress indicators. Clinicians have also expressed a desire for autonomy in selecting measures to help ensure they are relevant to their clients.[14] One way to ensure direct relevance of measures to families and clinicians is by including youth and caregiver-generated metrics in MBC, which focuses progress monitoring on youth and families' key concerns and treatment goals.[4,11] One example of this type of measure is the Top Problems Assessment (TPA), which uses youth and caregiver perspectives to identify and monitor the severity of the most important problems they are experiencing. The TPA can capture improvement during treatment[17] and to date, over 300 clinicians in Connecticut have been trained to use the TPA through the Modular Approach to Treatment for Children with Anxiety, Depression, Trauma, and Conduct Problems (MATCH-ADTC).[18]

Regardless of whether individualized measures are used alone or in addition to standardized scales, the use of **measures must be feasible.** In fact, the more feasible a measure is to administer and score, the more often clinicians have discussions about scores with youth and their families.[14] For children and their caregivers, the measures themselves should be **brief and easy to complete**, particularly when more than one type of measure is being used. This can help streamline the time needed to complete measures, which is a commonly expressed concern about implementing MBC.[15] Brief measures can also ease scoring and interpretation for clinicians, who continue to experience increasing caseloads and administrative burden as the impacts of high clinical need and high workforce turnover persist. The recently published PAPERS framework[16] was developed using input from multiple stakeholders in behavioral health and provides criteria for identifying and rating measures on these qualities. Recommendations include ensuring that measures are **readable at or below an 8th grade level**, have **clear cut-off scores** and a **streamlined scoring process,** and **use 10 or fewer items.**

Clinical systems and processes could also be applied to enhance youth and family participation in MBC. **Digital platforms are increasingly being used to help improve the feasibility of MBC by streamlining measure administration and scoring for clinicians.** These measurement feedback systems also present opportunities to include youth and family engagement; for example, by using visual aids or graphs to display progress, or by easing the ability to browse and select measures with youth and caregivers. In addition, collaborative documentation is a patient-centered process that includes completing progress notes with clients during the clinical session. Collaborative documentation enhances transparency in behavioral health care and could be a framework through which youth and caregiver-identified metrics are routinely referenced, progress is discussed, and treatment planning occurs collaboratively.

Recommendations for Making MBC Work for Children, Caregivers, and Clinicians:

Connecticut is a leader in evidence-based practices in children's behavioral health and has a strong network of clinical providers who are experienced in administering standardized measures. The following recommendations are proposed to improve the implementation of MBC so that it jointly engages youth, families, and clinicians and builds upon efforts to improve children's outcomes:

1. Research in MBC should include youth and family perspectives about what aspects of the MBC process they see as valuable and where changes may be needed to improve the utility of and engagement in regular progress monitoring and to reduce disparities in children's behavioral health services.

2. Organizations and clinicians should use youth and caregiver-generated (individualized) measures. Include individualized measures with traditional symptom and problem-focused measures, or if more feasible, explore using individualized measures as the primary focus of frequent progress monitoring. Aside from the Top Problems Assessment mentioned above, individualized measures can be easily created by rating how often a specific behavior occurred during the previous week or selecting 1-2 items on tools that are already being used in treatment (e.g., fear thermometer).

3. Organizations and clinicians should select measures that are practical for use in outpatient care and accessible for youth, caregivers, and clinicians. The PAPERS[16] framework provides guidance for identifying and selecting measures that are practical and accessible. Additionally, clinicians who work within schools and who have an account for the SHAPE system can access the free Screening and Assessment Library developed by the National Center of School Mental Health: www.theshapesystem.com/assessmentlibrary.

4. Public and private funders of children's behavioral health services must consider the time and costs of using measures and family-focused MBC in reimbursement rates and payment models. Incremental costs for training staff and administering and managing measures and data are modest, but without reimbursement or accountability, providers are disincentivized to practice family-focused MBC or use MBC at all.

5. Electronic measurement feedback systems that increase the feasibility of MBC should continue to be evaluated and supported to help increase session time available for clinical feedback and decision-making with youth and families.

6. Include MBC-specific training in graduate training programs for behavioral health providers. Many Connecticut providers who seek training in EBT models (e.g., TF-CBT, MATCH) are first exposed to MBC while training in these EBTs. However, providers may benefit from earlier training in MBC, separate from the demands of training in EBTs. Separating the training in this way can help:
   - increase the spread of EBP delivery through the less-intensive, but still evidence-based, MBC process.
   - increase clinician capacity to transition from mastery of MBC to mastery of more intensive EBT models like TF-CBT and MATCH.

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