

Evidence-Based Assessment in School Mental Health

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Although best practice for children's mental health services emphasizes ongoing assessment and monitoring of clinical progress, community based clinicians inconsistently implement assessment as part of clinical care due to a variety of practical barriers. The current study explores which factors may be related to the use and function of evidence-based assessment (EBA) in real-world, clinical settings, particularly school mental health (SMH). Mixed methodologies surveying a national sample of SMH clinicians and interviewing clinicians and program managers were used to explore current assessment practices, including use of specific tools and barriers, facilitators and attitudes toward EBA. Results indicate that clinician level of experience is negatively related to overall attitudes toward EBA, particularly openness. The most commonly-reported barriers to using assessments were difficulty reaching parents, respondents not understanding items, and clinicians not having access to measures they like or need. Also, supervision, when received, does not often include EBA. Academic indicators were more regularly collected than any of the 18 clinical assessment tools queried. Qualitative themes including barriers and facilitators to conducting EBA, specific measures' weaknesses and strengths, strategies to increase response rates and regular administration, and program management considerations regarding EBA implementation provide supporting details to these results. Implications for ongoing quality improvement efforts by program managers and clinicians related to the feasible implementation of EBA in school mental health settings are discussed.

EVIDENCE-BASED PRACTICE IN PSYCHOLOGY (EBPP) encompasses the application of both empirically supported assessment and intervention principles (American Psychological Association [APA] Presidential Task Force on Evidence-Based Practice, 2006). An evidence-based orientation to clinical practice with children and adolescents has been noted to incorporate three evidence-based elements: (a) assessment that informs diagnosis, treatment planning, and outcome; (b) intervention; and (c) ongoing progress monitoring (APA Task Force on Evidence-Based Practice with Children and Adolescents, 2008). Evidence-based assessment (EBA), in particular, is described as including the use of assessments that have demonstrated psychometric soundness and social validity, and that are used at regular intervals throughout a youth's treatment (Hunsley & Mash, 2007). EBA strategies assist in the accurate diagnosis of a youth's concerns, thus facilitating selection of the appropriate evidence-based treatments. EBA also includes the ongoing monitoring of a youth's progress, which can assist in determining whether modifi-

cations to treatment are needed and when treatment can end. At the conclusion of treatment, the use of EBA strategies can be used to inform the evaluation of the outcome (APA Task Force on Evidence-Based Practice with Children and Adolescents, 2008). The importance of EBAs is further underscored when considering that both obtaining an accurate diagnosis (Jensen-Doss & Weisz, 2008) and monitoring treatment progress (Lambert et al., 2003) are associated with success of treatment. Despite the importance and benefit of EBA strategies, the focus of EBPP efforts have largely centered on the application of evidence-based treatment strategies (Hoagwood et al., 2001; Hunsley & Mash, 2007; Mash & Hunsley, 2005).

Although best practice for children's mental health care emphasizes ongoing assessment and monitoring of clinical progress (Mash & Barkley, 2007; Mash & Hunsley, 2005), community-based clinicians inconsistently implement EBA as part of clinical care (Jensen-Doss & Hawley, 2011). Practicing psychologists, for instance, endorse the unstructured clinician interview as the most commonly and often only used method of assessment, despite a key aspect of EBA being the use of psychometrically strong, standardized assessment tools (Cashel, 2002). While limited, studies conducted on the topic indicate that master's-level clinicians who represent the majority of mental health providers for youth are less likely to engage in EBA and use fewer assessment tools than doctoral-level clinicians (Frauenhoffer, Ross, Gfeller, Searight, & Piotrowski, 1998; Palmiter, 2004). Taken together, limited findings about use

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of EBA indicate that neither master's- nor doctoral-level practitioners consistently use EBA in clinical practice.

Barriers to use of EBA include concerns with practicality (e.g., time burden, insufficient financial resources), social validity (e.g., relevance to diverse clinical populations), and utility (e.g., relative benefit of information gained from assessment measures as compared to clinical judgment) (Garland, Kruse, & Aarons, 2003; Hatfield & Ogles, 2007; Jensen-Doss & Hawley, 2011). Indeed, findings suggest that practical barriers, such as those related to a lack of financial resources to purchase certain assessments and the time to use lengthy assessment measures, are the primary challenges for clinicians implementing EBA (Hatfield & Ogles; Jensen-Doss & Hawley). Despite such barriers, the use of EBA strategies and measures remains critical to the provision of quality clinical care (Groth-Marnat, 2009), and thus should be attended to.

School-based clinicians are a particularly important group of practitioners to study in regards to their use of EBA, as schools are a critical setting for reaching youth with mental health needs. Moreover, barriers to EBA may be especially salient to school-based clinicians. However, to our knowledge, studies examining the barriers and facilitators for implementation of evidence-based practices have not examined implementation of EBA strategies, particularly in school settings (cf. Harrison, Legare, Graham, & Fervers, 2010; Lyon, Frazier, Mehta, Atkins, & Weisbach, 2011; Pagoto et al., 2007; Ploeg, Davies, Edwards, Gifford, & Miller, 2007). Given the importance of implementation of EBA in clinical practice, coupled with both evidence that EBA is underutilized and a scant literature base to indicate levers for bolstering use of EBA, it is critical to better understand the actual use of EBA among community-based mental health clinicians, particularly those in schools. Understanding the barriers and facilitators to EBA use within this population would assist in generating practical strategies for sustainable improvement of usual care in schools.

School Mental Health (SMH)

Within the field of children's mental health care, high rates of underidentification, limited treatment access, unmet needs, and low quality of care exists (U.S. Department of Health and Human Services, 2000). The majority of children and adolescents with a diagnosable mental illness, for instance, do not receive treatment, with estimates of unmet need decreasing very minimally over time (i.e., 70% to 80% per Greenberg et al., 2003, as compared to 64% per Merikangas et al., 2011). Critical to addressing this gap, schools have increasingly become the main site for the provision of mental health services to youth (Kazak et al., 2010). Of those youth who are able to access mental health care, approximately 70% do so in the context of schools (Rones & Hoagwood, 2000). These

findings, in light of strong evidence of SMH service success in improving emotional, behavioral, and educational outcomes of youth (Greenberg et al.; Hoagwood et al., 2007; Walter et al., 2011), highlight the importance of focusing quality improvement efforts on mental health care in schools.

With regards to the aforementioned barriers to EBA use, those noted may be especially salient for school-based mental health clinicians, who may be more likely to treat comorbid conditions or complex family, social, and environmental risk factors, as they are seeing youth who may not have the resources and support to seek care in traditional mental health settings. Based on concerns regarding the relevance of assessment instruments for ethnic minority youth (cf. Garland et al., 2003), it is possible that clinicians who serve minority youth and/or those of lower socioeconomic status, such as school-based clinicians, may be even less favorably inclined to the use of standardized assessment measures. Therefore, improving our understanding of the facilitators and barriers to EBA in schools may shed light on mechanisms for improving quality of care and reducing disparities among typically underserved youth and families.

Current Study

The focus of the current study is to explore which factors may be related to the use and function of EBA in real-world, clinical settings, particularly in schools. Using a national sample of SMH clinicians, the current study queries current assessment practices, including self-reported use, perceived ease of implementation, and clinical utility of 18 commonly used assessment tools available in the public domain. Overall attitudes toward EBA were also measured. Perceived barriers and attitudes toward assessments are of particular interest for understanding the function of EBA in real-world clinical settings. Thus, we examined whether demographic and professional characteristics were associated with the number of clinician-reported barriers to assessment as well as attitudes toward assessment instruments, with significant correlations followed by hypothesis testing for group differences. Qualitative interviews provided contextual information on facilitators of barriers to use of EBA tools.

Methods

A mixed-methods approach was used, incorporating quantitative and qualitative data collection strategies in order to provide a comprehensive understanding of the research questions (Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). This strategy was particularly relevant as the information of interest involved both "known" (i.e., deductive) and "unknown" (i.e., inductive) processes (Creswell, Klassen, Plano Clark, & Smith, 2011).

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