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The Development of an Operational Manual for the Assessment of Mental Health Treatment

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The Development of an Operational Manual for the Assessment of Mental Health Treatment

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2014

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

The Development of an Operational Manual for the Assessment of Mental Health Treatment

By Rebecca Miah

Background: The mental health care assessment field is largely qualitatively based, with treatment decisions primarily based on observations of client interaction and professional opinion. Like other mental health care organizations, Skyland Trail counselors use qualitative assessments and narratives to determine treatment outcomes and future courses of action. Quantitative data along with qualitative assessment ensures a more complete picture of client outcomes and ensures a standard of care across clients.

Aim: This special studies project was undertaken to promote the use of quantitative diagnosis-specific assessment data when making decisions about treatment.

Methods: A structured self-administered questionnaire was developed for counselors to counselors to assess attitudes towards the diagnosis-specific assessments. An operational manual with supplementary presentation slides was developed for use during training of current and future counselors. The manual emphasizes the importance of evidence-based assessment in evidence-based treatment and reinforces the diagnosis-specific assessments as the gold standard for quantitative evaluation of mental health symptoms.

Significance: Collecting both qualitative and quantitative evidence of treatment outcomes will demonstrate the efficacy of the Skyland Trail therapeutic model and improve treatment strategies.

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Chapter 1: Introduction

This special studies project is the work undertaken in the development of an operational manual for the use of diagnosis-specific assessments in treatment to improve quantitative data collection and evidence-based decision-making by current and future counselors at Skyland Trail, a non-profit mental health treatment organization. This introductory chapter contains the necessary background information for which an operational manual is created as a product of this project during the author's internship at Skyland Trail. The problem statement defines the need for this operational manual for counselors at the organization and the manual contents. Manuals are a resource for clinicians and an aide in promoting consistent assessments and ensuring internal measurement and treatment decision validity. Treatment or operational manuals, in conjunction with interactive and didactic training, have been shown to improve the translation of research into clinical practice to achieve target outcomes and increase positive attitudes through clear descriptions of the evidence with guidelines. The final section describes the significance and objectives of the project in promoting the use of diagnosis-specific assessments by counselors to guide treatment decisions in order to validate the quality of clinical services provided at Skyland Trail.

Background

Skyland Trail is a private, not-for-profit facility that provides treatment for adults ages 18 and older who have been diagnosed with mental health issues. Located in Atlanta, Georgia, this organization was founded in 1989 to address the lack of residential treatment facilities in Atlanta aimed at recovery rather than stabilization of acute mental disorders. Through over 20 years of service to the community, Skyland Trail has helped over 3,000 adults and their families to live independently and live with their illness and not in spite of it. Skyland Trail offers a unique

continuum of care with step-downs in illness level and reintegration points from residential and day treatment to job coaching as well as social opportunities for current or past clients living in the community.

Skyland Trail's continuum of care helps its clients gradually step down in treatment from one level of care to another level. In addition to the development of skills, Skyland Trail emphasizes symptom management to improve overall functioning and quality of life. Although treatment plans are individualized, all clients are categorized into particular recovery groups of clients with similar diagnoses. These include Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Cognition and First Episode (CAFE), Social Integration, and Dual Diagnosis. CBT focuses on changing negative thoughts and mood issues while DBT is a more specialized program for clients with mood or thought disorder in conjunction with a borderline personality disorder. The Cognition and First Episode recovery group provides services to college-aged young adults dealing with psychosis due to a thought or mood disorder. The Social Integration recovery community helps clients work on their socialization skills and how to integrate back into a normal life uninhibited by their mental illness. Substance abuse is oftentimes an additional struggle for people living with mental illness. Therefore Skyland Trail has the Dual Diagnosis recovery community for individuals who have a primary psychiatric diagnosis with a secondary substance use disorder.

The counselors at Skyland Trail have varying levels of education but all eleven have been trained to provide mental health care services. The two Lead Counselors are national certified and licensed professional counselors with over 3000 hours of mental health counseling experience. The remaining nine Primary Counselors have accreditations from licensed professional counselor and licensed marriage and family therapist to certified addiction

counselor. Their background and certification make each counselor an expert in their respective mental health care focuses.

With a vision to lead innovative psychiatric treatment in the U.S., Skyland Trail is a leader in community-based mental health services. It aims to achieve its mission of inspiring people with mental illness to thrive through a holistic program of evidence-based psychiatric treatment, integrated medical care, research, and education through the following strategies.

Goal: To support an innovative recovery model of care for people with mental illness and lead the industry by being a center of excellence in treatment, research, and education.

Strategies:

1. Develop strategic alliances with major academic center to support center of excellence activities in research, education, and treatment.

1.2 Establish a financially viable stand-alone mental health assessment practice to enhance diagnosis capabilities.

1.3 Develop expanded service offerings and capacity for the primary care clinic to extend this service to mental health consumers across the Southeast.

1.4 Develop a program for young adults (18-25) to include a preventive care program for those who are newly experiencing symptoms as well as a stand-alone dedicated program with targeted treatments.

1.5 Develop longitudinal services and research programs to assist in the continued recovery of clients post-discharge.

1.6 Explore the development of a child and adolescent treatment program, including a recovery-based treatment model for eating disorders.

1.7 Determine the best configuration and use of the organization's physical facilities and infrastructure in order to accomplish the goals of Skyland Trail.

The strategies that align with my special studies project contributions are 1.2 and 1.4 in ensuring the most appropriate and cost-effective treatment options for Skyland Trail's clients. This project focuses on the importance of mental health assessment in enhancing diagnosis symptoms assessment capabilities and providing more evidence-based and targeted treatments.

Problem Statement

Standardization of care ensures that there is consistency in treatment received by all clients. The mental healthcare assessment field is primarily qualitative, with focus on behavioral and mood change observations. Since the ultimate goal for recovery is reintegration into society, counselors at Skyland Trail use observations of clients and their social interactions to determine treatment options. As the gold standard in mental health research, diagnosis-specific assessments provide quantitative data that can be used in conjunction with the qualitative observations of counselors to ensure a standard of care across counselors and clients. Alex Balzer, Coordinator of the Research and Outcomes Department at Skyland Trail, has reported observations of inconsistent use of the diagnosis-specific assessments data. Results of a self-administered questionnaire assessing provider attitudes indicated that counselors ranked behavioral functionality, direct interaction with client, and behavioral observations over data from the diagnosis assessments as a basis for making decisions about individual client treatment. To address inconsistent and low use of quantitative assessment, an operational manual is being developed for use during training of current and future counselors at Skyland Trail.

Purpose Statement and Objectives

An operational manual along with training presentation slides will be developed as final products that counselors at Skyland Trail can use as a resource for conducting diagnosis-specific assessments and training to guide administration. The goal of this manual is to promote consistent use of quantitative data by current and future counselors when making treatment decisions in order to accomplish the following objectives:

1. To improve recovery evaluation using gold standard diagnosis-specific assessment tools.

2. To understand trends in outcomes and improve treatment strategies by using evidence-based measures.
3. To demonstrate efficacy of the Skyland Trail model of treatment.
4. To produce an additional mode of communicating improvement in symptoms to clients and their families.

Significance Statement

While professional insight is a very valuable tool in mental health treatment decision-making, it can be very subjective. Quantitative data, in conjunction with such qualitative assessment provide a more complete picture of client outcomes. Measuring quantitative outcomes through diagnosis-specific assessments is a functional approach that not only aides in the determination of treatment decisions but it is also a method of evaluating and improving treatment quality. Collecting quantitative treatment outcomes and using them to guide care will fulfill the goals of the Research and Outcomes department in demonstrating the efficacy of the Skyland Trail model of treatment, and it will further establish the organization as a center of excellence in treatment, research, and scholarship evaluation in the mental health care industry.

Chapter 2: Comprehensive Review of the Literature

The following literature review is organized into four parts. The first section is a brief introduction to the specific mental health diagnosis symptoms assessments that Skyland Trail uses to evaluate clients. This background section establishes the gold standard of care upon which the organization aims to operate. The second section discusses the value of evidence-based practices in raising standards of care and producing better health outcomes through evidence-based mental health care. This section is further separated into two parts; the first involves attitudes and adoption of evidence-based practices by counselors and the second focuses on provider training. The third section of this literature review describes the importance of consistently measuring outcomes to ensure consistent and effective treatment. The final section includes a summary of the literature and a discussion of research relevancy to this special studies project.

Assessment Tools Used at Skyland Trail

Brief Psychiatric Rating Scale

The Brief Psychiatric Rating Scale was developed to provide a short, simple-to-administer instrument of assessing psychopathology and to measure change in clinical treatment of psychiatric clients (Overall & Gorham, 1962). This rating scale includes symptoms that assess the clinical condition of clients with or suspected of having schizophrenia or other psychotic illnesses. Originally a 16-item measurement, the BPRS was extended to 18 items and then to 24 in order to increase its sensitivity to affective and psychotic disorders as well as to include outpatients living in the community (Zanello et al., 2013). The assessment is administered in a 10 to 40 minute clinical interview with a primary provider, with observations of the client's behavior over the previous two to three days. Each of the areas is rated on a severity scale of 1 as

not present, to 7 being extremely severe (Fulford et al., 2014). The four factor construct of the BPRS, consisting of negative symptoms, positive symptoms, manic-hostility, and anxiety-depression (Zanello et al., 2013), has been shown to be consistently valid across a broad spectrum of schizophrenia clients (Kopelowicz et al., 2008) and across cultures as well (Ruggeri et al., 2005). The Brief Psychiatric Rating Scale is therefore not only a good measure of monitoring schizophrenic symptoms of clients as well as for potential psychotic relapse, but the utility of the assessment has also been demonstrated as an effective indicator of improved client outcomes following psychosocial rehabilitation programs (Inch et al., 1997). The BPRS is therefore a fitting assessment for Skyland Trail to measure symptom reduction and also the success of it's recovery program in treating clients suffering from schizophrenia and other affective, or mood disorders. The goal for Skyland Trail is symptom reduction exemplified by a BPRS score of 54 or less.

Montgomery-Asberg Depression Rating Scale

The MADRS was specifically designed to measure the degree of severity of symptoms and to be sensitive to effects of treatment on symptom severity of depression (Montgomery & Asberg, 1979). This assessment has high inter-rater reliability, does not factor in symptoms related to anxiety disorders and has only one item pertaining to sleep disturbance. The MADRS is also the preferred assessment used when evaluating symptom reduction due to psychotropic drugs (Zimmerman et al., 2004). The assessment instrument is administered in a 15-minute interview by a trained provider (Montgomery & Asberg, 1979). The 10-item checklist has cut-off scores to represent gradations of severity from 'remission' to 'very severe'. However conceptual disagreements regarding the specific cutoff points have resulted in the use of various thresholds in several antidepressant efficacy trials (Zimmerman et al., 2004). 'Remission' is the ultimate

goal of treatment efforts, determined by severity of depressive symptoms exhibited by clients at the end of treatment, persistence of symptom resolution, and ultimately the client's return to normal[1] levels of functioning. The threshold for remission defined by various antidepressant efficacy trials ranged from a score of 4 to 9 on the MADRS (Zimmerman et al., 2004). The threshold for remission used at Skyland Trail is a score of less than 7, reflecting complete absence of clinically significant symptoms of depression.

Young Mania Rating Scale

The Young Mania Rating Scale (YMRS) was developed to address the lack of adequate mania-rating assessments. There were instruments to measure the severity of depression[2] but treatment studies of mania often relied on a combination of a global rating and another scale that assessed psychotic disorders, such as the Brief Psychiatric Rating Scale (Young et al., 1978). The YMRS was therefore designed to assess the symptoms of mania, severity of those symptoms, and any changes due to treatment. The 11-item assessment is based on symptoms of the manic state of bipolar disorder and is administered through a provider interview as with the BPRS and MADRS. It is important to note that only manic symptoms are assessed by the YMRS and that there are no items measuring depression. However the MADRS and YMRS are administered in tandem as mania is a finite illness and clients often move from mania to depression. The total score ranges from 0 to 60 in which the severity ratings of each of the 11 items is based on the client's subjective report of symptoms within the past 48 hours and the provider's observations

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[1] While 'normality' may be an objective qualifier, the statistical and medical models of 'normal' are considered in this context. The statistical model, used in psychological testing, refers to the bell-shaped curve of population distributions with deviant scores from the normal. Abnormality is therefore determined by an individual's performance compared to the population. On the contrary, the medical perspective defines normality as the absence of pathology. Thus individuals with disorders would be considered abnormal and those without the disorder would be excluded from studies. (Zimmerman et al., 2004).

[2] Montgomery-Asberg Depression Rating Scale

of the client during the interview (Lukasiewicz et al., 2013). When administered by a trained clinical rater, the YMRS has demonstrated high inter-rater reliability. Multilingual versions of the assessment (Colom et al., 2002; Favre et al., 2003; Kongsakon & Bhatanaprabhabhan, 2005; Vilela et al., 2005) further demonstrate its validity across cultural populations. The validity and sensitivity to change in clients receiving treatment for mania has been successfully established for the YMRS within such studies, illustrating the efficacy of the instrument in assessing changes due to therapeutic treatment of mania. The total score of the YMRS can range between 0 and 60. The treatment goal at Skyland Trail is a score of 10 or less because higher scores are indicative of more severe episodes with greater levels of psychosis and longer recovery time.

Hamilton Anxiety Rating Scale

The Hamilton Anxiety Rating Scale (HAM-A) was developed to fill the gap in available scales measuring the reduction in severity of anxiety symptoms and changes due to therapeutic treatment. The HAM-A is intended for clients who have been diagnosed with neurotic anxiety states. However it may only be used to assess neurotic anxiety states and not for assessing anxiety in clients diagnosed with other disorders that may show symptoms of anxiety (Hamilton, 1960). The assessment also focuses largely on somatic symptoms. Like all of the prior assessments discussed, the HAM-A is administered in a one-on-one interview with a primary counselor. It is a simple-to-use assessment instrument that takes 10 to 15 minutes to complete. Each of the 14 items is scored with a five-point scale from not present (0) to very severe (4), yielding a total denomination of 56 with higher scores indicating increasing anxiety. The validity and reliability of the HAM-A has been demonstrated in many clinical studies measuring clinically significant levels of anxiety and it is therefore the most widely used scale in studies of anxiety and treatment outcomes (Bruss et al., 1994). Structured interview guides have also been

developed to increase inter-rater reliability of this assessment tool (Bruss et al., 1994; Shear et al., 2001). These guides allow the scale to be administered in settings where extensive training is difficult or not possible. Trainings and guided assessments provide knowledge and a particular emphasis on the disorders being measured. It is necessary for counselors and other care administrators to be cognizant of the fact that results of an investigation may be very different if different assessment scales are used (Keedwell et al., 1996). The HAM-A has therefore been designated at Skyland Trail as the assessment for measuring symptoms of anxiety and changes in symptoms due to treatment over time. The treatment goal at Skyland Trail is a score less than 17 on the HAM-A.

Evidence-based Mental Health Clinical Practice for Better Health Outcomes

Introduction to Evidence-based Practices

Evidence-based practices are clinical guidelines that have been developed to help practitioners and clients make decisions about the appropriate health care treatment option for a specific diagnosis. Clinical practice guidelines promote clinical practices based on the best evidence to improve mental, behavioral, and physical health (Hollon et al., 2014). Providers use these guidelines to ensure that treatment is reliable and efficient, with less variability in heath care (Moreira, 2005). The foundations of clinical practice guidelines can be traced to the development of the Agency for Health Care Policy and Research (AHCPR) following the amendment of the Public Health Service Act in 1989. The aim of this agency was to "enhance the quality, appropriateness and effectiveness of heath care service" (IOM, 1990) through research, data development, and other activities. Guidance on how to do this came from a study committee within the Institute of Medicine that provided advice on definition of terms, what makes good guidelines, and how to implement and evaluate them (IOM, 1990). In 1995 the American Psychological Association approved the *Template for Developing Guidelines: Interventions for Mental Disorders and Psychosocial Aspects of Physical Disorders* developed by a joint task force of the Board of Scientific Affairs, Professional Affairs, and the Committee for the Advancement of Professional Practice (Hollon et al., 2014). This template described evidence that should be considered when developing mental health guidelines and stressed that all guidelines should be based on thorough evaluation of research and clinical expertise.

Although recommendations for appropriate care can be found in ancient writings (Chassin & Galvin, 1988), emphasis has since been on the evidence behind guidelines and effective use and evaluation. Consistent scientific evidence proves efficacy of the clinical

guidelines in improving client outcomes. The gold standard in determining evidence-based practice is considered to be several randomized clinical trials comparing the practice to a control case or alternative approaches. Secondary research, such as a meta-analysis or systematic reviews, in which research has proven its efficacy, shows the superiority of the practice to alternative treatment options (Drake et al., 2001). Some experiments that are not randomized may still represent the best evidence available if determined by panels of research scientists. Open clinical trials, on the other hand, lack independent comparison groups and do not provide sufficiently strong scientific evidence and clinical observations based on expert opinion are not considered evidence-based practices because they are not research-based (Drake et al., 2001). Although some evidence-based practices refer to guidelines that are not based on research, true evidence-based practices are grounded in consistent research evidence. This enables assessment of the quality of the practices rendered as well as the outcomes. Consensus guidelines define practices through a consensus process among experts in the field if research-based evidence may not yet exist. The primary disadvantage of such guidelines is that these expert opinions may reflect biases from professional experience rather than effectiveness of care (Drake et al., 2001). Clinical practice guidelines are determined by a consensus of experts who base decisions on evidence of best practice. Developing the most appropriate guidelines is the principle component of delivering the most effective and cost-efficient care practices.

To understand how specific guidelines are determined and recommended for implementation, it is necessary to understand factors that influence guideline committees' decision-making processes. The main evaluation factors for clinical practice guideline groups when constructing guidelines include the strength of evidence, usability of the guidelines, adequacy of procedures, and political acceptability (Moreira, 2005). The diversity of knowledge

of mental health sciences and clinical practice that go into the decision-making process are a reflection of the compositions of the multidisciplinary guideline groups (Moreira, 2005). These multidisciplinary panels include representatives of key specialties involved in the treatment of the target disorder. For the treatment of unipolar depression across the life span, for instance, the guideline development panel may include physicians, psychiatrists, a research methodologist, specialists in child and in geriatric depression, and a patient or lay representative to provide input from the consumer perspective (Hollon et al., 2014). Guideline groups work with researchers to determine the 'best fit' of scientific knowledge to the practice recommended in order to agree on appropriate clinical practice. This shows that guidelines are more than just the scientific evidence, but are determined with considerations of efficacy and feasibility of implementation in a clinical setting or a community-based mental health treatment site.

Despite these checks by the guideline development committees, there are still challenges in the implementation of new clinical practice guidelines. Negative perceptions of the practices and reluctance to adopt in an existing system are such barriers to translating research to clinical practice. Provider training may address these issues in motivating counselors to accept and see the value of innovation. Research has emphasized the importance of competence training of necessary skills for implementation of treatment because the use of the traditional written materials, workshops, and conferences has demonstrated little or no changes in health professional behavior or health outcomes when used alone (Oxman et al., 1995).

The Dissemination and Implementation of Evidence-Based Care in Mental Health

1. Provider Attitudes and Adoption of Innovation

Despite the proven efficacy of evidence-based practices in real-world settings, adoption in the mental health field has been slow. Evidence shows that mental health care counselors more often rely on experience with clients over research-based practices and have a reluctant attitude, believing that the mandated practices devalue their professional experience or judgment (Dulcan, 2005). Therefore the main barrier identified to adoption of innovation is provider attitudes. An Evidence-Based Practice Adoption Scale (EBPAS) was formed to understand such attitudes towards new treatments, interventions, and practices (Aarons, 2004). In the development of this scale, the four dimensions of attitudes that impact implementation of innovation determined include appeal of the practice, likelihood of adoption under the requirements, openness to innovation, and divergence of usual practice with the new practice. Source of the information and sense of efficacy to implement can affect how appealing it is and despite requirements to utilize practices, counselors may or not comply (Garland et al., 2003). Counselors must be open to try new strategies and refrain from being automatically skeptical of transferability from research to practice (Aarons, 2004).

The dimensions of attitudes to adopt evidence-based practice are further influenced by provider characteristics such as education level and years of expertise. Level of education and clinical experience and judgment determine whether the practitioner is open to adopting new practice methods in their treatment. While higher educational attainment may instill an intuitive appeal to evidence-based practices, graduate and intern-level counselors are more receptive to learning about and willing to adopt new strategies of practice (Aarons, 2004). Contrastingly, more years of experience has been shown to be negatively associated with openness to adopt

evidence-based practice (Aarons & Sawitzky, 2006) as counselors may rely more on their professional expertise in practice. However, the number of years of experience has been found to be unrelated to ratings of competence as practicing psychologists frequently are *not* more accurate than graduate students (Brosan & Moore, 2007), despite the belief and attitudes of counselors and clients that more experience translates to better outcomes, especially when new evidence is elucidated.

The atmosphere of the organization (Aarons, 2004; Aarons & Sawitzky, 2006) and supervisor leadership (Aarons & Sommerfeld, 2012) also influence provider attitudes. Organizational context, the climate and culture, can impact change by hindering or encouraging adoption of new practices. Norms and expectations of behavior and workings of the organization define culture while climate refers to workers' perceptions of, and emotional reactions to the work environment (Aarons & Sawitzky, 2006). A positive, supportive organizational culture is not only associated with better client outcomes in mental health services, but more positive provider attitudes toward evidence-based practices as well (Aarons & Sawitzky, 2006). Motivational leadership influences implementation by promoting a strong climate and positive attitudes (Aarons & Sommerfeld, 2012) and articulating specific roles and tasks for counselors. This improves the climate by demarcating expectations and increasing accountability (Aarons & Sawitzky, 2006).

2. Provider Training of Evidence-based Treatments

Training is a factor that influences provider attitudes towards evidence-based practice and the likelihood to adopt changes. Since new evidence-based practices require learning about the intervention and the techniques and protocols involved, counselors cited access to training and ongoing expert consultation as desirable for new treatments (Nelson et al., 2006). They are more

hesitant to try new treatments, even interventions with heavily backed research and evidence, if they have not been trained to implement them within their treatments. A successful training program adequately delivers content while taking into account the constraints of the organization, whether being time, finances, or staff (Stirman et al., 2010). Another important consideration is the target audience of counselors. Some may welcome the specialized training while others may not be as receptive. There may be concerns that the new practice is too divergent to their usual practice or that protocol rigidity inhibits a relationship-building environment between counselors and clients (Aarons, 2004).

Trainers should encourage open communication and welcome skepticism as a normal reaction to change (Ford, Ford & D'Amelio, 2008). A supportive environment and organizational culture are essential to implement and sustain new practices (Aarons, 2004; Aarons & Sawitzky, 2006; Stammen et al., 2015). Ongoing support is necessary in order to properly and effectively administer new treatments. Training involves more than just one workshop introducing the new practice. Those who receive continued consultation reach adequate skill levels compared to counselors attending just a workshop (Miller et al., 2004). Interactive rather than instructional trainings have also been shown to be more effective (Stirman et al., 2010). A challenge of disseminating novel practices through training workshops is that they can be time-consuming and keep counselors from attending to clients. To address this issue workshops can be broken into small blocks of time, also allowing counselors time to process information delivered (Stirman et al., 2010).

Training materials should also have the right balance between providing sufficient information without overwhelming counselors. With a large number of caseloads, counselors do not have time to peruse extensive written materials. They prefer concise, user-friendly, integrated

manuals with clear guidelines and summaries of research applied to clinical practice with recommendations (Dulcan, 2005). Manuals should also include copies of assessment instruments with instructions for implementation. Manuals provide a way to ensure internal validity of practices by promoting consistency through evidence-based guidelines (Addis & Krasnow, 2000). Treatment or operational manuals, in conjunction with interactive and didactic training, have been shown to improve the translation of research into clinical practice to achieve target outcomes (Dulcan, 2005). Manuals may also be effective in increasing positive attitudes about evidence-based interventions as a tangible product that provides clear descriptions of the evidence with guidelines for implementation (Leathers & Strand, 2013).

Outcome Measures

Evidence-based Assessment

While evidence-based practices and treatment have been established as the gold standard in care, the transferability from research to clinical practice cannot be heralded as 'best practice' if there is no verification of efficacy. Empirical assessment of outcomes is thus necessary to demonstrate practice-based evidence of efficacy. Since evidence-based practice emphasizes the evaluation of outcomes, there has been increased pressure on mental health services counselors to collect and standardized outcome data of their clients (Garland et al., 2003). Evidence-based assessments use research and theory to guide what should be assessed, the methods and measures to be used, and the manner in which the assessment process unfolds to evaluate clinical practice (Hunsley & Mash, 2007). Outcome assessments are beneficial at an aggregate organizational level and an individual provider level. At the aggregate organizational level, standardized outcome data may be useful for treatment and program planning, funding decisions, and quality monitoring (Garland et al., 2003). Such evaluation of treatment outcomes can help to improve

care services. Standardized outcome assessments can help at an individual provider level by enabling counselors to use the collected data to make more informed and accurate judgments and decisions about treatment planning. Clinical psychologists employ cognitive heuristics to make judgments and rely on professional opinion, though it has been shown that formal, statistical data more accurately predicts human behavior than clinical predictions (Garb, 1996; Grove et al., 2000). Thus there is an emphasis on standardized assessment tools over counselors' judgment for clinical assessment and decision-making.

Despite evidence of effectiveness, most counselors are unlikely to use standardized assessment tools to assess clients unless mandated. They may administer the evidence-based assessments as a component of the evidence-based treatment, but they may not use assessment data to evaluate treatment effectiveness (Bickman et al., 2000). When surveyed, psychologists reported less frequent use of standardized measures to evaluate effectiveness of treatment compared to other methods such as behavioral observation (Piotrowski et al., 1998; Garland et al., 2003). Counselors often complained that standardized measurement was too cumbersome and intrusive of professional practice, citing barriers of feasibility, perceived invalidity, and difficulty interpreting (Garland et al., 2003). Counselors instead relied on anecdotal observations and intuitions. However, such personal judgments are subject to biases and have been shown to be less reliable and valid than standardized measurement data (Garb 1996; Garland et al., 2003). In addition to cognitive heuristics and intuitions, studies have suggested that psychologists often compare clients to prototypes when making diagnoses or assessing symptoms. They have a hypothetical client as a prototype who best represents a particular disorder (Garb 1996; Evans et al., 2002). This exemplifies the subjective nature of using clinical judgment because counselors may have different conceptions of what makes the perfect prototypical model. These results

imply that inter-rater reliability will be low when psychologists do not envision the same prototypes and agreement between counselors' assessments will be affected by the dissimilarity of the counselors' prototypes to the criteria.

Inter-rater reliability for Consistency in Treatment

An approach to studying clinical judgment is to assess inter-rater reliability among counselors to see if different counselors make similar ratings when evaluating the same set of clients. Inter-rater reliability is necessary in order to ensure that counselors are reaching the same conclusions regarding client symptom severity and consequently providing the most appropriate and consistent treatment across clients. Using assessments through structured interviews as instructed, agreement between diagnoses made by mental health professionals is higher than when they rely on clinical judgment for determining diagnoses (Basco et al., 2000; Miller et al., 2001; Garb 2005). Semi-structured interviews are used to ensure that diagnoses are based on specific criteria and rules. Although the assessments discussed in this project measure symptom reduction rather than determine diagnoses, these findings show that clinical determinations are inconsistent when different assessment methods are utilized and that evidence-based assessments have higher accuracy than professional opinion.

Various misjudgments are possible when counselors make decisions based on clinical opinion rather than structured interviews. Often counselors tend to under or over-diagnose many mental disorders, such as schizophrenia (Zimmerman et al., 2008; Kotwicki & Harvey, 2013). One reason for the lower validity of clinical practice diagnosis compared to semi-structured interviews is that counselors do not always ask about important symptoms. Counselors have even been shown to evaluate only half of the key criteria that would be assessed in provider interviews (Miller et al. 2001). Structured interviews do make a difference, as revealed by the disparity in

clinical and structured interview diagnoses and symptom assessments. Counselors are more likely to adhere to criteria in structured interviews and inter-rater reliability will be at least fair.

Summary

Solid evidence-based practices are grounded in research evidence. The main component of delivering the most effective and cost-efficient care is to follow the most appropriate guidelines for care. The robustness of practice guidelines depends on the strength of the evidence, usability of the guidelines, adequacy of the recommended procedures, and the general attitudes of acceptability. Despite strong evidence of effectiveness in a research and clinical setting, challenges to the implementation of new clinical practice remain. There may be overall negative perceptions of practices or a resistance to make changes to an existing system of care.

Mental health care counselors often rely on experience with clients and observations of social and behavioral functionality rather than research-based practices. Resistance to mandated practices may be due to feelings of diminishment of professional experience or judgment. The main barrier identified in implementing changes to treatment protocol is provider attitudes towards the new practice. Attitudes are not only influenced by individual opinions but also by the environment in which the individual is working. A supportive, encouraging organizational culture is essential to implement and sustain new practices. Ongoing support is necessary in order to properly and effectively administer new treatments or assessment protocol.

Training on practices also influences provider attitudes. Counselors feel more competent when trained in the implementation or administration of new treatment practices. However training should involve more than just an instructional workshop that inundates counselors with information. Manuals have been shown to improve the translation of research to clinical practice to ultimately improve client outcomes when used in conjunction with training. Manuals are also

effective in increasing positive attitudes regarding evidence-based implementation as a tangible product that provides clear descriptions of the evidence with guidelines for implementation.

Evidence-based assessments are needed to measure and demonstrate efficacy of these evidence-based practices guided by research. Evaluating treatment outcomes using structured assessments provides a way to demonstrate quality assurance of treatment, identifying needs for improvement. Evidence-based assessments are beneficial to mental health organizations because they provide data that can be used for treatment and program planning, making funding decisions, and monitoring quality of treatment in order to ultimately improve care services. Assessment data can be used by counselors to make more informed treatment decisions.

Despite the demonstrated benefit for counselors, clients, and the organization, studies have shown that mental health care counselors only administer assessments as mandated but do not necessarily use them for treatment planning. They rely more on behavioral observation and professional judgment, which is very subjective and therefore has no guarantee of inter-rater reliability. Inter-rater reliability is necessary to ensure that counselors reach the same conclusions about diagnoses and symptomology and consequently make consistent treatment recommendations for clients. When relying only on clinical judgment alone, mental health care counselors may over or under diagnose disorders or miss key symptom indicators, rendering treatment ineffective if not addressing the client's specific needs. Administering evidence-based assessments through semi-structured interviews ensures that treatment judgments are based on specific criteria and rules. It is more likely that counselors will adhere to established criteria when using semi-structured interviews because they will have specific standards when evaluating clients. However, in some circumstances, evaluations based on therapy sessions will be more accurate than semi-structured interviews because therapists are able to observe and

interact with clients over time. The key detail about this is that these are not completely structured sessions and clients are able to elaborate on their answers (Garb, 2005).

Based on this review of literature on the subject of evidence-based practices for better client outcomes, Skyland Trail is not unique in its struggles to utilize evidence-based assessments as a resource for clinical decision-making. Several mental health treatment organizations have demonstrated low or inconsistent use of assessments or quantitative data. The mental health field is very qualitatively driven with decisions dictated by narratives. While professional opinion and expertise is very valuable in a behavioral, cognitive change treatment objective, this falls short in providing a complete picture of the client. Quantitative data may be helpful information when deciding on the most appropriate treatment option. It is important to convey to counselors the value of these gold standards in assessment. A manual will be designed to help counselors at Skyland Trail gain a better understanding of diagnosis-specific assessments and influence their attitudes and use of assessment tools when making treatment decisions.

Chapter 3: Methodology

Introduction

The purpose of this special studies project was to develop an operational manual that counselors at Skyland Trail can use when delivering diagnosis-specific assessments to clients. This manual can also be used as a training resource in capacity building of new counselors to guide implementation of assessments. The goal of this manual is to promote consistent quantitative data collection that can be used to evaluate treatment outcomes. Diagnosis-specific assessments can be used to measure the efficacy of Skyland Trail strategies and recovery modalities when treating adults diagnosed with mental issues and determine necessary improvements. Assessment data can thus be used in conjunction with other client evaluation methods to help counselors make decisions about treatment such as step-up or step-down in care or transitioning from a higher level of treatment to a lower level.

Diagnosis-specific assessments are conducted by counselors on a bi-weekly basis for each client receiving treatment services. Skyland Trail staff refer to them as "Feedback Friday." Assessments represent gold standard measures, tested for validity and reliability, and are expected to take 15 minutes or less to complete. Feedback Friday measures are integral to outcomes evaluation of clients from admission to discharge. Scored data are entered into the Electronic Health Record (EHR) once the primary counselor completes assessments. There is an audit procedure in place if counselors are not able to administer assessments for a client during a Feedback Friday cycle. An Excel query is conducted through the EHR the Tuesday after each bi-weekly measurement cycle to verify that assessment scores have been entered for all clients currently in treatment services. If there are missing scores, then the client's counselor is notified by email that a measurement period was missed. This email is to remind counselors to complete

assessments for these clients as soon as possible or to prioritize assessment administration during the next Feedback Friday cycle. Reasons for missed assessments may include new admission, leave of absence, hospitalization, or if the client is too symptomatic to conduct the assessment. Counselors administer these assessments as mandated but observations by the Research and Outcomes Dept. Coordinator, Alex Balzer, indicate that assessment data is rarely reexamined. Although these assessments provide real-time feedback, counselors and other treatment team members do not make use of the scores.

Procedures

The first step in developing an operational manual was to glean insight of provider attitudes towards the disease-specific assessments. I constructed a structured questionnaire that evaluated attitudes towards the assessments and whether they are being utilized to determine treatment decisions (See Appendix 1). This questionnaire was emailed to counselors at Skyland Trail with a request to print, complete, and deliver back to the Research & Outcomes Department. All eleven questionnaires, accounting for 100% of counselors at Skyland Trail, had been collected approximately one week later and data entered into SPSS. Results indicated a high variability among counselors in their administration of assessments and use of data. Some counselors administered assessments completely with clients during the session, while others completed them after the session. However, 100% reported that they never or almost never considered assessment scores during Treatment Team meetings when they discussed client progress and made decisions about future treatment course of action. When asked to rank factors that contribute to the decision-making process of determining treatment options, the diagnosis-specific assessments were overwhelmingly marked last; 64% said they do not use the assessments to make decisions about treatment, with observations of behavioral functionality and

social interaction of the client were ranked among the top. However, over half of the counselors claimed that the assessment tools are valuable to them in determining client progress. This indicates a lack of consistency in individual attitudes of counselors. The assessments do seem to have some value, yet they are not being used to guide treatment planning. The results of the self-administered questionnaire suggested that counselors at Skyland Trail may not know exactly how and why these gold standard diagnosis-specific assessments are helpful. There was therefore a need for a better understanding of these assessment tools and why they are important in showing treatment outcomes.

Contents of Manual

a. Introduction to Skyland Trail
b. Evidence-based Practice and Assessment
c. The Assessments
    i. Brief Psychiatric Rating Scale (BPRS)
    ii. Montgomery-Asberg Depression Rating Scale (MADRS)
    iii. Young Mania Rating Scale (YMRS)
    iv. Hamilton Anxiety Rating Scale (HAM-A)
d. Sample Outcomes Assessment Graph
e. Feedback Friday: A Snapshot

The operational manual is a resource to be used during training of current and future counselors in gaining a better understanding of these diagnosis-specific assessments. Manuals must be flexible in the implementation of prescribed interventions (Dulcan, 2005). This infers that they should not be a strict code of conduct but rather guidelines to provide direction for counselors to mold for each individual client. This specific operational manual is concise, providing sufficient information without being overwhelming. The operational manual began with a brief overview of Skyland Trail and its mission in delivering the most effective, evidence-based treatment to adults diagnosed with mental disorders. The concept of evidence-based

practice was discussed along with the necessity of the specific assessments used at Skyland Trail. Each of the four assessments was described as the standard assessment tool for evaluation of that specific diagnosis. This information was also condensed into a table format as a quick reference guide. An effective manual should have printed guidelines with copies of assessment instruments and instructions for administration (Dulcan, 2005). Therefore, a copy of each of the diagnosis instruments has been included so that counselors have access to them together as one single entity. The manual concluded with a graphical example of how the assessments can be used to track client outcomes.

Presentation slides were created for use in tandem with the operational manual during clinician training at Skyland Trail. The presentation slides began with an introduction to the purpose of outcomes assessment and how it is beneficial for Skyland Trail; the ultimate goal to improve care services. Going from a broad organizational level to an individual perspective, the next part of the presentation included as discussion on how the assessments can help counselors at Skyland Trail make more informed decisions about treatment. The assessment process is then described as what staff at this organization knows to be “Feedback Friday” and why they have this procedure. Each of the diagnosis-specific assessments is described in more detail with a sample graphical representation of a client’s outcomes using the assessment. The purpose of this presentation is to provide an informative training module to supplement the manual.

Chapter 4: Discussion

Discussion

The purpose of this special studies project was to develop an operational manual for the use of diagnosis-specific assessments to guide treatment decisions of Skyland Trail counselors. As a leader in community-based mental health services, this nonprofit organization offers a holistic program of evidence-based psychiatric treatment, integrated medical care, research, and education. Treatment outcomes must be evaluated in order to realize the impact of Skyland Trail's evidence-based treatment modalities. Empirical assessment of outcomes is necessary to demonstrate practice-based evidence of efficacy. This is why counselors at Skyland Trail have been instructed to use the BPRS, MADRS, YMRS, and HAM-A to assess symptom reduction in schizophrenia, depression, mania, and anxiety, respectively. Assessment scores can indicate client treatment progress and inform future direction of treatment. Successful symptom reduction is a reflection of successful evidence-based treatment at Skyland Trail.

The diagnosis-specific assessments provide useful information about client progress, however this data is not included when decisions about treatment are made. Along with observations of the Research & Outcomes Dept. Coordinator at Skyland Trail, the structured, self-administered questionnaire developed for this special studies project revealed that counselors at Skyland Trail prioritize behavioral observations and professional clinical judgment over assessment data to guide treatment decisions. The questionnaire indicated that counselors ranked the diagnosis-specific assessments as the last among factors used to determine treatment decisions. Although within that same questionnaire, Skyland Trail counselors stated that they *do* think that assessment tools are valuable. These conflicting results suggest that there is some support for evidence-based assessments but that some hesitation remains.

An operational manual and supplementary presentation slides were created as products of this special studies project to promote the consistent use of the quantitative diagnosis-specific assessments to make treatment decisions. The manual and slides contain information on the BPRS, MADRS, YMRS, and HAM-A scales and describe their usefulness for counselors themselves and Skyland Trail as a whole. The ultimate goal is identified as improvement of treatment services at Skyland Trail. The manual and slides introduce the concept of evidence-based practice and assessment as necessary complements of each other, to inform and enhance treatment.

As revealed in the literature review, provider attitudes are the main barrier in the adoption of practice. Reasons cited by providers for their resistant attitudes towards the assessments include practicality, perceptions of invalidity, difficulty interpreting assessment data, financial and time burden, assessment priority discrepancy between providers and administrators, and staff turnover that affects knowledge of assessment and administration. The individual attitudinal barriers pertinent to Skyland Trail are practicality, perceptions of invalidity, and interpretation difficulties. While perceptions of feasibility in terms of time burden are beyond the scope of this special studies project, it is not an issue for counselors at Skyland Trail because each of the assessments—BPRS, MADRS, YMRS, and HAM-A—takes approximately 10-15 minutes and no more than 30 minutes to administer. Furthermore, they are administered on a bi-weekly basis in which 15 minutes from one of two 45-minute individual counseling session is a feasible amount of time compared to potentially 60-minutes for other assessment tools (Garland et al., 2003). Financial burden is also not an issue since Skyland Trail has licensed access to all assessment instruments used. And with regards to validity of the assessments, the BPRS, MADRS, YMRS, and HAM-A have all been established as the gold standard, tested for

reliability and validity for assessing symptom reduction in schizophrenia, depression, mania, and anxiety, respectively. Therefore any reservations expressed by providers concerning these standardized measures reflect the need for further understanding of the evidential support for the utility of the instruments.

Difficulty in interpreting the assessment scores inhibits communication and application of scores to make treatment decisions. Providers from other studies have stated that they would like narratives as opposed to quantitative values, perceiving minimal rewards to collecting quantitative data (Garland et al., 2003). Since the intent of the enforcement of diagnosis assessment outcomes measurement is to allay the prioritization of the narrative and emphasize the use of quantitative data to make treatment decisions, constructing narratives of these assessments would be a regressive move. Therefore, one option of addressing this issue and making the assessment data more "user friendly" is to create graphical representations of client outcomes, illustrating treatment progress as included in the operational manual. All of the barriers expressed by providers regarding outcome evaluation are important to acknowledge for successful adoption of empirically supported intervention and assessment techniques in community-based practice settings. While this special studies project attempts to address these issues, it is vital to discuss the limitations of the project.

Limitations

One limitation in the design of this special studies project is that the self-administered questionnaire given to providers was too structured. The purpose of this questionnaire was to understand attitudes of primary counselors at Skyland Trail towards the diagnosis-specific assessments and whether or not they used the assessment data to make decisions about treatment. The questions provided answers to choose from, leaving no room for further explanation. Two

semi-open ended questions asked to rank the factors that contribute to their decision-making process of determining treatment options and to list their top five determinants of successful program completion. In order to allow for the provision of more information, almost all question had a blank "other" option with space to specify. However having more open-ended questions for free-response would enable counselors to share explanations that may provide useful information for the project.

Perhaps the most significant limitation of this project is that it will not include an evaluation of the effectiveness of this operational manual and training slides. The purpose of this project is to improve use of quantitative data by current and future counselors at Skyland Trail. The operational manual and presentation are intended to contribute to the knowledge, attitudes, and behavior of providers regarding the diagnosis-specific assessments used at Skyland Trail. However, I will not be able to measure the effectiveness of the manual in accomplishing these goals and therefore I suggest methods of evaluation in the "Recommendations" section.

A limitation that is beyond the scope of this project is the environment of the organization. As discussed in the literature review, the climate and culture of the organization influence provider attitudes towards adoption of new practices by creating an encouraging or hindering environment. Along with this is the type of leadership at Skyland Trail. Motivational leadership promotes a strong climate and positive attitudes. I have provided suggestions on how to address these limitations and propose further recommendations for the success of this project.

Recommendations

The following recommendations are made in order to address potential barriers and solidify the consistent administration and use of the diagnosis-specific assessments at Skyland Trail. The first recommendation is training that should be conducted to more extensively cover

these psychiatric assessments. Training also provides a way to foster a more supportive work environment thereby motivating behavior change. To ensure complete understanding of the assessments, score thresholds should be clearly communicated and understood so that counselors can recognize significant change when it occurs. The final recommendation is for the institution of a feedback loop in which counselors are able to evaluate assessment scores collected over time. Providing feedback to clients is also beneficial in enhancing treatment outcomes.

Training

A vital component of the effectiveness of this special studies project is that training must be incorporated along with the operational manual. One of the most essential challenges of mental health research and practice is the need to increase the acceptability of outcome measures for providers (Beutler, 2001). Dissemination of manuals alone is insufficient to change behavior and attitudes, thus training should be done in conjunction (Miller et al., 2004; Sholomskas et al., 2005). Training is necessary to communicate the essential information and proper techniques for practices and assessments. When evaluating whether providers' ability to implement empirically supported therapies changed after merely reading a manual, findings suggested that smaller and more short-lived changes occurred than those of providers who participated either in traditional seminar-based training or Web-based training.

Educating providers is an ongoing process. Following face-to-face training, direct supervision may be most effective for knowledge dissemination (Sholomskas et al., 2005; Stirman et al., 2010). In order to improve the environment of the organization and address one of the limitations identified previously, training activities should be interactive, involving counselors in the discussion (Garland et al., 2003). Counselors should be encouraged to use the assessment reports to begin discussions of clients' treatment and progress. This will enable

counselors to reflect on any discrepancies between the qualitative narratives of the clients' experiences and the quantitative results, therefore assessing the counselor's perception accuracy (Allen et al., 2009).

Computer-based training may be a strategy for training larger numbers of providers to learn novel approaches. While face-to-face training may be most effective in knowledge dissemination, extensive training and hours of supervision may be a time and financial burden (Sholomskas et al., 2005). Access to computer-based training provides one way to address the "practicality" barrier of clinician turnover and allow future providers to learn about the assessments and how to administer them. Web or computer based training would also enable providers and administrators to access the training material, and ideally receive the same level of understanding of priorities and importance of outcomes measurement and the utility of these diagnosis-specific assessments.

Thresholds

To further address consistent use and knowledge gaps, using clear thresholds, or benchmarks, for assessment scores are necessary. Benchmarking refers to the establishment of reference points for easier interpretation of data, derived from the practice by artisans of marking a workbench to make measurement of work in progress easier (Barkham et al., 2001). Benchmarking is usually considered to be a process of seeking out and implementing the best and most cost-effective practices (Ettorchi-Tardy et al., 2012) but benchmarks are also used to make data interpretation easier (Barkham et al., 2001). Benchmarks can be at the individual level or the service level. This means that individual client data can be aggregated at the level of an individual practitioner's caseload, at a service level, or for a type of service (Barkham et al., 2001). Monitoring outcomes and comparing to benchmarks may also be helpful to predict

potential outcomes, such as relapse history, severity, and comorbidity (Barkham et al., 2001). Research has shown that this type of information about the client's progress is difficult for clinicians to extract and interpret from numerical assessment values (Ettorchi-Tardy et al., 2012). This points to the need for training in the use of assessment instruments and what the thresholds mean.

An essential aspect of treatment and symptom evaluation is cutoff scores that indicate recognizable and substantial changes (i.e., reliable and clinically significant). This involves evaluating when a score on the diagnosis-specific assessment shows that a patient has made progress sufficient to be classified as reliably improved or recovered (Lambert et al., 2003). If counselors at Skyland Trail understand thresholds for 'remission' or 'moderate severity' etc. and how it affects "step down" in level of care and determines readiness for graduation, then they can compare their clients' scores and get a global understanding of client progress or problems. Benchmarks, or thresholds, at Skyland Trail would help determine eligibility for step down in care and graduation from the program or granted certain "privileges" due to symptom improvement. "Step down" indicates improvement or progress and may refer to going from north campus to south campus or moving to transitional housing.

Outcomes Feedback and Evaluation

Feedback is another important component of the evaluation of treatment and symptom reduction. After trainings have been conducted and counselors ideally now have an enhanced understanding of assessments and can better interpret the thresholds, feedback of aggregate scores will further help them to understand the data and personally see the impact of treatment on symptom reduction. In one study measuring the effects of feedback, therapists were given

graphical progress reports with a color-coded dot that visibly conveyed the status of client progress. A written message corresponding to the dot provided a brief summary.

> "White Feedback: 'Functioning at normal range, consider termination.'
>
> Green Feedback: 'The rate of change is in adequate range. No change in the treatment plan is recommended.'
>
> Yellow Feedback: 'The rate of change the client is making is less than adequate.
>
> Recommendations: consider altering the treatment plan by intensifying treatment, shifting intervention strategies, and monitoring progress especially carefully. This client may end up with no significant benefit from therapy.'
>
> Red Feedback: 'The client is not making the expected level of progress. Chances are he/she may drop out of treatment prematurely or have a negative treatment outcome. Steps should be taken to carefully review this case and decide upon a new course of action such as referral for medication or intensification of treatment. The treatment plan should be reconsidered.'" (Lambert et al., 2003).

Such graphical representations simplify these quantitative assessment data and the corresponding messages can further clarify the meaning of a particular score range and fulfill counselors' preference for narratives over numbers.

The utility of treatment monitoring and feedback has been demonstrated in several studies. In a meta-analytic review of several randomized clinical trials tracking treatment outcomes for thousands of adults across a range of psychotherapeutic treatment approaches (Lambert et al., 2003), monitoring patient progress was shown to have significant impact on clients who illustrated poor treatment response initially, increasing positive outcomes following feedback. In another study, 64% of patients met reliable or clinically significant change in

improved outcomes after feedback was shared with counselors and clients (Bickman, 2008). Feedback was even helpful across levels of training, when given to experienced or to counselors in training (Lambert et al., 2003).

While feedback to counselors has enhanced treatment outcomes and symptom reduction, provision of progress information to both patients *and* therapists has greater effects than when feedback is provided *only* to therapists. A weaker effect was found when only counselors were provided feedback about a patient's treatment progress (Hawkins et al., 2004). This implies that it is most beneficial when clients receive the information along with their counselors. Clients have even expressed very strong interest in receiving information about their progress in treatment and that they were capable of receiving objective feedback about their treatment progress without being negatively affected (Hawkins et al., 2004). Therefore feedback reports can be used to stimulate dialogue between counselor and client regarding treatment, and to inform future treatment strategies (Bickman, 2008). This would fulfill the final objective of this project in utilizing this manual and training to produce an additional mode of communicating symptom improvement to clients and their families.

A feedback system is not only beneficial for data interpretation and the evaluation of diagnosis-specific assessments, it is also a method of evaluating the effectiveness of this project, of the operational manual and the presentation slides. A feedback system makes it more likely that whatever was learned in training will continue to be used reliably because there will be evidence of compliance. The concept of assessing the results of any treatment is a key step in the classic evidence-based medicine approach to practice; therefore it can be used as an approach to evaluate this project. Assessment of compliance rates and key performance indicators is recommended for the evaluation of the efficacy of this project. Compliance refers to the

completion of assessments at admission, midpoint, and discharge for all clients receiving treatment services at Skyland Trail. Compliance rates for Feedback Friday fluctuate every month; from 83% in January 2016 it dropped significantly to 42% and then rose again 93% in March. These rates demonstrate the inconsistent use of the diagnosis-specific assessments by counselors at Skyland Trail. Compliance rates can be monitored regularly to evaluate whether there has been a positive change in assessment use and whether or not rates are consistent each month. A Key Performance Indicator (KPI) for Skyland Trail fulfillment of treatment goals is assessing whether all graduating clients achieved statistically significant decrease in symptoms as measured by the diagnosis-specific assessment tools, at a 95% confidence interval. This indicator conveys the overall outcome, positive or negative, of Skyland Trail treatment modalities; it shows whether assessment scores have improved. An improvement in scores as measured by the assessments suggest that treatment decisions are having the desired effect. However monitoring of KPI and compliance rates are not sufficient to determine whether these treatment decisions were driven by the assessment scores. To gain the most accurate understanding of what role the scores had in clinician treatment decision making, it is further recommended that a questionnaire similar to the one given at the beginning of this project be administered after several Feedback Friday cycles as a self-report evaluation. Such a questionnaire should be designed to assess counselor attitudes toward the diagnosis-specific assessments and measure change in decision-making criteria.

Conclusion

Counselors at Skyland Trail prioritize behavioral observations and professional clinical judgment over data from the diagnosis-specific assessments to guide treatment decisions. Narratives are an important aspect of mental health treatment, but they may provide an

incomplete assessment of client progress. Thus there must be another method of assessing client symptom improvement. The BPRS, MADRS, YMRS, and HAM-A assessment scales have all been established as the gold standard, tested for reliability and validity for assessing symptom reduction in schizophrenia, depression, mania, and anxiety, respectively. Therefore these assessment tools provide counselors with evidence-based derived information about client progress. Counselors can conduct assessments and use the information to decide what course of action should be taken for the future in order to improve treatment outcomes.

Through this special studies project, an operational manual was developed for the use of diagnosis-specific assessments by counselors at Skyland Trail to guide their decisions about client treatment. The operational manual and supplementary presentation slides contain information on the assessment tools and why they should be a priority for counselors. It must be acknowledged that a manual is not enough to change knowledge, behavior, or attitudes of counselors towards these assessment scales. Other measures should be taken to improve recovery evaluation, understand trends in outcomes and improve treatment strategies by using evidence-based measures, and demonstrate efficacy of the Skyland Trail model of treatment (See Objectives pg. 7)

The first and foremost recommendation is the conduction of training to more extensively cover these psychiatric assessments. An interactive, motivational training provides a way to foster a more supportive work environment thereby encouraging behavior change. Score thresholds, or benchmarks, should be discussed during these trainings to ensure complete understanding of the assessments so that counselors can recognize significant change when it occurs. Thresholds can be implemented as a narrative form of the assessment data so counselors can use this information when making decisions about step down in level of care and

determining readiness for graduation. Finally, a feedback loop is recommended to provide reports of client treatment progress in symptom reduction as measured by the diagnostic-specific assessments. Counselors can use this to also provide this feedback to clients, communicating improvement in symptoms to clients and their families (see Objectives, pg. 7)

Empirical assessment of outcomes is necessary to demonstrate practice-based evidence of efficacy. Counselors at Skyland Trail have been instructed to use the BPRS, MADRS, YMRS, and HAM-A to assess symptom reduction in schizophrenia, depression, mania, and anxiety, respectively. Assessment scores show client treatment progress and can inform future direction of treatment. Successful symptom reduction and treatment outcomes are a reflection of successful evidence-based treatment at Skyland Trail.

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Appendices

Appendix 1: Counselor Questionnaire

COUNSELOR QUESTIONNAIRE

1. How long do you meet with clients for weekly psychotherapy?
    a. 30 minutes
    b. 45 minutes
    c. 60 minutes
    d. Other _____
2. Do you complete the Diagnosis Specific Assessments?
    a. Interview style – run through the questions at once
    b. Organically – thread questions throughout appointment
    c. Other _____
3. How do you complete assessments?
    a. Completely during session with client
    b. After the session
    c. A combination of both
4. On average, how often are you able to review prior week's assessment results before meeting with clients?
    a. Never
    b. Almost never
    c. Occasionally/Sometimes
    d. Almost every time
    e. Every time
5. Do you discuss assessment scores with clients?
    a. Using numerical scores
    b. Using descriptors (mild depression, etc.)
    c. Do not discuss assessment scores with clients
    d. Other _____
6. If discussing assessment scores with clients, when do you discuss? Circle one which reflects what you most often do.
    a. At the beginning of the appointment
    b. At the end of the appointment
    c. Immediately before conducting next assessment
    d. During the following week
    e. Do not discuss with clients
7. Do you discuss assessment scores during Treatment Team meetings?
    a. Never
    b. Almost never

c. Occasionally/Sometimes
d. Almost every time
e. Every time

8. How do you use Diagnosis Specific Assessment scores to determine treatment options?
a. Using numerical scores
b. Using descriptors (mild depression, etc.)
c. Do not use assessments to make decisions about treatment
d. Other _____

9. How do you use SMORES scores during Treatment Team meetings?
a. Using numerical scales
b. Using descriptors
c. Do not use SMORES during meetings
d. Other _____

10. Please rank the factors that contribute to your decision-making process of determining treatment options. (1 = Essential)
_____Symptom reduction
_____ADL functionality
_____Behavioral functionality
_____Direct interaction with client
_____Interaction with peers
_____Interaction in social milieu
_____Other Treatment Team members' (adjunctive therapy, etc.) observations of client
_____Diagnosis- Specific Assessment scores
_____SMORES scores
_____Other _____

11. How do you determine improvement?
a. Improvement in functional tasks
b. Behavioral observations
c. Emotional insight
d. Improvement in Diagnosis Specific Assessment scores
e. Improvement in SMORES scores
f. All of the above

12. How often do you use Diagnosis Specific Assessment scores to determine levels of care during admission?
a. Never
b. Almost never
c. Occasionally/Sometimes
d. Almost every time
e. Every time

13. How often do you use Diagnosis Specific Assessment scores to determine step down in care? (Transition from South to North, level 1 to 2, etc.)

a. Never
b. Almost never
c. Occasionally/Sometimes
d. Almost every time
e. Every time

14. Who makes final decisions to determine graduation?

a. Psychiatrists
b. All Treatment Team members
c. At least two Treatment Team members
d. Primary Counselor
e. Client
f. Other

15. Please list the top five determinants of a client's eligibility for graduation.

_____
_____
_____
_____
_____

16. Is symptom remission synonymous with graduation? Y / N

17. Overall, how valuable are assessment tools to you as a professional in determining client progress?

a. Not at all valuable
b. Slightly valuable
c. Somewhat valuable
d. Very valuable
e. Extremely valuable

Appendix 2. An Operational Manual for Using Diagnosis-Specific Assessments

Skyland Trail

Offering Hope, Changing Lives

FEEDBACK FRIDAY: AN OPERATIONAL MANUAL FOR USING DIAGNOSIS-SPECIFIC ASSESSMENTS TO EVALUATE TREATMENT AT SKYLAND TRAIL

PREPARED FOR
Skyland Trail Counselors and Staff
May 2016

INNOVATIVE PATHS TO MENTAL WELLNESS

Skyland Trail is a nationally recognized nonprofit mental health treatment organization for adults ages 18 and older with a primary mood or thought disorder.

Through our residential and day treatment programs, we help our clients grow, recover, and reclaim their lives.

www.skylandtrail.org

Skyland Trail

Offering Hope, Changing Lives

TABLE OF CONTENTS

INTRODUCTION TO SKYLAND TRAIL

Skyland Trail is a private, not-for-profit facility that provides treatment for adults ages 18 and older who have been diagnosed with mental health issues. Located in Atlanta, Georgia, this organization was founded in 1989 to address the lack of residential treatment facilities in Atlanta aimed at recovery rather than stabilization of acute mental disorders. In the 1980s, there was no residential psychiatric treatment program that provided therapy in addition to helping clients build the skills needed to reintegrate back into the community. Community-based treatment programs have been shown to have a positive impact not only on psychopathology but family and social adjustment as well as relapse rate for clients with acute mental health disorders.

Through over 20 years of service to the community, Skyland Trail has helped over 3,000 adults and their families to live independently and keep their disorder from acting as an obstacle. The residential and day treatment programs help clients grow, recover, and take back control of their lives. Skyland Trail offers a unique continuum of care with "step-downs" in illness level and reintegration points from residential and day treatment to job coaching as well as social opportunities for current or past clients living in the community. Treatment options are individualized for each client through a mix of evidence-based and supportive therapies. An integrated medical, mental and social model includes a variety of services that help clients develop strategies to improve mental health, physical wellness, independence, and social relationships.

With a vision to lead innovative psychiatric treatment in America, today Skyland Trail is a leader in community-based mental health services. Skyland Trail aims to achieve its mission of inspiring people with mental illness to thrive through a holistic program of evidence-based psychiatric treatment, integrated medical care, research, and education.

EVIDENCE-BASED PRACTICE AND ASSESSMENT

Evidence-based practices are clinical guidelines that have been developed to help practitioners and clients make decisions about the appropriate health care treatment option for a specific diagnosis. Clinical practice guidelines are a method utilized by counselors to ensure that treatment is reliable and efficient, with less variability in heath care (Moreira, 2005). The foundations of clinical practice guidelines can be traced to the development of the Agency for Health Care Policy and Research (AHCPR) following the amendment of the Public Health Service Act in 1989. The aim of this agency was to "enhance the quality, appropriateness and effectiveness of heath care service" (IOM, 1990) through research, data development, and other activities. The purpose of clinical practice guidelines is not only to improve the quality and measurement of clinical care but also to help reduce the financial costs of inappropriate, unnecessary, or dangerous care (Institute of Medicine Committee on Clinical Practice Guidelines, 1992).

Consistent scientific evidence has proven the efficacy of the clinical guidelines in improving client outcomes. The main evaluation factors for clinical practice guideline groups when constructing guidelines include the strength of evidence, usability of the guidelines, adequacy of procedures, and political acceptability (Moreira, 2005). The diversity of knowledge of mental health sciences and clinical practice that go into the decision-making process are a reflection of the compositions of the multidisciplinary guideline groups, including general practitioners, client representatives, nurse practitioners, pharmacists, and consultants (Moreira, 2005). Guideline groups work with researchers to determine the 'best fit' of scientific knowledge to the practice recommended in order to agree on appropriate clinical practice. This shows that guidelines are more than just the scientific evidence, but are determined with considerations of efficacy and feasibility of implementation in the real world.

Despite these checks by the guideline development committees, there are still challenges in the implementation of new clinical practice guidelines. Negative perceptions of the practices and reluctance to adopt in an existing system are such barriers to translating research to clinical practice. Provider training may address these issues in motivating counselors to accept and see the value of innovation.

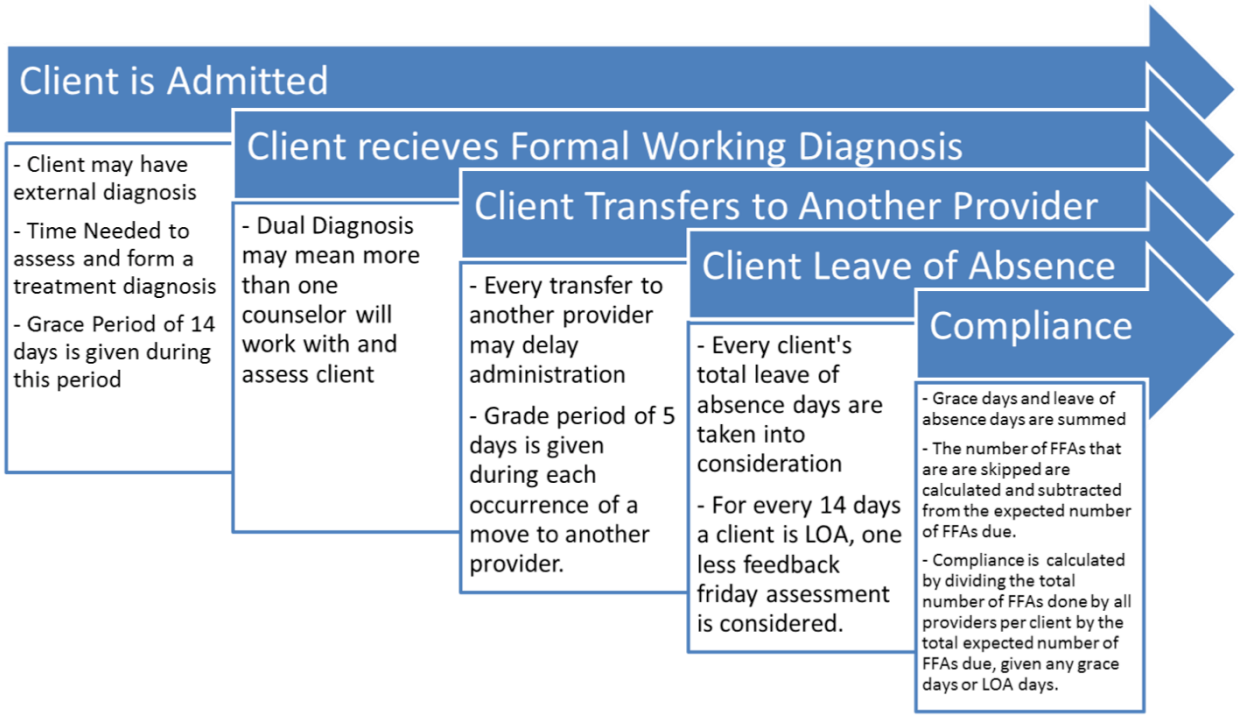
While evidence-based practices and treatment have been established as the gold standard in care, the transferability from research to clinical practice cannot be heralded as

'best practice' if there is no verification of efficacy. Empirical assessment of outcomes is necessary to demonstrate practice-based evidence of efficacy. Evidence-based assessments use research and theory to guide what should be assessed, the methods and measures to be used, and the manner in which the assessment process unfolds to evaluate clinical practice (Hunsley & Mash, 2007). Outcome assessments are beneficial both at an aggregate organizational level and at an individual provider level. At the aggregate organizational level, standardized outcome data may be useful for treatment and program planning, funding decisions, and quality monitoring (Garland et al., 2003). Such evaluations of treatment improve upon care services outcomes can help to. Standardized outcome assessments can help at an individual provider level by enabling counselors to use the collected data to make more consistent professional observations and decisions about treatment planning across clients.

EVALUATION AND ASSESSMENT PROCESS

- Understanding effectiveness of interventions contingent upon using clinically appropriate measures.
- Clinically appropriate outcome measures strengthen evaluation practices.
- Evidence-based practices are needed to ensure improvement in performance and accountability.

FEEDBACK FRIDAY: A SNAPSHOT



THE ASSESSMENTS

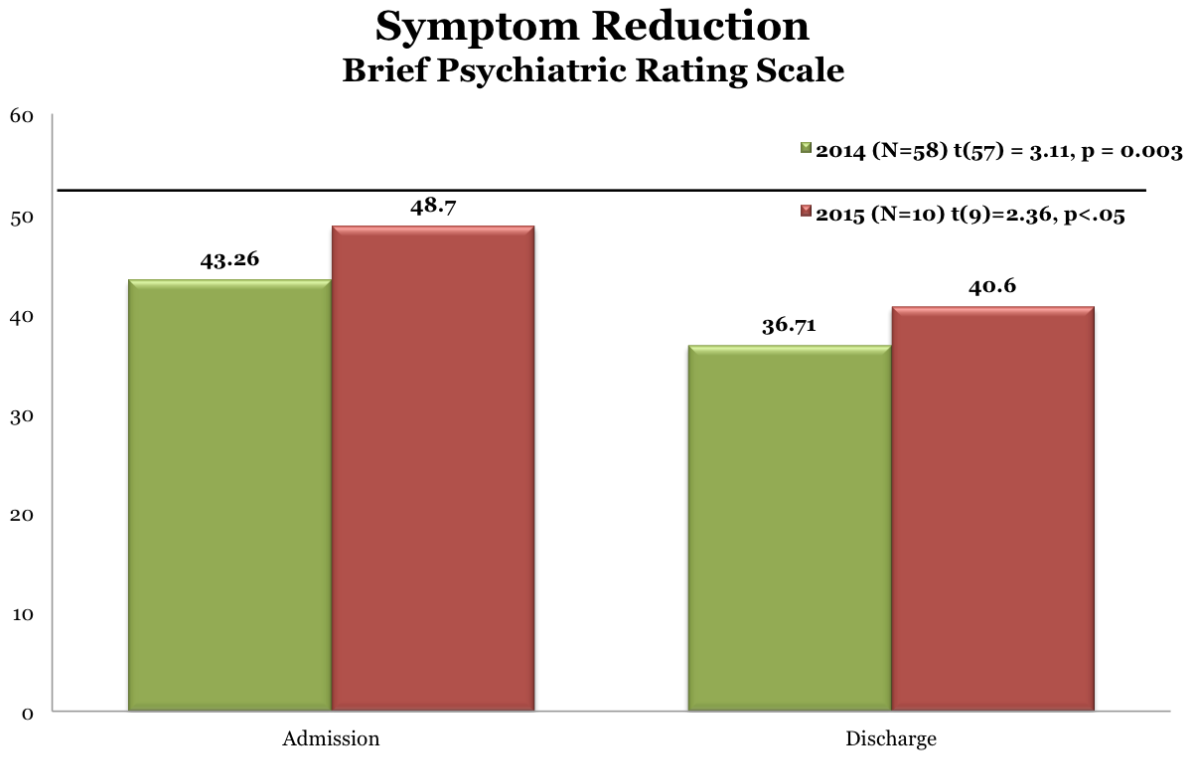
FOR PSYCHOSIS

BRIEF PSYCHIATIC RATING SCALE

The BPRS was developed to provide a short, simple-to-administer instrument of assessing psychopathology and to measure change in clinical treatment of psychiatric clients. This rating scale includes symptoms that assess clients with schizophrenia or other psychotic illnesses. The assessment is administered in a 10 to 40 minute clinical interview with a primary provider, with observations of the client's behavior over the previous two to three days. Each of the areas is rated on a severity scale of 1 as not present, to 7 being extremely severe. The four factor construct of the BPRS, consisting of negative symptoms, positive symptoms, manic-hostility, and anxiety-depression, has been shown to be consistently valid across a broad spectrum of schizophrenia clients and across cultures. The utility of the assessment has also been demonstrated as an effective indicator of improved client outcomes following psychosocial rehabilitation programs. The BPRS is therefore a fitting assessment for Skyland Trail to measure symptom reduction for clients suffering from schizophrenia and other affective, or mood disorders.

Treatment Goal at Skyland Trail is BPRS score < 54

Clinical Assessment Tools			SKYLAND TRAIL *Offering hope, changing lives*
Assessment Tool	*General Indication*	*Administration*	*Description*
Brief Psychiatric Rating scale (BPRS)	Designed to assess psychopathology (including positive, negative, and affective psychopathology) in clients with, or suspected of having, schizophrenia or other psychotic illnesses.	Primary Provider Interview (with observations of the client's behavior over the previous 2–3 days) 15–30 minutes	18 items **Possible Answers** 0 = Not assessed 1 = Not present 2 = Very mild 3 = Mild 4 = Moderate 5 = Moderately severe 6 = Severe 7 = Extremely severe ***Score Range:*** 0 – 126 1 – 18 = Not present 19 – 54 = Remission *(all items at 3 or less)* >55 = Extremely Severe **GOAL IS < 54**



BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Patient Name _____ **Today's Date** _____

Please enter the score for the term that best describes the patient's condition.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

Score	
	1. SOMATIC CONCERN Preoccupation with physical health, fear of physical illness, hypochondriasis.
	2. ANXIETY Worry, fear, over-concern for present or future, uneasiness.
	3. EMOTIONAL WITHDRAWAL Lack of spontaneous interaction, isolation deficiency in relating to others.
	4. CONCEPTUAL DISORGANIZATION Thought processes confused, disconnected, disorganized, disrupted.
	5. GU ILT FEELINGS Self-blame, shame, remorse for past behavior.
	6. TENSION Physical and motor manifestations of nervousness, over-activation.
	7. MANNERISMS AND POSTURING Peculiar, bizarre, unnatural motor behavior (not including tic).
	8. GRANDIOSITY Exaggerated self-opinion, arrogance, conviction of unusual power or abilities.
	9. DEPRESSIVE MOOD Sorrow, sadness, despondency, pessimism.
	10. HOSTILITY Animosity, contempt, belligerence, disdain for others.
	11. SUSPICIOUSNESS Mistrust, belief others harbor malicious or discriminatory intent.
	12. HALLUCINATORY BEHAVIOR Perceptions without normal external stimulus correspondence.
	13. MOTOR RETARDATION Slowed, weakened movements or speech, reduced body tone.
	14. UNCOOPERATIVENESS Resistance, guardedness, rejection of authority.
	15. UNUSUAL THOUGHT CONTENT Unusual, odd, strange, bizarre thought content.
	16. BLUNTED AFFECT Reduced emotional tone, reduction in formal intensity of feelings, flatness.
	17. EXCITEMENT Heightened emotional tone, agitation, increased reactivity.
	18. DISORIENTATION Confusion or lack of proper association for person, place or time

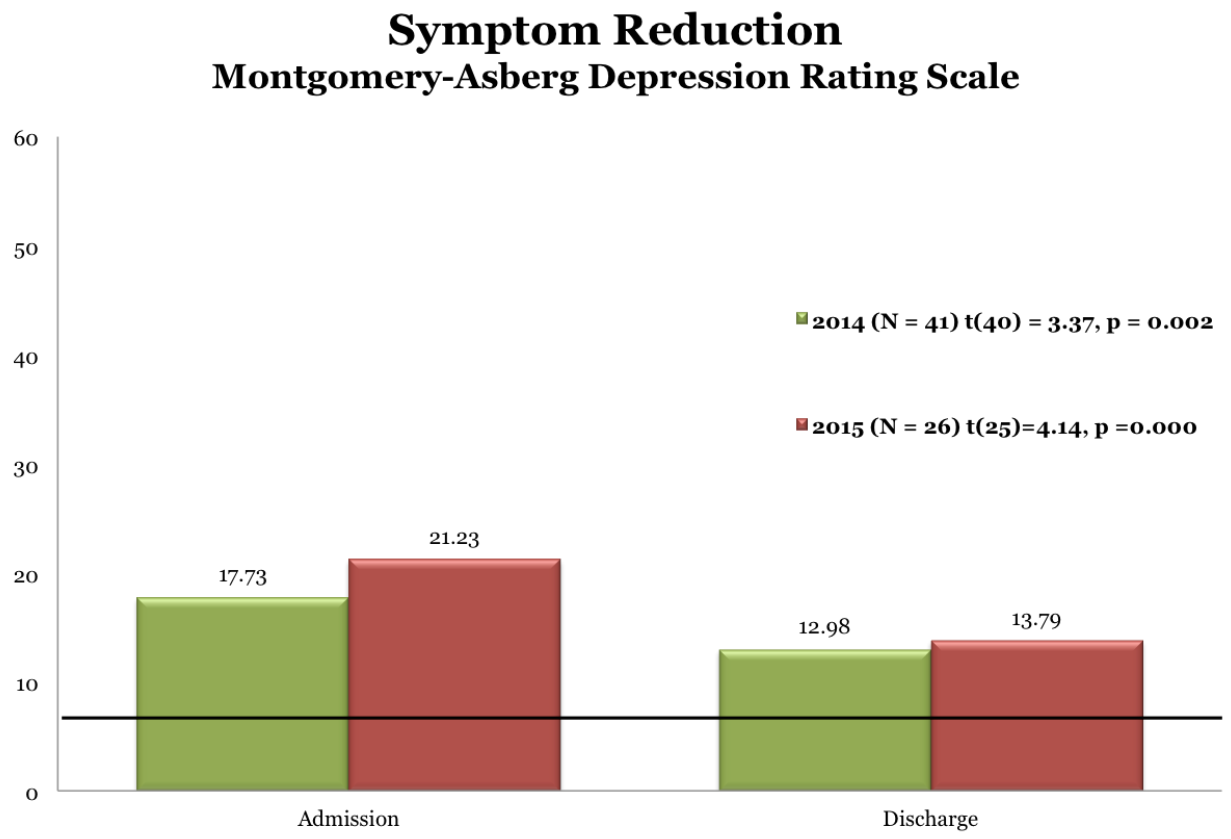
FOR DEPRESSION

MONTGOMERY-ASBERG RATING SCALE

The MADRS was specifically designed to measure the degree of severity of symptoms and to be sensitive to effects of treatment on symptom severity of depression. This assessment has high inter-rater reliability and does not factor in symptoms related to anxiety disorders and has only one item pertaining to sleep disturbance. The MADRS is also the preferred assessment used when evaluating symptom reduction due to psychotropic drugs. The MADRS assessment instrument is administered in a 15-minute interview by a trained provider. The 10-item checklist has cut-off scores to represent gradations of severity from remission to very severe. However conceptual disagreements regarding the specific cutoff points have resulted in the use various thresholds in several antidepressant efficacy trials. 'Remission' is the ultimate goal of treatment efforts, determined by severity of depressive symptoms exhibited by clients at the end of treatment, persistence of symptom resolution and ultimately the client's return to normal levels of functioning. The threshold for remission defined by various antidepressant efficacy trials ranged from a score of 4 to 9 on the MADRS. The goal of treatment is remission, reflecting a complete absence of clinically significant symptoms of depression.

Treatment Goal at Skyland Trail MADRS score < 7 (remission)

Clinical Assessment Tools			SKYLAND TRAIL *Offering hope, changing lives*
Assessment Tool	*General Indication*	*Administration*	*Description*
Montgomery-Åsberg Depression Rating Scale (MADRS)	Designed to be used in clients with major depressive disorder to measure the degree of severity of depressive symptoms, and the change in symptom severity during the treatment of depression.	Primary Provider Interview 15 minutes	10 items **Possible Answers** 0 = No abnormality 2 = Mild abnormality 4 = Moderate abnormality 6 = Severe ***Score Range:*** 0 – 60 0 – 7 = Remission 8 – 15 = Mild 16 – 25 = Moderate 26 – 31 = Severe >32 = Very severe **GOAL IS < 7**



Montgomery-Åsberg Depression Rating Scale (MADRS)

The rating should be based on a clinical interview moving from broadly phrased questions about symptoms to more detailed ones which allow a precise rating of severity. The rater must decide whether the rating lies on the defined scale steps (0, 2, 4, 6) or between them (1, 3, 5) and then report the appropriate number. The items should be rated with regards to how the patient has done over the past week.

1. Apparent sadness

Representing despondency, gloom and despair (more than just ordinary transient low spirits), reflected in speech, facial expression, and posture. Rate by depth and inability to brighten up.

0 = No sadness.
2 = Looks dispirited but does brighten up without difficulty.
4 = Appears sad and unhappy most of the time.
6 = Looks miserable all the time. Extremely despondent

2. Reported sadness

Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or the feeling of being beyond help and without hope.

0 = Occasional sadness in keeping with the circumstances.
2 = Sad or low but brightens up without difficulty.
4 = Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.
6 = Continuous or unvarying sadness, misery or despondency.

3. Inner tension

Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread or anguish. Rate according to intensity, frequency, duration and the extent of reassurance called for.

0 = Placid. Only fleeting inner tension.
2 = Occasional feelings of edginess and ill-defined discomfort.
4 = Continuous feelings of inner tension or intermittent panic which the patient can only master with some difficulty.
6 = Unrelenting dread or anguish. Overwhelming panic.

4. Reduced sleep

Representing the experience of reduced duration or depth of sleep compared to the subject's own normal pattern when well.

0 = Sleeps as normal.
2 = Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep.
4 = Moderate stiffness and resistance
6 = Sleep reduced or broken by at least 2 hours.

5. Reduced appetite

Representing the feeling of a loss of appetite compared with when-well. Rate by loss of desire for food or the need to force oneself to eat.

0 = Normal or increased appetite.
2 = Slightly reduced appetite.
4 = No appetite. Food is tasteless.
6 = Needs persuasion to eat at all.

6. Concentration difficulties

Representing difficulties in collecting one's thoughts mounting to an incapacitating lack of concentration. Rate according to intensity, frequency, and degree of incapacity produced.

0 = No difficulties in concentrating.
2 = Occasional difficulties in collecting one's thoughts.
4 = Difficulties in concentrating and sustaining thought which reduced ability to read or hold a conversation.
6 = Unable to read or converse without great difficulty.

7. Lassitude

Representing difficulty in getting started or slowness in initiating and performing everyday activities.

0 = Hardly any difficulty in getting started. No sluggishness.
2 = Difficulties in starting activities.
4 = Difficulties in starting simple routine activities which are carried out with effort.
6 = Complete lassitude. Unable to do anything without help.

8. Inability to feel

Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.

0 = Normal interest in the surroundings and in other people.
2 = Reduced ability to enjoy usual interests.
4 = Loss of interest in the surroundings. Loss of feelings for friends and acquaintances.
6 = The experience of being emotionally paralysed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends.

9. Pessimistic thoughts

Representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse and ruin.

0 = No pessimistic thoughts.
2 = Fluctuating ideas of failure, self-reproach or self- depreciation.
4 = Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future.
6 = Delusions of ruin, remorse or irredeemable sin. Self- accusations which are absurd and unshakable.

10. Suicidal thoughts

Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and preparations for suicide. Suicide attempts should not in themselves influence the rating.

0 = Enjoys life or takes it as it comes.
2 = Weary of life. Only fleeting suicidal thoughts.
4 = Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intenstion.
6 = Explicit plans for suicide when there is an opportunity. Active preparations for suicide.

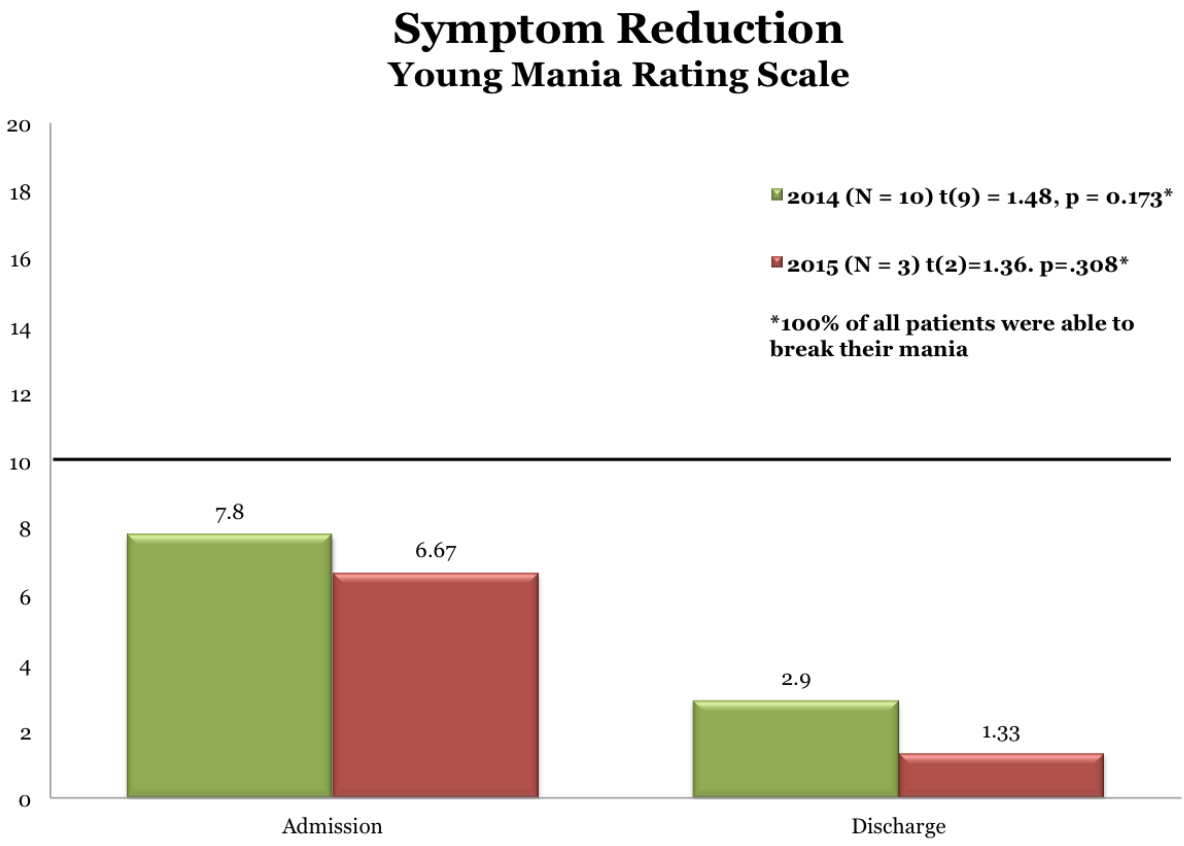
FOR MANIA

YOUNG MANIA RATING SCALE

The Young Mania Rating Scale (YMRS) was developed to address the lack of adequate mania-rating assessments. There were instruments to measure the severity of depression but treatment studies of mania often relied on a combination of a global rating and another scale that assessed psychotic disorders, such as the Brief Psychiatric Rating Scale. The YMRS was therefore designed to assess the symptoms of mania, severity of those symptoms, and any changes due to treatment. The 11-item assessment is based on symptoms of the manic state of bipolar disorder and is administered through a provider interview as with the BPRS and MADRS. It is important to note that only manic symptoms are assessed by the YMRS and that there are no items measuring depression. However, the MADRS and YMRS are administered in tandem as mania is a finite illness and clients often revert from mania to depression. The total score ranges from 0 to 60 in which the severity ratings of each of the 11 items is based on the client's subjective report of symptoms within the past 48 hours and the provider's observations of the client during the interview. When administered by a trained clinical rater, the YMRS has demonstrated high inter-rater reliability. The validity and sensitivity to change in clients receiving treatment for mania has been successfully established for the YMRS in studies illustrating the efficacy of the instrument in assessing changes due to therapeutic treatment of mania. Higher scores are indicative of more severe episodes with greater levels of psychosis and longer recovery time.

Treatment Goal at Skyland Trail is YMRS score < 10

Clinical Assessment Tools			SKYLAND TRAIL *Offering hope, changing lives*
Assessment Tool	*General Indication*	*Administration*	*Description*
Young Mania Rating Scale (YMRS)	Designed to assess manic symptoms, assess severity of symptoms for mania, and response to therapeutic interventions over time.	Primary Provider Interview 15–30 minutes	11 items 4 items scored 0-8 (Question: 5, 6, 8, 9) 8 items scored 0-4 (Question: 1-4, 7, 10, 11) ***Score Range:*** Total score between 0 – 60 >14 = manic/clinically meaningful episodes Higher scores indicative of more severe episodes, assoc. with greater levels of psychosis and longer recovery time. **GOAL IS < 10**



Young Mania Rating Scale (YMRS)

Guide for Scoring Items – The purpose of each item is to rate the severity of that abnormality in the patient. When several keys are given for a particular grade of severity, the presence of only one is required to qualify for that rating.

The keys provided are guides. One can ignore the keys if that is necessary to indicate severity, although this should be the exception rather than the rule.

Scoring between the points given (whole or half points) is possible and encouraged after experience with the scale is acquired. This is particularly useful when severity of a particular item in a patient does not follow the progression indicated by the keys.

1. *Elevated Mood*
   - 0 Absent
   - 1 Mildly or possibly increased on questioning
   - 2 Definite subjective elevation; optimistic, self-confident; cheerful; appropriate to content
   - 3 Elevated, inappropriate to content; humorous
   - 4 Euphoric; inappropriate to content; singing

2. *Increased Motor Activity – Energy*
   - 0 Absent
   - 1 Subjectively increased
   - 2 Animated; gestures increased
   - 3 Excessive energy; hyperactive at times; restless (can be calmed)
   - 4 Motor excitement; continuous hyperactivity (cannot be calmed)

3. *Sexual Interest*
   - 0 Normal; not increased
   - 1 Mildly or possibly increased
   - 2 Definitive subjective increase on questioning
   - 3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
   - 4 Overt sexual acts (towards patients, staff, or interviewer)

4. *Sleep*
   - 0 Reports no decrease in sleep
   - 1 Sleeping less than normal amount by up to one hour
   - 2 Sleeping less than normal by more than one hour
   - 3 Reports decreased need for sleep
   - 4 Denies need for sleep

5. *Irritability*
   - 0 Absent
   - 2 Subjectively increased
   - 4 Irritable at times during interview; recent episodes of anger or annoyance on ward
   - 6 Frequently irritable during interview; short, curt throughout
   - 8 Hostile, uncooperative; interview impossible

6. *Speech (Rate and Amount)*
   - 0 No increase
   - 2 Feels talkative
   - 4 Increased rate or amount at times, verbose at times
   - 6 Push; consistently increased rate and amount; difficult to interrupt
   - 8 Pressured; uninterruptible, continuous speech

7. *Language – Thought Disorder*
   - 0 Absent
   - 1 Circumstantial; mild distractibility; quick thoughts
   - 2 Distractible; loses goal of thought; changes topics frequently; racing thoughts
   - 3 Flight of ideas; tangentiality; difficult to follow; rhyming; echolalia
   - 4 Incoherent; communication impossible

8. *Content*
   - 0 Normal
   - 2 Questionable plans, new interests
   - 4 Special project(s); hyperreligious
   - 6 Grandiose or paranoid ideas; ideas of reference
   - 8 Delusions; hallucinations

9. *Disruptive – Aggressive Behavior*
   - 0 Absent; cooperative
   - 2 Sarcastic; loud at times; guarded
   - 4 Demanding; threats on ward
   - 6 Threatens interviewer; shouting; interview difficult
   - 8 Assaultive; destructive; interview impossible

10. *Appearance*
    - 0 Appropriate dress and grooming
    - 1 Minimally unkempt
    - 2 Poorly groomed; moderately disheveled; overdressed
    - 3 Disheveled; partly clothed; garish makeup
    - 4 Completely unkempt; decorated; bizarre garb

11. *Insight*
    - 0 Present; admits illness; agrees with need for treatment
    - 1 Possibly ill
    - 2 Admits behavior change, but denies illness
    - 3 Admits possible change in behavior, but denies illness
    - 4 Denies any behavior changes

Name: _____

Rater: _____

Date: _____

Score: _____

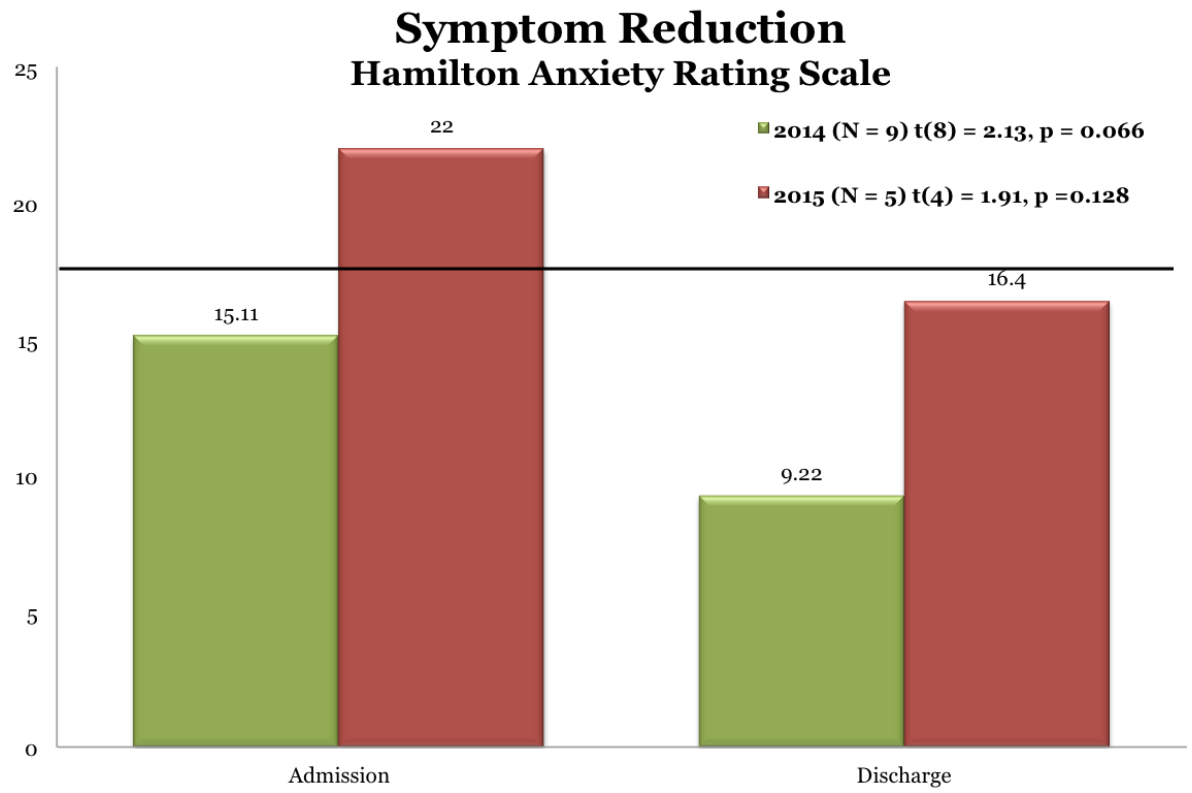
FOR ANXIETY

HAMILTON ANXIETY RATING SCALE

The Hamilton Anxiety Rating Scale (HAM-A) was developed to fill the gap in available scales measuring the reduction in severity of anxiety symptoms and changes due to therapeutic treatment. The HAM-A is intended for clients who have been diagnosed with neurotic anxiety states. However, it may only be used to assess neurotic anxiety states and not for assessing anxiety in clients diagnosed with other disorders that may show symptoms of anxiety. The assessment also focuses largely on somatic symptoms. The HAM-A is administered in a one-on-one interview with a primary counselor. It is a simple-to-use assessment scale that takes 10 to 15 minutes to complete. Each of the 14 items is scored with a five-point scale from not present (0) to very severe (4), yielding a total denomination of 56 with higher scores indicating increasing anxiety. The validity and reliability of the HAM-A has been demonstrated in many clinical studies measuring clinically significant levels of anxiety and is therefore the most widely used scale in studies of anxiety and treatment outcomes. Structured interview guides have also been developed to increase inter-rater reliability of this assessment tool. These guides allow the scale to be administered in settings where extensive training is difficult or not possible. Trainings and guided assessments provide knowledge and a particular emphasis on the disorders being measured. It is necessary for counselors and other care administrators to be cognizant of the fact that results of an investigation may be very different if different assessment scales are used. The HAM-A has therefore been designated at Skyland Trail as the assessment for anxiety.

Treatment Goal at Skyland Trail is HAM-A score < 17

Clinical Assessment Tools			SKYLAND TRAIL *Offering hope, changing lives*
Assessment Tool	*General Indication*	*Administration*	*Description*
Hamilton Anxiety Rating Scale (HAM-A)	Designed to quantify the severity of anxiety symptoms and to assess the response to therapeutic interventions.	Primary Provider Interview 10–15 minutes	14 items **Possible Answers** 0 = Not present 1 = Mild 2 = Moderate 3 = Severe 4 = Very Severe ***Score Range:*** 0 – 56 0 – 17 = Mild severity 18 – 21 = Mild to moderate severity 25 – 30 = Moderate to severe >30 = Extremely severe **GOAL IS < 17**



Patient Name:_____ Date:_____

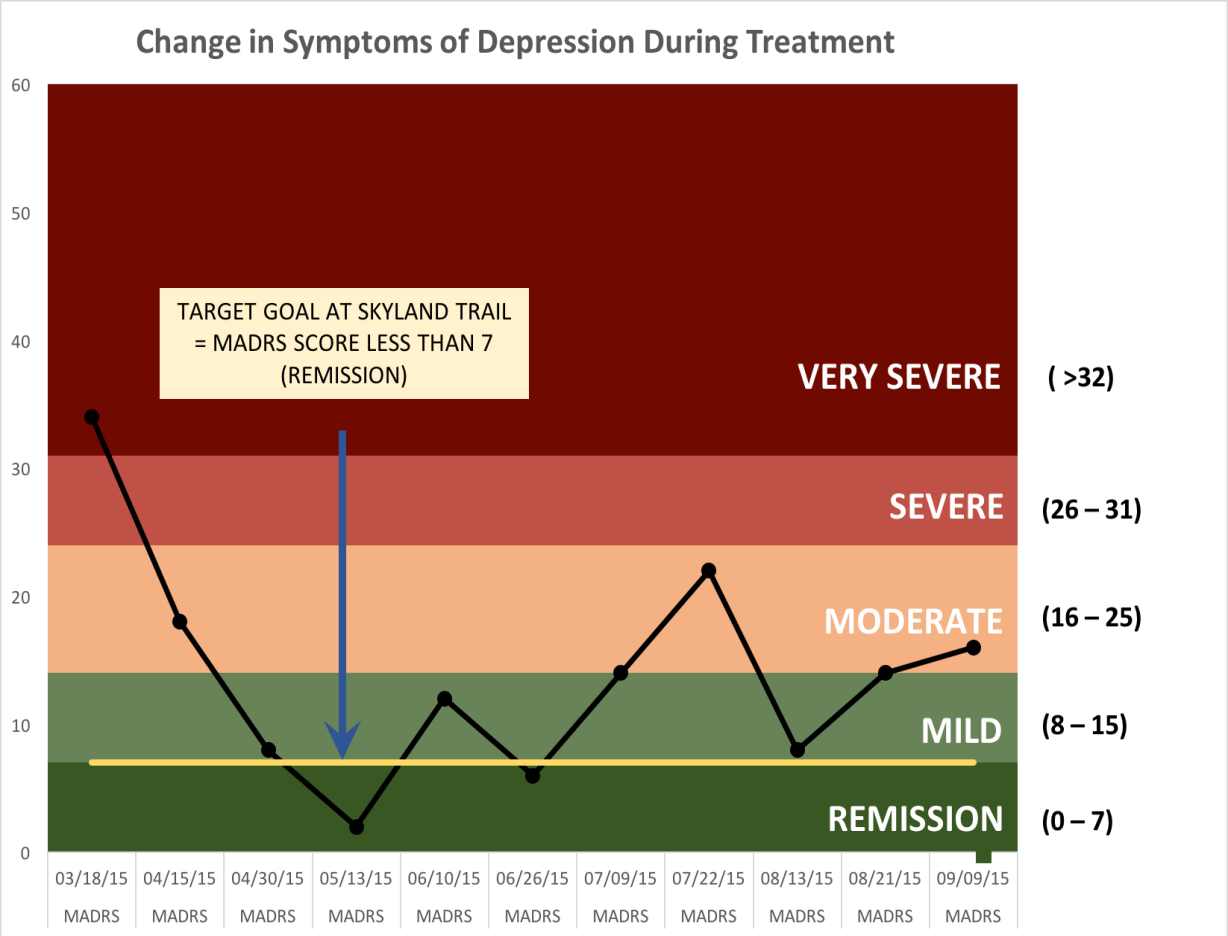
Hamilton Rating Scale for Anxiety

Instructions: This checklist is to assist the physician or psychiatrist in evaluating each patient as to the degree of anxiety and pathological condition. Please fill in the appropriate rating:

NONE = 0 MILD = 1 MODERATE = 2 SEVERE = 3 SEVERE, GROSSLY DISABLING = 4

Item			Rating
1.	Anxious	Worries, anticipation of the worst, fearful anticipation, irritability	_____
2.	Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax	_____
3.	Fears	Of dark, of strangers, of being left alone, of animals, of traffic, of crowds	_____
4.	Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night-terrors	_____
5.	Intellectual (cognitive)	Difficulty in concentration, poor memory	_____
6.	Depressed Mood	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing	_____
7.	Somatic (muscular)	Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone	_____
8.	Somatic (sensory)	Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation	_____
9.	Cardiovascular Symptoms	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat	_____
10.	Respiratory Symptoms	Pressure or constriction in chest, choking feelings, sighing, dyspnea	_____
11.	Gastrointestinal Symptoms	Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation	_____
12.	Genitourinary Symptoms	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence	_____
13.	Autonomic Symptoms	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair	_____
14.	Behavior at Interview	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos	_____
		TOTAL	_____

SAMPLE ASSESSMENT OUTCOMES GRAPH



Appendix 3: Diagnosis-Specific Assessments Training for Counselors

Feedback Fridays:
Diagnosis-Specific Assessments

25

What are Feedback Fridays?

- The utilization of diagnosis-specific assessments to measure efficacy of treatment strategies and recovery modalities at Skyland Trail

- *"To really qualify as an evidence-based program, organizations and physicians must intentionally build a commitment to evidence-based treatment [...]constantly reviewing new data and outcomes"* –CMO Ray Kotwicki, MD, MPH

25

What is the point of assessment?

- Assessment of outcomes is necessary to demonstrate practice-based evidence of efficacy
- Evidence-based assessments use research and theory to guide what should be assessed, the methods and measures to be used, and the manner in which the assessment process unfolds to evaluate clinical practice

How does it help Skyland Trail?

- treatment and program planning
- funding decisions
- quality monitoring

Improve care services

How does it help me?

- Use the collected data to make more informed and accurate judgments and decisions about treatment planning
- provide clients with regular reports of their progress from an *objective perspective*
- How can this be used in treatment?
  - ❖ Individual sessions
  - ❖ Treatment team
  - ❖ Supervision when approving passes and level changes
  - ❖ Reference of "new" clients

25

Evaluation and Assessment Process

- Understanding effectiveness of interventions contingent upon using clinically appropriate measures.
- Clinically appropriate outcome measures strengthen evaluation practices.
- Evidence-based practices are needed to ensure improvement in performance and accountability.

25

Assessments Used at Skyland Trail

- Brief Psychiatric Rating Scale (BPRS)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- Young Mania Rating Scale (YMRS)
- Hamilton Anxiety Rating Scale (HAM-A)

❖ Represent gold standard measures
❖ Tested for validity and reliability
❖ 15 minutes or less to complete

What are Feedback Fridays?

- The utilization of diagnosis-specific assessments to measure efficacy of treatment strategies and recovery modalities at Skyland Trail
- Provides real-time feedback to treatment team, case managers and patients.
  - All assessments are available in Profiler for completion and will automatically scored upon completion
- To explain our evidence based treatment outcomes to the Skyland Trail staff, community and external stakeholders.
- Scores collected between baseline measure at admission and the final measure at discharge are important to explaining why the clients scores improved, stayed the same, or declined.
- Measures previously occurred on a bi-weekly basis
- Integral part of treatment planning from admission to discharge

Procedure

- Once diagnosis is confirmed at admission, staff should begin using the appropriate assessment
- Assessments should be completed in Profiler but paper versions will also be available
  - If paper versions are used, must transfer to Profiler immediately (or as soon as possible) after completion
- Staff will receive a "report card" to present to clients with "feedback" based on each assessment period

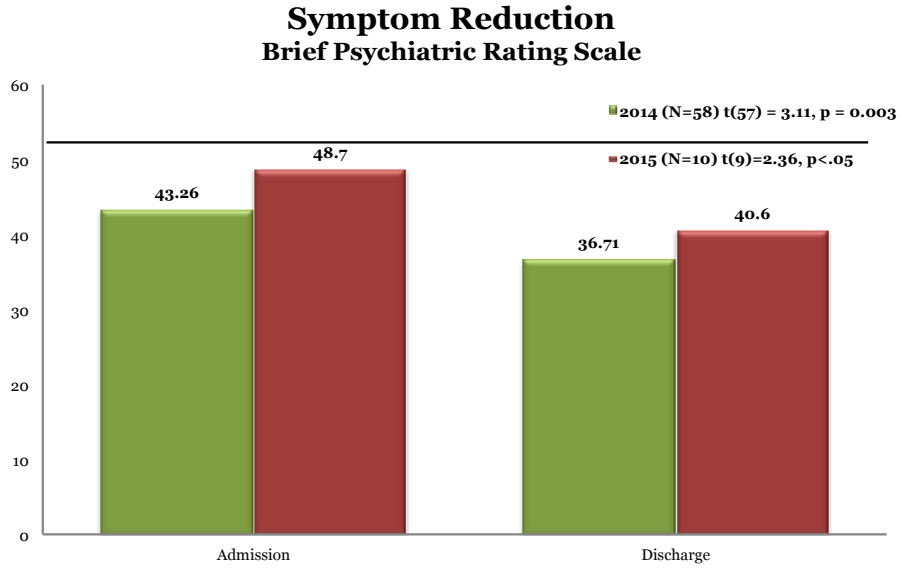
Diagnosis-Specific Assessments - BPRS

For Schizophrenia or Schizoaffective Disorder

- 24 question PC interview, used to rate patient behaviors and symptoms (during specific time frame) according to the following criteria:
  Is symptom present?
  Frequency?
  Degree of impairment?
- Do not compare the client to others with the same diagnosis
- Questions are provided to allow probing for answers
- A total pathology score can be obtained by adding each of the items.
- Sub-scores can also be derived by adding scores on specific items together.
- Can also select a symptom(s) of interest, obtain a baseline and reassess later for changes.
- **Possible Answers**
  0 = Not assessed
  1 = Not present
  2 = Very mild
  3 = Mild
  4 = Moderate
  5 = Moderately Severe
  6 = Severe
  7 = Extremely Severe
- ***Score Range:*** 0 – 126
  1 – 18 = Not present
  19 – 54 = Remission *(all items at 3 or less)*
  >55 = Extremely Severe
- Rating clients on basis of PC's observation, clients' self-report, and information from collateral sources.
- **If unsure of particular rating, always rate 'up'**
- **Goal**
  - **Client Scores indicate clinical remission**
  - **Statistically significant improvement**

Diagnosis-Specific Assessments - BPRS

For Schizophrenia or Schizoaffective Disorder



Diagnosis-Specific Assessments - MADRS

For Major Depression

- 10 items, PC interview
- designed to be sensitive to effects of anti-depressant medications; disorder to measure the degree of severity of depressive symptoms, and the change in symptom severity during the treatment of depression.

Possible Answers
0 = No abnormality
2 = Mild abnormality
4 = Moderate abnormality
6 = Severe

- **If unsure of particular rating, always rate 'up'**

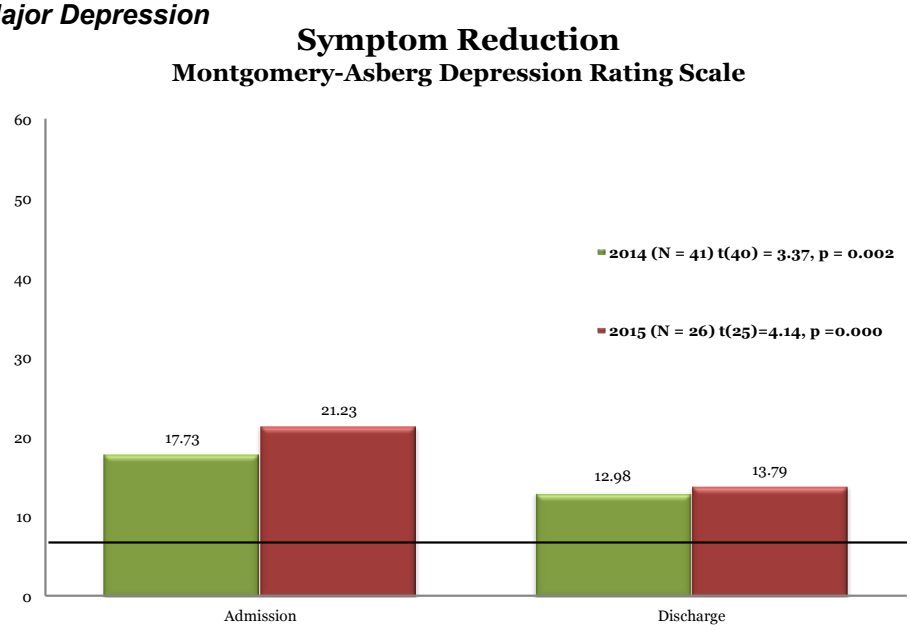
Score Range: 0 – 60

0 – 7 = Remission
8 – 15 = Mild
16 – 25 = Moderate
26 – 31 = Severe
>32 = Very severe

- **GOAL**
  - **<7 Clinical Remission**
  - **Statistically significant improvement**

Diagnosis-Specific Assessments

For Major Depression



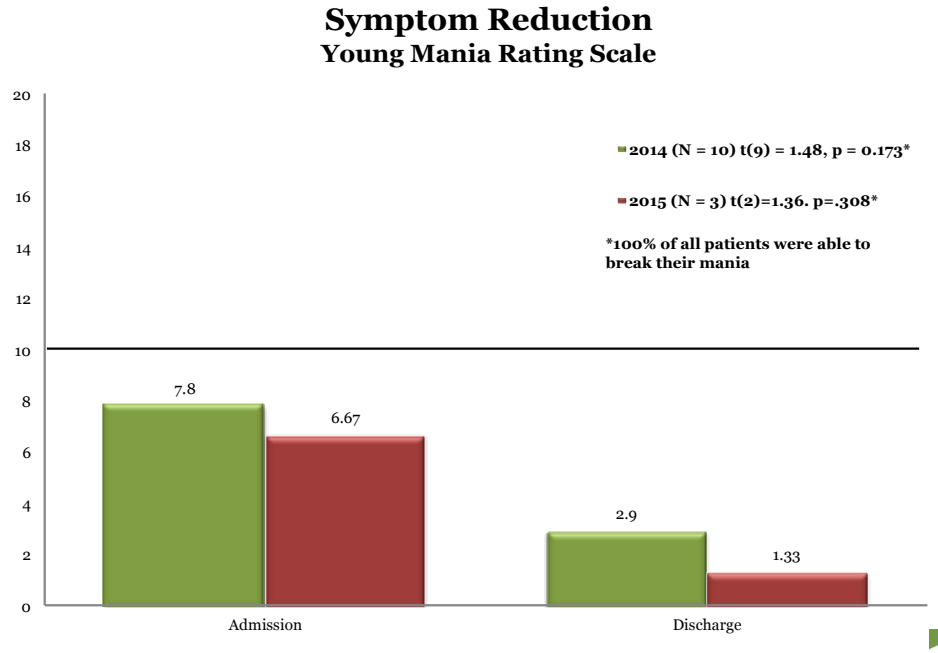
Diagnosis-Specific Assessments - YMRS

For Bipolar Disorder

- Gold Standard for assessing manic symptoms.
- 11 item PC interview
  4 items scored 0-8
  (Irritability, speech, thought content, disruptive/aggressive behavior)
  7 items scored 0-4
- **Score Range: 0-60**
- from the patient's subjective reported symptoms over the previous 48 hours and from clinical observation during the interview
- YMRS does not assess associated depressive symptoms that can follow a manic episode and should be administered in conjunction with a depression rating scale (MADRS). This is also the case when a patient is experiencing a mixed episode: meeting the diagnostic criteria for both a manic episode as well as a major depressive episode nearly every day for at least a full week.
- **Goal**
  - **Clinical Improvement to YMRS ≤10**
  - **Statistically Significant Improvement**

Diagnosis-Specific Assessments - YMRS

For Bipolar Disorder



Diagnosis-Specific Assessments – HAM-A

For Anxiety Disorder

Designed to quantify the severity of anxiety symptoms and to assess the response to therapeutic interventions.

- 14 item PC interview
  - 7 items address psychic anxiety
  - 7 items address somatic anxiety

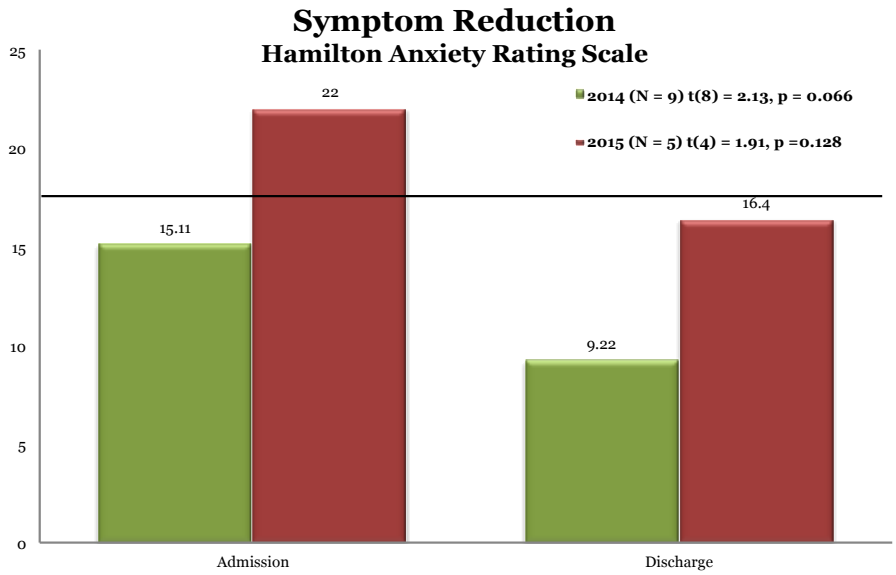
Possible Answers
0 = Not present
1 = Mild
2 = Moderate
3 = Severe
4 = Very Severe

Score Range: 0-56
- <17 – mild severity
- 18-24 – mild to moderate severity
- 25-30 – moderate to severe
- Over 30 – extremely severe

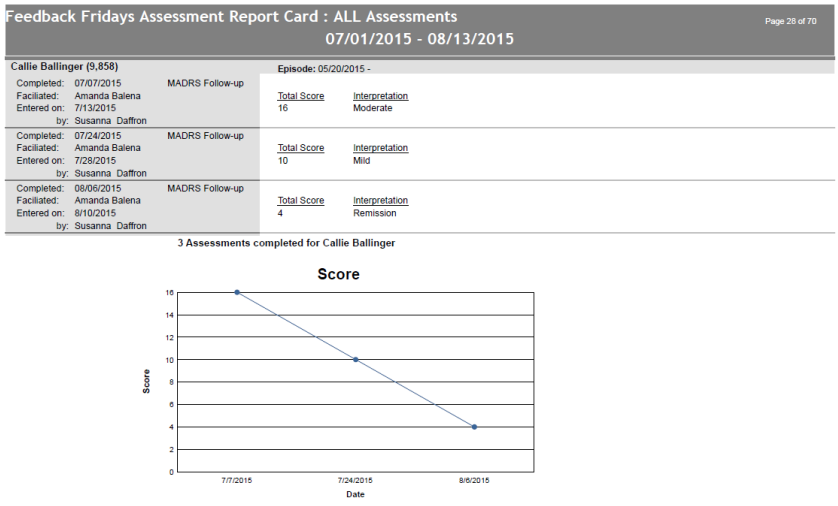
GOAL
- **Clinical Improvement <17**
- **Statistically significant improvement**

Diagnosis-Specific Assessments

For Anxiety Disorder



PCs need the Feedback in Feedback Friday



Feedback Fridays Assessment Report Card : ALL Assessments
07/01/2015 - 08/13/2015
Page 28 of 70

Callie Ballinger (9,858) — **Episode:** 05/20/2015 -

Completed: 07/07/2015 Facilitated: Amanda Balena Entered on: 7/13/2015 by: Susanna Daffron	MADRS Follow-up	Total Score 16	Interpretation Moderate
Completed: 07/24/2015 Facilitated: Amanda Balena Entered on: 7/28/2015 by: Susanna Daffron	MADRS Follow-up	Total Score 10	Interpretation Mild
Completed: 08/06/2015 Facilitated: Amanda Balena Entered on: 8/10/2015 by: Susanna Daffron	MADRS Follow-up	Total Score 4	Interpretation Remission

3 Assessments completed for Callie Ballinger

Score

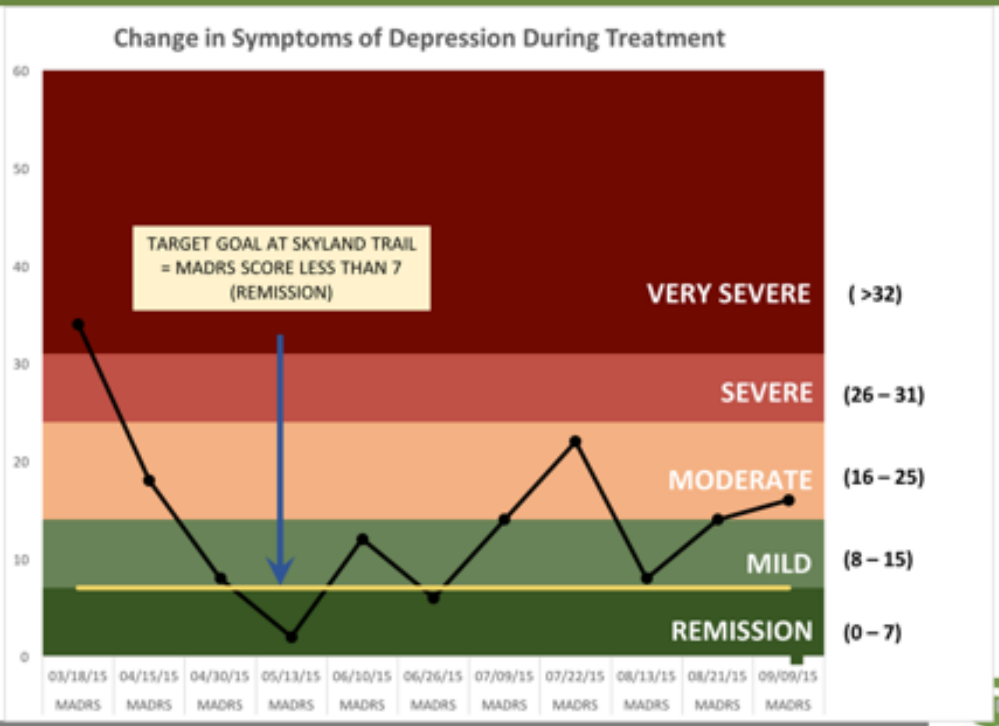
SKYLAND TRAIL
Offering hope, changing lives

Prepared By: Alexandra Balzer

Database: UniCare
Version: 08/17/2012

Printed on: August 13, 2015
11:43:17 AM

Useful Feedback



Snapshot of Feedback Fridays

Client is Admitted

- Client may have external diagnosis
- Time Needed to assess and form a treatment diagnosis
- Grace Period of 14 days is given during this period

Client recieves Formal Working Diagnosis

- Dual Diagnosis may mean more than one counselor will work with and assess client

Client Transfers to Another Provider

- Every transfer to another provider may delay administration
- Grade period of 5 days is given during each occurrence of a move to another provider.

Client Leave of Absence

- Every client's total leave of absence days are taken into consideration
- For every 14 days a client is LOA, one less feedback friday assessment is considered.

Compliance

- Grace days and leave of absence days are summed
- The number of FFAs that are are skipped are calculated and subtracted from the expected number of FFAs due.
- Compliance is calculated by dividing the total number of FFAs done by all providers per client by the total expected number of FFAs due, given any grace days or LOA days.

Compliance for Completing Assessments

- Compliance Rates Since January 2016 83%, 42%, 93%
- What are the challenges to Compliance?
- Communication
  - knowing it needs to be done
  - Knowing when to do it
- Education
  - Process for completing assessment
  - Scoring assessment
  - Using assessment in treatment
  - Training Module for future user training and references for current users