Strengths and Outcome for Youth Receiving Acute Care Inpatient Mental Health Services

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INTRODUCTION

- Current models of inpatient psychiatric & mental health service focus on risk reduction & symptom stabilization within a brief length of stay
- Growing concern about emphasis on impairment and limits related to psychiatric illness, rather than emphasis on strengths and personal assets
- Goal is to develop a strengths-based model of care that balances individual vulnerabilities and strengths

INTRODUCTION

- Paucity of research using standardized assessments of strengths for children & adolescents with psychiatric illness
- Individual, family, & social support factors are associated with resiliency in at-risk groups of youth
  - Individual: youth’s temperament, intelligence, social competence
  - Family: warmth, cohesion, caring adult
  - Social support: school, religious involvement, community agency
- Strengths can vary as a function of age and developmental stage

INTRODUCTION

- No published studies describing strengths for youth receiving acute care inpatient psychiatric services
- Lyons, Uziel-Miller, Reyes, & Sokol (2000)
  - 450 youth (5 – 19 years) in residential facilities in Florida
  - Child & Adolescent Strengths Assessment (CASA)
    - 50 items on 6 dimensions: family, school/vocational, psychological, peer, moral/spiritual, extracurricular
    - Most commons strengths were: sense of humour (37%), ability to enjoy positive experiences (32%), & strong sibling relationship (23%)
    - Higher levels of strengths associated with less severe psychopathology and greater improvement in level of risk

OBJECTIVES

- Pilot study
- To assess the prevalence of strengths in a pediatric inpatient population receiving acute care services
- To explore the relationship between strengths and change in acuity of risk over the course of admission (i.e., outcome)
- To explore age differences in strengths between children and adolescents
METHOD
Participants
- Total N = 132 youth
  - admitted to 6 East between July 2002 and September 2003
  - CANS data available
- 22 children ages 6 to 12 (M=10.4 yrs, SD=2.0)
- 110 adolescents ages 13 to 17 (M=15.2 yrs, SD=1.3)
- No differences in gender distribution, length of stay or purpose of admission (e.g., emergency vs. planned admissions)
- Adolescents more likely to be admitted with a mood disorder (46% vs. 18%)

METHOD
Procedure
- Routine collection of clinical data at admission
  - Youth: YSR, CDI, MASC-10
  - Parent/Caregiver: CBCL
  - Staff: CANS-MH, CAPI, background history, demographics
- Use of clinical information throughout admission for assessment and treatment planning
- Written informed consent for use of clinical information for program evaluation
- Collection of outcome data at discharge
  - Youth: CDI, MASC-10 (if length of stay 14 days or more)
  - Staff: CAPI, treatment plan

CHILD & ADOLESCENT NEEDS AND STRENGTHS (LYONS, 1999)
- Structured assessment of youth's strengths and needs for use in managing and planning individualized mental health services
- Assesses stable characteristics along clinically relevant dimensions
- Case descriptor & decision-support tool
- Good reliability and validity
- Ratings based on 30-day period prior to admission
- Completed by psychiatrist, psychologist, SW, or OT

CHILD & ADOLESCENT NEEDS AND STRENGTHS (LYONS, 1999) cont’d
- 42 items
  - 0 (no evidence) to 3 (severe) rating
  - Problem Presentation (i.e., symptoms)
  - Risk Behaviours
  - Functioning
  - Care Intensity & Organization
  - Family/Caregiver Needs and Strengths
  - Strengths
    - 0 or 1 rating = strength is present
    - 2 rating = potential for strength
    - 3 rating = no evidence of a strength
    - U rating = information is not available

RE-ORGANIZATION OF CANS-MH STRENGTH ITEMS
- Individual
  - Interpersonal skills
  - Well-being
  - Talents / Interests
- Family
  - Family
  - Relationship stability
- Social
  - Educational system
  - Religious / Spiritual
  - Inclusion in community

CHILDHOOD ACUITY OF PSYCHIATRIC ILLNESS SCALE (LYONS, 1998)
- Specifically designed to measure outcome for children and youth who receive mental health services
- Reliable and valid
- Sensitive to short term change (24-hour period)
- Clinical uses for key workers
  - assess risk and needs of each patient
  - helps in decision making (e.g., passes, discharge)
  - helps advocate for each patient
- Monitors quality of care
- Facilitates communication by whole team by providing a common language

Presented at the 17th Annual RTC Conference, Tampa FL, 2/29 – 3/3 2004. For more information, contact Stephanie Greenham: greenham@cheo.on.ca
CAPI cont’d

- Completed by case coordinator or front-line staff
- 20 items
- Total Acuity score
- Subscales: Risk Behaviours, Symptoms, Functioning, Systems Support

FREQUENCY OF CANS-MH STRENGTHS

<table>
<thead>
<tr>
<th>CANS-MH Items</th>
<th>Strength</th>
<th>Potential Strength</th>
<th>No Evidence</th>
<th>Strength</th>
<th>Potential Strength</th>
<th>No Evidence</th>
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<tbody>
<tr>
<td>Individual</td>
<td>41</td>
<td>48</td>
<td>14</td>
<td>58</td>
<td>36</td>
<td>8</td>
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<tr>
<td>Interpersonal</td>
<td>14</td>
<td>68</td>
<td>18</td>
<td>14</td>
<td>72</td>
<td>17</td>
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<tr>
<td>Total Acuity</td>
<td>46</td>
<td>32</td>
<td>23</td>
<td>62</td>
<td>26</td>
<td>13</td>
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</table>

Support

<table>
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<tr>
<th>No Problem</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td>No problem</td>
<td>Flag</td>
<td>Needs action</td>
<td>Immediate action</td>
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</table>

MEAN RATINGS ON CANS-MH STRENGTHS ITEMS

<table>
<thead>
<tr>
<th>Item</th>
<th>Children (n = 19)</th>
<th>Mean</th>
<th>SD</th>
<th>Adolescents (n = 106)</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Individual Strengths</td>
<td></td>
<td>1.8</td>
<td>.6</td>
<td></td>
<td>1.3</td>
<td>.9</td>
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<tr>
<td>Family Strengths</td>
<td></td>
<td>1.2</td>
<td>.3</td>
<td></td>
<td>1.3</td>
<td>.9</td>
</tr>
<tr>
<td>Social Strengths</td>
<td></td>
<td>2.0</td>
<td>.7</td>
<td></td>
<td>1.9</td>
<td>.8</td>
</tr>
</tbody>
</table>

Note: MANOVA was not significant. The lower the mean, the greater evidence of Strengths.

PRESENTED AT THE 17TH ANNUAL RTC CONFERENCE, TAMPA FL, 2/29 – 3/3 2004. FOR MORE INFORMATION, CONTACT STEPHANIE GREENHAM: greenham@cheo.on.ca

CORRELATIONS BETWEEN CANS-MH & ACUITY (ALL YOUTH WITH ADM & D/C ACUITY DATA)

<table>
<thead>
<tr>
<th>CANS-MH Items</th>
<th>Individual</th>
<th>Interpersonal</th>
<th>Well-being</th>
<th>Talents/Interests</th>
<th>Family</th>
<th>Relationship</th>
<th>Permanence</th>
<th>Social Support</th>
<th>Educational</th>
<th>Spiritual/Religious</th>
<th>Inclusion</th>
<th>Change in Acuity</th>
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<tbody>
<tr>
<td>Items Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
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<td>.3</td>
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<td>.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Well-being</td>
<td>2.0</td>
<td>.7</td>
<td>1.9</td>
<td>2.0</td>
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<td>1.9</td>
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<td>2.0</td>
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<td>1.9</td>
<td>.7</td>
<td>2.0</td>
</tr>
</tbody>
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Note: MANOVA was not significant. The lower the mean, the greater evidence of Strengths.

* p < .05  ** p < .01
CONCLUSIONS

- CANS-MH a useful tool for identifying a wide range of strengths and potential strengths for children and adolescents receiving acute inpatient services
- Individual, family and social support factors were equally prevalent
- Subtle differences were observed in the profiles of strengths between children and adolescents
- Importance of:
  1) an individualized approach for service delivery
  2) developmental perspective
  - Interpersonal skills, spiritual/religious, & talents/interests more prevalent for adolescents
  - Interpersonal skills were related to greater improvement during admission, and this should be further explored as a component of intervention (e.g., addition of social skills group to programming)

Both existing and potential strengths need to be incorporated into individualized treatment planning (e.g., well-being)

- On a systems level, the identification of strengths and areas of potential strength contribute to the development of strength-based models of care in keeping with the philosophy of care
- Longer-term follow-up data are important to address whether strengths observed during hospitalization represent protective factors for improved mental health
- Goal is to have a common philosophy within the System of Care

Questions/Comments

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