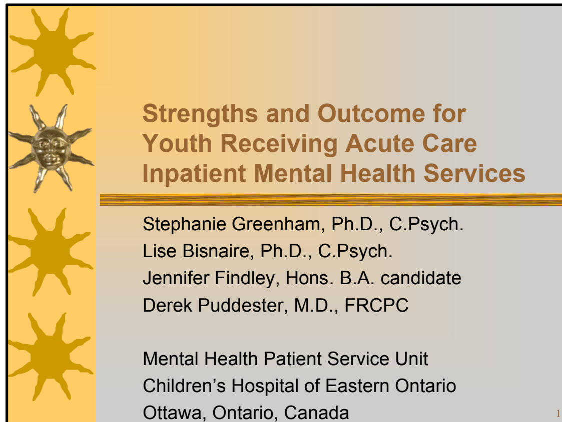
Strengths and Outcome for Youth Receiving Acute Care Inpatient Mental Health Services
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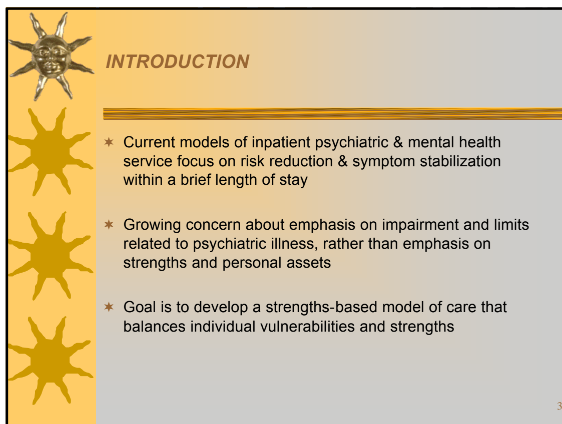
INTRODUCTION
Current models of inpatient psychiatric & mental health service focus on risk reduction & symptom stabilization within a brief length of stay
Growing concern about emphasis on impairment and limits related to psychiatric illness, rather than emphasis on strengths and personal assets
Goal is to develop a strengths-based model of care that balances individual vulnerabilities and strengths
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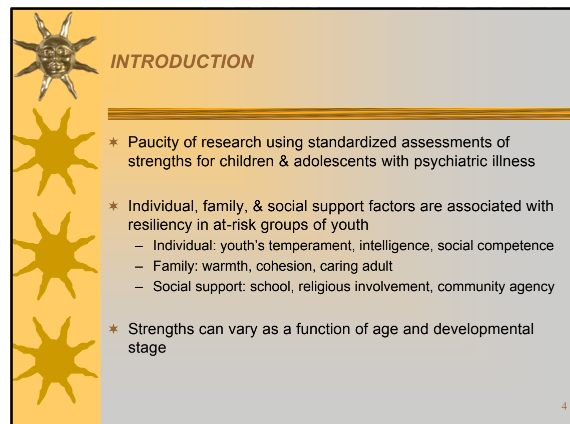
INTRODUCTION
Paucity of research using standardized assessments of strengths for children & adolescents with psychiatric illness
Individual, family, & social support factors are associated with resiliency in at-risk groups of youth
– Individual: youth's temperament, intelligence, social competence
– Family: warmth, cohesion, caring adult
– Social support: school, religious involvement, community agency
Strengths can vary as a function of age and developmental stage
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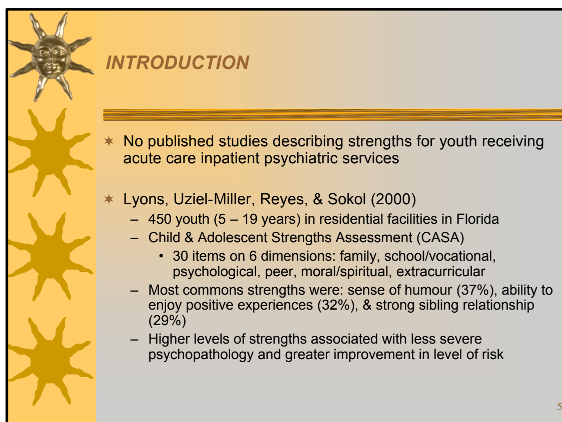
INTRODUCTION
No published studies describing strengths for youth receiving acute care inpatient psychiatric services
Lyons, Uziel-Miller, Reyes, & Sokol (2000)
– 450 youth (5 – 19 years) in residential facilities in Florida
– Child & Adolescent Strengths Assessment (CASA)
• 30 items on 6 dimensions: 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 (29%)
– Higher levels of strengths associated with less severe psychopathology and greater improvement in level of risk
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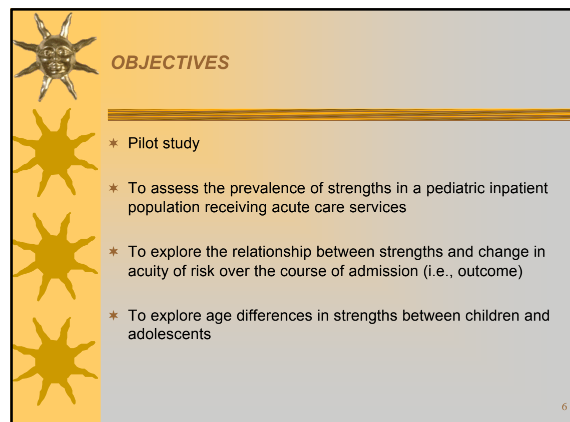
OBJECTIVES
Pilot study
To assess the prevalence of strengths in a pediatric inpatient population receiving acute care services
To explore the relationship between strengths and change in acuity of risk over the course of admission (i.e., outcome)
To explore age differences in strengths between children and adolescents
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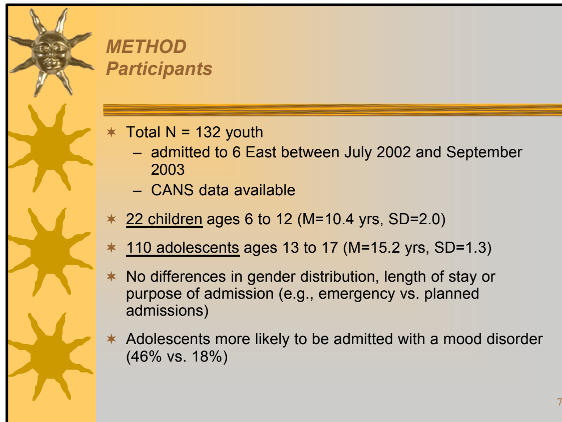
METHOD
Participants
Total N = 132 youth
– admitted to 6 East between July 2002 and September 2003
– CANS data available
22 children ages 6 to 12 (M=10.4 yrs, SD=2.0)
110 adolescents ages 13 to 17 (M=15.2 yrs, SD=1.3)
No differences in gender distribution, length of stay or purpose of admission (e.g., emergency vs. planned admissions)
Adolescents more likely to be admitted with a mood disorder (46% vs. 18%)
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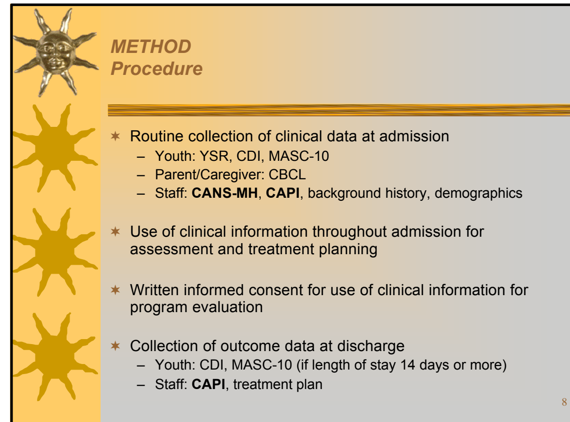
METHOD
Procedure
Routine collection of clinical data at admission
– Youth: YSR, CDI, MASC-10
– Parent/Caregiver: CBCL
– Staff: CANS-MH, CAPI, background history, demographics
Use of clinical information throughout admission for assessment and treatment planning
Written informed consent for use of clinical 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
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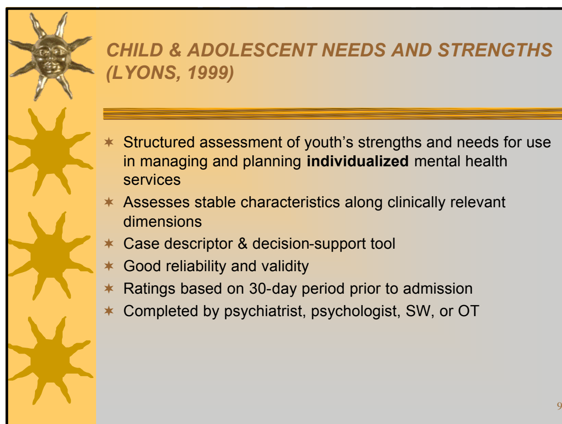
CHILD & ADOLESCENT NEEDS AND STRENGTHS (LYONS, 1999)
Structured assessment of youth's strengths and needs for use in managing and planning individualized mental health services
Assesses stable characteristics along clinically relevant dimensions
Case descriptor & decision-support tool
Good reliability and validity
Ratings based on 30-day period prior to admission
Completed by psychiatrist, psychologist, SW, or OT
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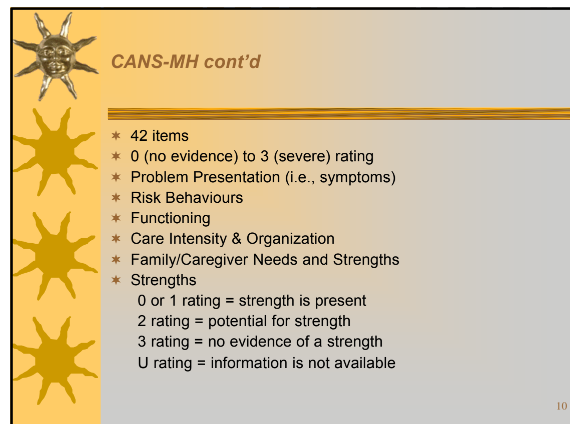
CANS-MH cont'd
42 items
0 (no evidence) to 3 (severe) rating
Problem Presentation (i.e., symptoms)
Risk Behaviours
Functioning
Care Intensity & Organization
Family/Caregiver Needs and Strengths
Strengths
0 or 1 rating = strength is present
2 rating = potential for strength
3 rating = no evidence of a strength
U rating = information is not available
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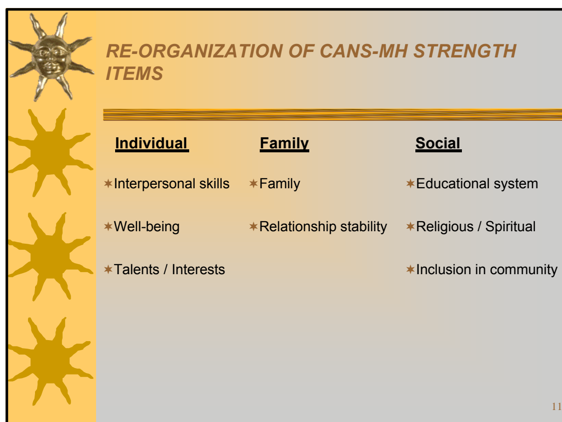
RE-ORGANIZATION OF CANS-MH STRENGTH ITEMS
Individual
Family
Social
Interpersonal skills
Family
Educational system
Well-being
Relationship stability
Religious / Spiritual
Talents / Interests
Inclusion in community
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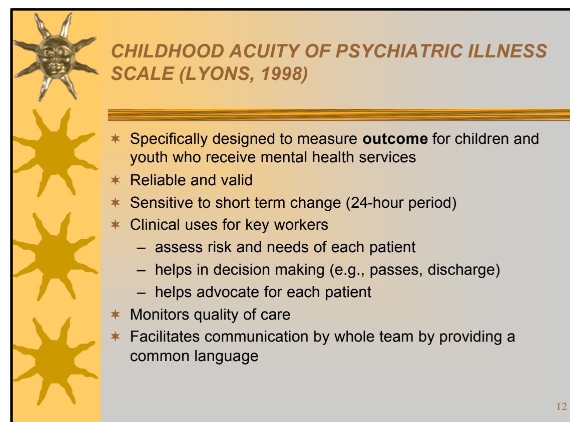
CHILDHOOD ACUITY OF PSYCHIATRIC ILLNESS SCALE (LYONS, 1998)
Specifically designed to measure outcome for children and youth who receive mental health services
Reliable and valid
Sensitive to short term change (24-hour period)
Clinical uses for key workers
– assess risk and needs of each patient
– helps 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
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CAPI cont'd

- Completed by case coordinator or front-line staff
- 20 items

0	1	2	3
No Problem	Mild	Moderate	Severe
No problem	Flag	Needs action	Immediate action

- Total Acuity score
- Subscales: Risk Behaviours, Symptoms, Functioning, Systems Support

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FREQUENCY OF CANS-MH STRENGTHS

CANS-MH Items	Children: Strength	Children: Potential Strength	Children: No evidence	Adolescents: Strength	Adolescents: Potential Strength	Adolescents: No evidence
Individual						
Interpersonal	**41**	46	14	**56**	36	8
Well-being	**14**	68	18	**11**	72	17
Talents/ Interests	**46**	32	23	**62**	26	13
Family						
Family	**41**	41	18	**44**	36	21
Relationship Permanence	**77**	9	14	**66**	26	9
Social						
Education	**46**	27	27	**49**	20	31
Spiritual/ Religious	**16**	27	46	**31**	21	46
Inclusion	**27**	50	23	**33**	30	36

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MEAN RATINGS ON CANS-MH STRENGTHS ITEMS

Items	Children (n = 19) Mean	Children SD	Adolescents (n = 106) Mean	Adolescents SD
Individual Strengths	1.8	.6	1.5	.6
Family Strengths	1.2	.9	1.3	.9
Social Strengths	2.0	.7	1.9	.8

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

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CORRELATIONS BETWEEN CANS-MH & ACUITY (all youth with Adm & D/C Acuity data)

CANS-MH Items	Inter-personal	Well-being	Talents/ Interests	Family	Relationship Permanence	Educational	Spiritual/ Religious
Individual							
Interpersonal	-						
Well-being	.51**	-					
Talents/ Interests	.42**	.41**	-				
Family							
Family	.43**	.18	.20	-			
Relationship Permanence	.30	.07	-.02	.42**	-		
Social Support							
Educational	.36*	.53**	.18	.14	-.01	-	
Spiritual/ Religious	.35*	.25	.44**	.08	.06	.34*	-
Inclusion	.56**	.49**	.54**	.13	.16	.42**	.43**
Change in Acuity	**-.33***	**-.23**	**-.05**	**-.17**	**-.02**	**-.15**	**-.12**

N = 41 Partial correlations controlling for Total Admission Acuity score
$^{*}p < .05$ $^{**}p < .01$

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CORRELATIONS BETWEEN STRENGTHS & SYMPTOMS - CHILDREN

CANS-MH Strengths Items	Psychosis	Attention Deficit / Impulse	Depression / Anxiety	Oppositional Behavior	Antisocial Behavior	Substance Abuse	Adjustment to Trauma	Attachment
	CANS-MH Problem Presentation Items							
Individual								
Interpersonal	.23	.59**	-.03	.46*	.51*	-	.57**	.58**
Well-being	.18	.63**	-.33	.55**	.61**	-	.09	.21
Talents / Interests	.02	.67**	-.09	.46*	.50*	-	.32	.54**
Family								
Family	-.17	.06	-.10	.38	.10	-	.64**	.54**
Relationship Permanence	.05	.27	.11	.24	.24	-	.81**	.65**
Social Support								
Education	-.08	.67**	-.20	.69**	.63**	-	.35	.54**
Spiritual / Religious	-.04	.32	-.44	.18	-.09	-	-.01	-.15
Inclusion	-.03	.04	-.07	.20	.30	-	.02	.15

$^{*}p < .05.$ $^{**}p < .01.$

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CORRELATIONS BETWEEN STRENGTHS & SYMPTOMS - ADOLESCENTS

CANS-MH Strengths Items	Psychosis	Attention Deficit / Impulse	Depression / Anxiety	Oppositional Behavior	Antisocial Behavior	Substance Abuse	Adjustment to trauma	Attachment
	CANS-MH Problem Presentation Items							
Individual								
Interpersonal	.04	.39**	-.08	.49**	.48**	.18	.27**	.36**
Well-being	-.07	.22*	-.09	.30**	.26**	.06	.25**	.35**
Talents/ Interests	.01	.40**	.02	.47**	.41**	.29**	.27**	.28**
Family								
Family	-.24*	.35**	.09	.44**	.39**	.30**	.32**	.46**
Relationship Permanence	-.21*	.21*	.06	.35**	.31**	.35**	.39**	.44**
Social Support								
Education	-.02	.40**	.07	.37**	.37**	.33**	.10	.22*
Spiritual / Religious	-.13	.40**	-.05	.31**	.31**	.20*	.11	.09
Inclusion	-.02	.34**	-.04	.36**	.29**	.18	.18	.23*

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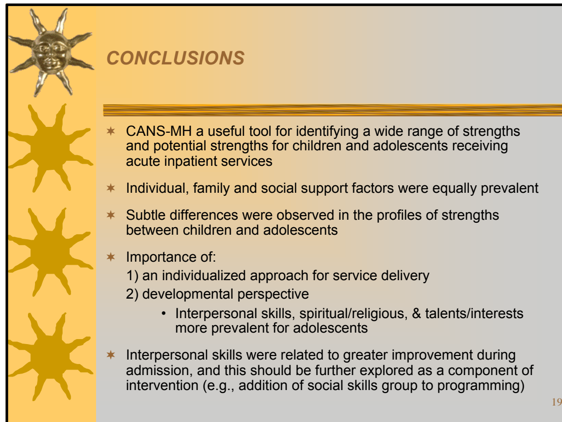
CONCLUSIONS
CANS-MH a useful tool for identifying a wide range of strengths and potential strengths for children and adolescents receiving acute inpatient services
Individual, family and social support factors were equally prevalent
Subtle differences were observed in the profiles of strengths between 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)
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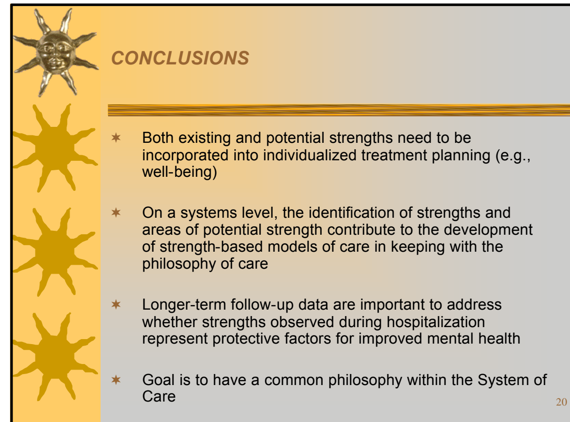
CONCLUSIONS
Both existing and potential strengths need to be incorporated into individualized treatment planning (e.g., well-being)
On a systems level, the identification of strengths and areas of potential strength contribute to the development of strength-based models of care in keeping with the philosophy 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
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Questions/Comments
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