

Care Benchmarks:

Overview and Sources

Overview. The benchmarks provided in this quality review represent a synthesis of the current best evidence from previous quality reviews and from the research literature. There are no well-established, federally recognized practice benchmarks for behavioral health care quality in America. In lieu of these being created and promulgated, we turn to what we know from the literature on care effectiveness in real-world (community) settings. The findings tell us how the frequency and type of certain practices improve outcomes for youth and their families.

The United States has no commonly accepted set of behavioral health care standards or benchmarks.

How to understand these benchmarks. These benchmarks are our current best estimate of what it take to routinely achieve youth and family treatment goals. Because everyone is different some youth might do better, and some worse, with care that meets these benchmarks. But on the whole, youth experiencing care meeting these standards are substantially more likely to experience improvement in symptoms and functioning than when care does not meet these standards.

The standards are not absolute – they are probabilistic. This means that getting closer to a standard makes it more likely that a person will meet their goals. Also, meeting multiple standards makes it more likely that a person will meet their goals than when only one practice standard is met.

How to use these benchmarks. These benchmarks provide a reference for when care merits attention. Care which consistently meets and exceeds the benchmarks may signal an exceptional practitioner or organization. Care which consistently fails to meet benchmarks indicates a need for individual or organizational supports to improve the quality and outcomes of care. When care is consistently below standard across organizations it signals a need to examine system policy and practice supports. They may be inadequate to provide high-quality care, or may be inadvertently creating a barrier to high-quality care. In this brief we describe the benchmarks for two types of services: therapy (psychosocial treatment) and intensive care coordination. References for all cited publications follow the descriptions of benchmarks for the two service types.

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THErapy BENCHMARKS

Treatment Dose

The general rule for dose of care is that more severe or complex clinical presentation requires a greater dose of care in order to be effective. There is also some evidence regarding a minimum dose of care (approximately eight sessions) required for treatment to be effective. Providing enough treatment is a foundational step in effective care. The content of care is likely to matter only if it is provided frequently enough to address the barriers to meeting a person's goals.

The existing literature indicates that, in community treatment clinics, less than 8 sessions of care is associated with worse treatment outcomes for youth with depression (Weersing & Weisz, 2002). Similarly, changing parent interactions with youth is significantly related to number of treatment sessions attended (Garland, et al., 2014). Modular treatments of depression, anxiety, and conduct problems in community treatment settings involve about 16 sessions of treatment provided in approximately six months (Weisz, et al., 2012). As problems become more serious or impairing, more intensive treatments require higher doses of care. Multi-Systemic Therapy, for instance, involves 60 hours of direct treatment provided over four months. Functional Family Therapy requires 12-30 hours of treatment provided over 3 months (Blueprints for Violence Prevention, 2004, p. 26-27).

The takeaway from the review, meta-analyses, and findings from specific treatments is two-fold. First, change is unlikely to occur when a minimum dose of care is not provided. Second, more severe or complex concerns require higher doses of treatment in brief periods of time. Our practice standard for treatment dose is a weekly dose of one hour of direct treatment. This reflects the fact that some youth will have more complex needs and require a higher dose of care, and some youth will have less intensive needs and may be successfully treated with a modestly smaller dose.

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THErapy BENCHMARKS

Skilling

Providing new and alternative behaviors to address problematic emotions or behaviors is a cornerstone of treatment. We include documented efforts which involve introducing, selecting, teaching, and working to generalize new behaviors as 'skilling.'

The available literature on community-based treatment strongly supports the notion that a consistent focus on developing new, more useful behaviors is related to better treatment outcomes. For younger children these new behaviors are most likely taught to parents, and for older children they are directly taught to the youth.

Reviews of treatment as usual in community care, as well as of evidence-based treatments, indicate that increasing focus on practices which teach new behaviors is related to better treatment outcomes (Garland, et al., 2014; Weisz, et al., 2012). In one large-scale study conducted outside of the United States, similar effects to evidence-based care were found when community clinicians used evidence-based treatment practices (closely related to skilling) in about 60% of their treatment sessions (Merry, et al., 2020). In one state children's mental health care system, their monthly practice reviews found that skill development was a focus of over 50% of sessions (State of Hawai'i Child and Adolescent Mental Health Division, 2017). In that fiscal year nearly 70% of youth were discharged having substantially met their goals. These findings indicate that when skill development or skill generalization activities are present in half or more sessions, usual care is likely to be effective.

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THERAPY BENCHMARKS

Supporters

Core promising and effective treatments for youth all involve the consistent, active participation of an adult supporter. These span both internalizing and externalizing disorders. Treatments include Functional Family Therapy, Multi-Systemic Therapy, Brief Strategic Family Therapy, Cognitive Behavioral Therapy for Anxiety, and Cognitive Behavioral Therapy for Depression. Modular, cross-diagnosis treatments also require and have observed frequent involvement of family members in child or youth treatment. For instance, the developers of such a treatment indicated that only about one-third of session only involve the child (Weisz et al., 2012). Meta-analyses of the treatment of internalizing disorders have found that parental involvement improves both the initial and long-term (2-year post-treatment) success of treatments (Manassis et al., 2014; Sun, Rith-Najarian, Williamson & Chorpita, 2019). In the state referenced in the previous section, reviews indicated an explicit focus on family treatment in 40% of all monthly reviews (State of Hawai'i Child and Adolescent Mental Health Division, 2017).

Effective treatments for younger children focus primarily, if not exclusively on changing parental behavior in order to support new behavior from the child. Treatments for older youth typically engage caregivers as a secondary focus of treatment, though family-based treatments are often an exception to this. Supporters can also include family members, fictive kin, natural supports from the community, and the significant others of older adolescents. Given that some interventions require caregiver or other supporter involvement in nearly all sessions, and that demonstrably effective community-based treatments routinely involve families more than 40% of the time, our threshold for supporter-involvement is set at 50% of treatment sessions.

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CARE COORDINATION BENCHMARKS

Overview

Our benchmarks for care coordination are based in the literature on the best-researched care coordination intervention for youth, high-fidelity Wraparound. A very recent meta-analysis found that larger effects of Wraparound were associated with Wraparound conditions with higher fidelity (Olson et al., 2021). This provides us with some confidence in adopting benchmarks based on the fidelity standards of Wraparound. Wraparound includes some flexibility in practice. Different states, working to implement Wraparound with fidelity, define fidelity standards modestly differently. Our benchmarks are drawn from both the Wraparound practice manuals of neighboring states (Oregon and Washington), as well as the Wraparound fidelity tools provided by the National Wraparound Initiative. In this section we will refer to Wraparound meetings as 'Child and Family Team' (CFT) meetings to denote the formal, structured team meetings which are the backbone of the Wraparound intervention.

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CARE COORDINATION BENCHMARKS

CFT Frequency

The required frequency of CFT meetings has changed over time as Wraparound's phases and activities have become better defined. An initial attempt to define Wraparound phases stated that the first phase of Wraparound should complete in 1-2 weeks and that the second phase of Wraparound should take another 1-2 weeks and should include 1 or 2 formal meetings (Walker et al., 2004). Little information was provided on the needed frequency of Wraparound meetings beyond this initial specification.

Approximately a decade later, a Wraparound review tool (WrapSTAR) specified that, "Families are engaged in Wraparound services within 10 days of a referral and develop their initial Wraparound plan within 30 days of being engaged. Then, teams meet regularly (at least every 30-45 days) to review and modify the Plan of Care as needed" (National Wraparound Implementation Center, 2015, p. 13).

The most recent version of this review tool, named the Document Assessment and Review Tool (DART v.2, National Wraparound Implementation Center, 2019), indicates that, "(c) During phase two of Wraparound, meet at a minimum of two times each month during the youth's enrollment in Wraparound; and (d) Convene at a minimum of one time per month and as necessary to meet the needs of the youth and family, as determined by the youth, family, and Wraparound team when not in phase two of Wraparound." This is further reinforced by another item on the tool evaluating whether during the "Last three (or two if fewer than three have been held) Child and Family Team Meetings....[there is] No gap greater than 35 days between last 2 or 3 CFTMs." This provides clear guidance that formal CFT meetings should be held at least monthly, and represents a move towards ensuring more frequent use of CFTs with families.

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Task Completion

A core principle of high-fidelity Wraparound is a continuous focus on reaching the goals of youth and families. This has been described as a process in which, “The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly” (Bruns, Walker & The National Wraparound Initiative Advisory Group, 2008). Frequent, structured CFT meetings are designed to create accountability among diverse stakeholders for helping youth and families make progress.

The earliest attempts to describe Wraparound practices have focused on accountability for tasks assigned at CFTs, "Finally, when the team has selected the next set of actions designed to meet needs, the team members will Assign and take responsibility for specific actions. After each meeting, the facilitator should update the plan of care to reflect the adjustments and assignments made by your team.Between wraparound team meetings, you and your team members communicate as needed to complete the tasks listed in the plan" (Miles, Bruns, Osher, Walker & National Wraparound Initiative Advisory Group (2006), p.12). A Wraparound fidelity tool further specified that, “All team members take ownership over their assigned tasks and work together to meet the family’s needs” (WrapStar, 2015, p. 13). One state Wraparound practice manual states succinctly the requirement that, “Tasks are clearly assigned and updated each CFT” (State of Washington, Department of Social and Health Services, 2018, p. 29).

What is clear from these statements is that Wraparound is designed to help insure that goal-relevant actions are assigned to the appropriate parties and then completed between meetings. The standard we have set for task completion between meetings is 75%. This reflects the idea that most actions assigned should be able to be completed between CFTs. Data from previous reviews indicates that people following through on assigned tasks strengthens youth and families’ trust and motivation throughout care.

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Supporters

Wraparound is a coordination and accountability process used most frequently with individuals who have multi-system involvement. Moreover, these youth often have difficulty in functioning in more than one environment. Wraparound is designed to bring together key representatives across systems and environments. These representatives then establish and work towards common, youth-defined goals using coordinated resources and interventions. Convening CFTs with the relevant parties present is fundamental to Wraparound's success.

Likely because of their centrality to Wraparound's success, the indicators of fidelity for supporter attendance at CFTs are very clear. They include the following:

"At least one caregiver or close family member attended every Child and Family Team Meeting";

"At least one natural support (e.g., extended family, friends, and community supports) for the family attended every Child and Family Team Meeting";

"All key representatives from school, child welfare, and juvenile justice agencies who seem integral to the plan of care attended nearly every Child and Family Team meeting."

The lowest bar for supporter attendance is attending "nearly every Child and Family Team meeting" (National Wraparound Implementation Center, 2019). We have created a numerical standard (75%) which should serve as a lower bound for attendance of key representatives. Supporters' active participation in less than 75% of CFTs would clearly violate both the intent of Wraparound, as well as the fidelity indicators created by the NWIC.

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PEER SUPPORT BENCHMARKS

Contact, Content, Supporters

The Peer Partner benchmarks are based on the reasoning and empirical findings behind the Therapy and Care Coordination benchmarks. Because the role and tasks of Peer Partners are not yet clearly defined in the industry, these benchmarks are preliminary. Findings of focus groups with Peer Partners indicate that they often act as a bridge between Therapists, Care Coordinators and family members. Peer Partners help translate the technical language of therapists and care coordinators into the everyday language and achievable tasks. In at least one study, they also spent significantly more time face-to-face with caregivers and youth than did either therapists or care coordinators. To the extent that these interactions follow-up on tasks identified in treatment and coordination meetings, they are likely to improve the effectiveness of these services.

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Treatment Dose

Treatment

Dose

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Care Coordination

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Treatment Dose

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