Utah Youth Suicide Study
How To for Juvenile Offenders

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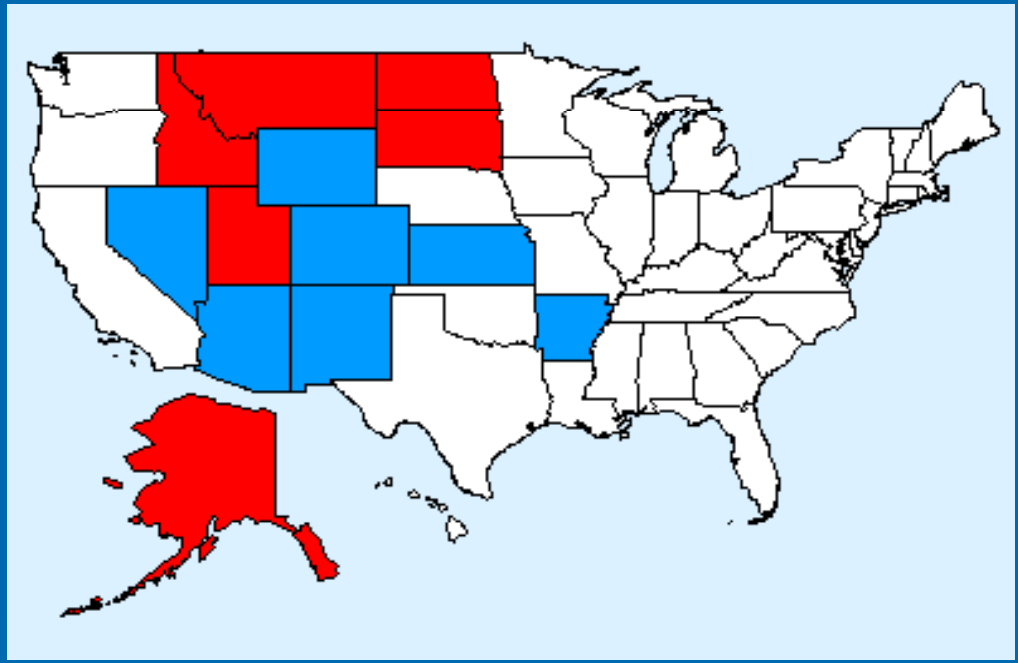
Today's Presentation

- Who is Partner?
- Why Partner?
- What Partnership will do?
- How will we convince stakeholders?
- When and Where?
- Prevent with Policy!
- Choosing Outcome Measures
  - Data protects everyone, as Shellie's known to say, "it keeps your boogiemen away"

Utah Youth Suicide Study Partnership with Courts?

WHO?

Suicide Rates
10-19 years 1989-1998



At or above the 90th NATIONAL percentile

At or above the 75th but less than the 90th NATIONAL percentile

Less than the 75th NATIONAL percentile

CDC WISQUARS Injury Mortality Report
Suicide Deaths and Rates per 100,000
All Races, Both Sexes, All Ages

Objectives
Phase I

- Develop a descriptive profile of Utah youth suicide victims.
- Understand the relationship between suicide victims and the community.
- Evaluate these connections as possible places for intervention.

Medical Examiner's Data

- 151 Consecutive Youth Suicides
  - 89% Males, 11% Females
  - 58% Used Firearms
  - 60% Died at Home
  - 93% Caucasian
  - 3% Toxicology Positive for Psychotropic Medication at Time of Death
  - 1% In Public Mental Health Treatment at Time of Death

Agency Contact

n=126

Subjects aged 13-21

School records searched

SCHOOL

JUVENILE COURT	**Yes**	**No**	**Total**
Yes	**31% (39)**	**36% (45)**	67% (84)
No	26% (33)	**7% (9)**	33% (42)
Total	57% (72)	43% (54)	100% (126)

Chi-square=11.81, DF=1, p<.001

Juvenile Justice Data

- 63% of youth suicide completers had contact with the Juvenile Court System (n=95 of 151).
- 54% of the 95 subjects involved with Juvenile Court had a referral(s) for substance possession, use, or abuse (n=51 of 95).
- 32% had one felony referral (n=30 of 95).

Conclusions
Phase I

- Majority of Suicide Completers
  - Male
  - Contact with Juvenile Courts
    - Multiple minor offenses over several years
    - > 7 Juvenile Offenses increases risk 5 times
  - 1% in Public Mental Health Treatment
  - 3% on Psychotropic Medication
  - 93% in School or Juvenile Court System

Utah Youth Suicide Study Convincing Courts

WHY?

Background
Phase V

- Preliminary results (N=151) of the Utah Youth Suicide Study showed that 65% of youth suicide completers had contact with Juvenile Court.
- Referral to Juvenile Court was a risk factor for completed suicide.
- We hypothesized that the Juvenile Court would provide new opportunities for mental health screening, as a future method of suicide prevention.

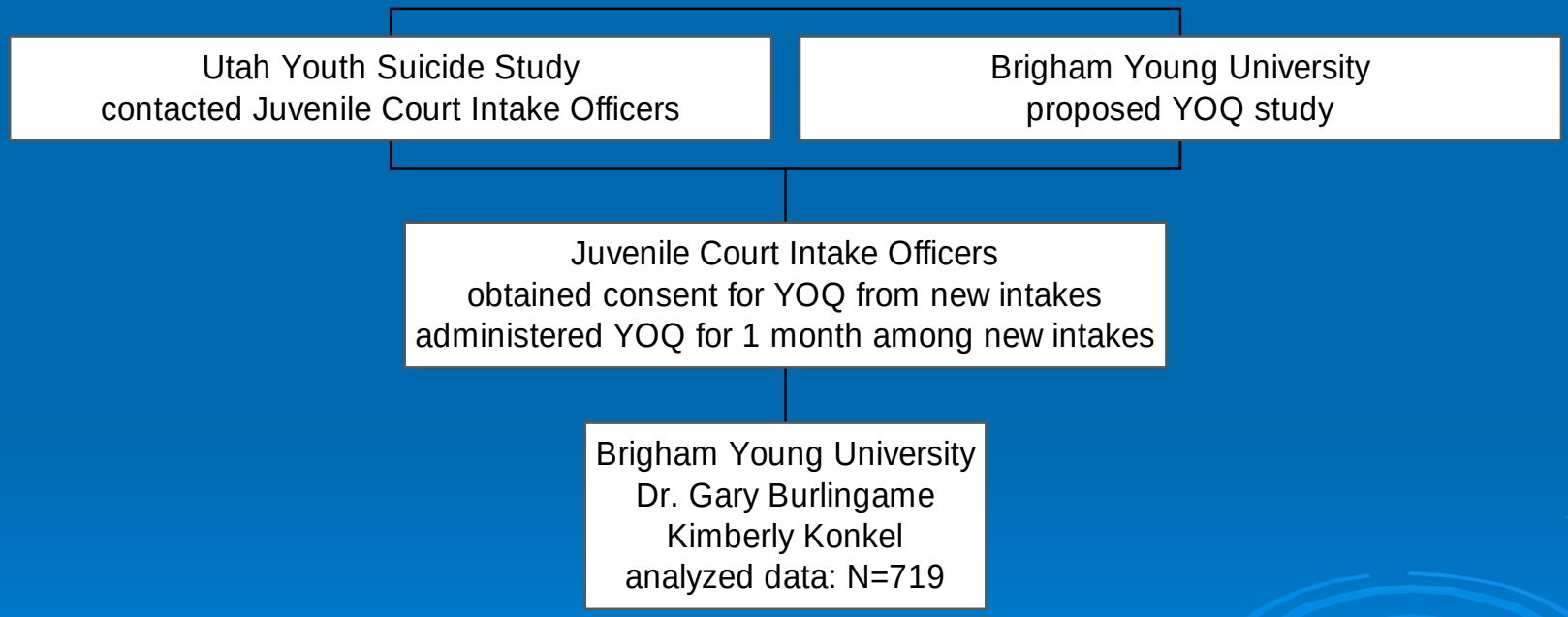
Objectives
Phase V

- To examine the mental health status of a Juvenile Court population.
- To determine if mental health influences rate of recidivism.

Choosing Measurement Tool

- Process vs. Outcome
- Both important, what is most important?
- Considerations before you plunge
  - Least threatening to parents and kids-stigma
  - Time effective—Take home results
  - Easy to implement, web-based, multi-language
  - Availability (cost, copyright)
  - Quality of results—useability of data to convince boogiemen

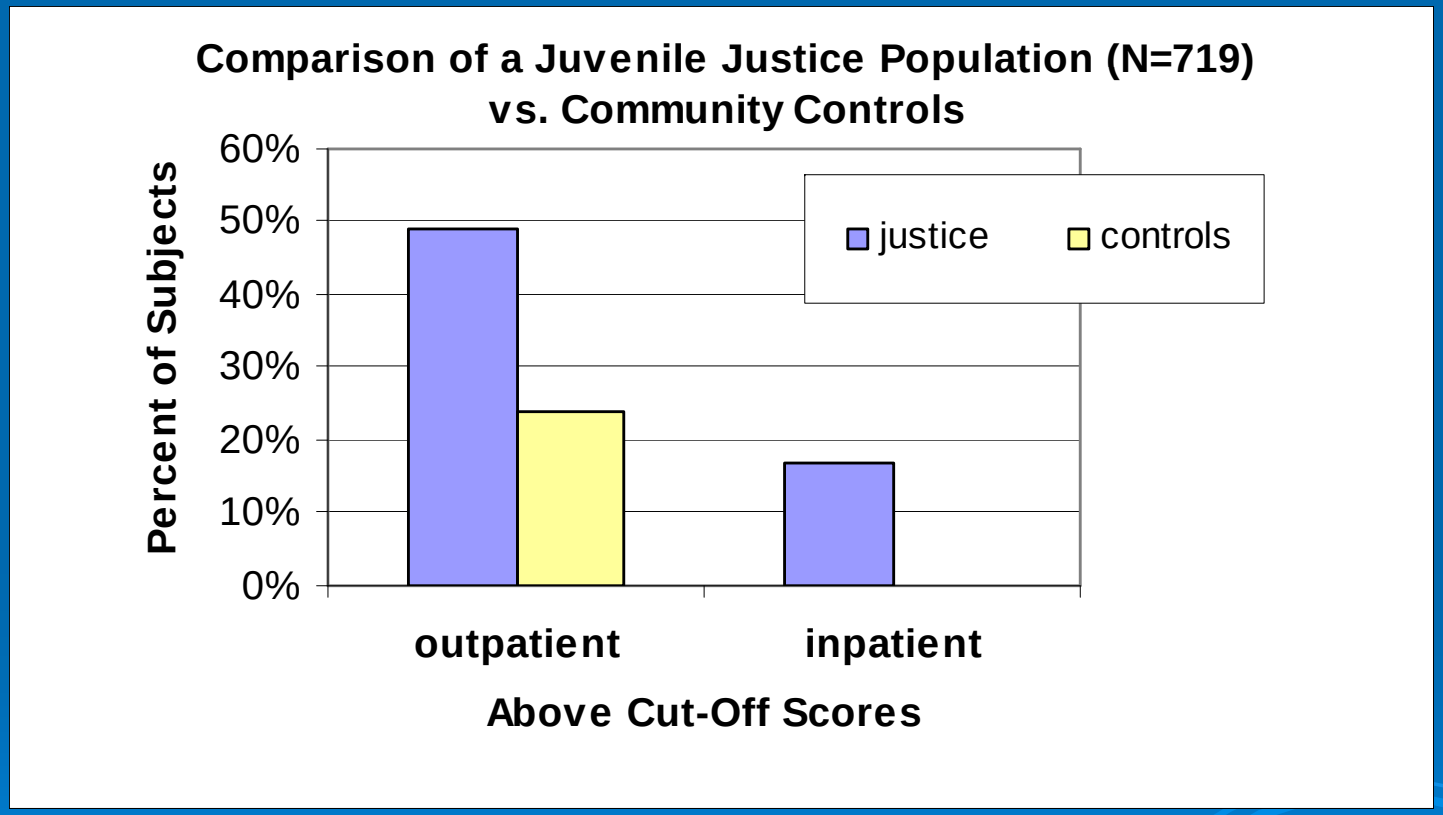
Methods
Phase V



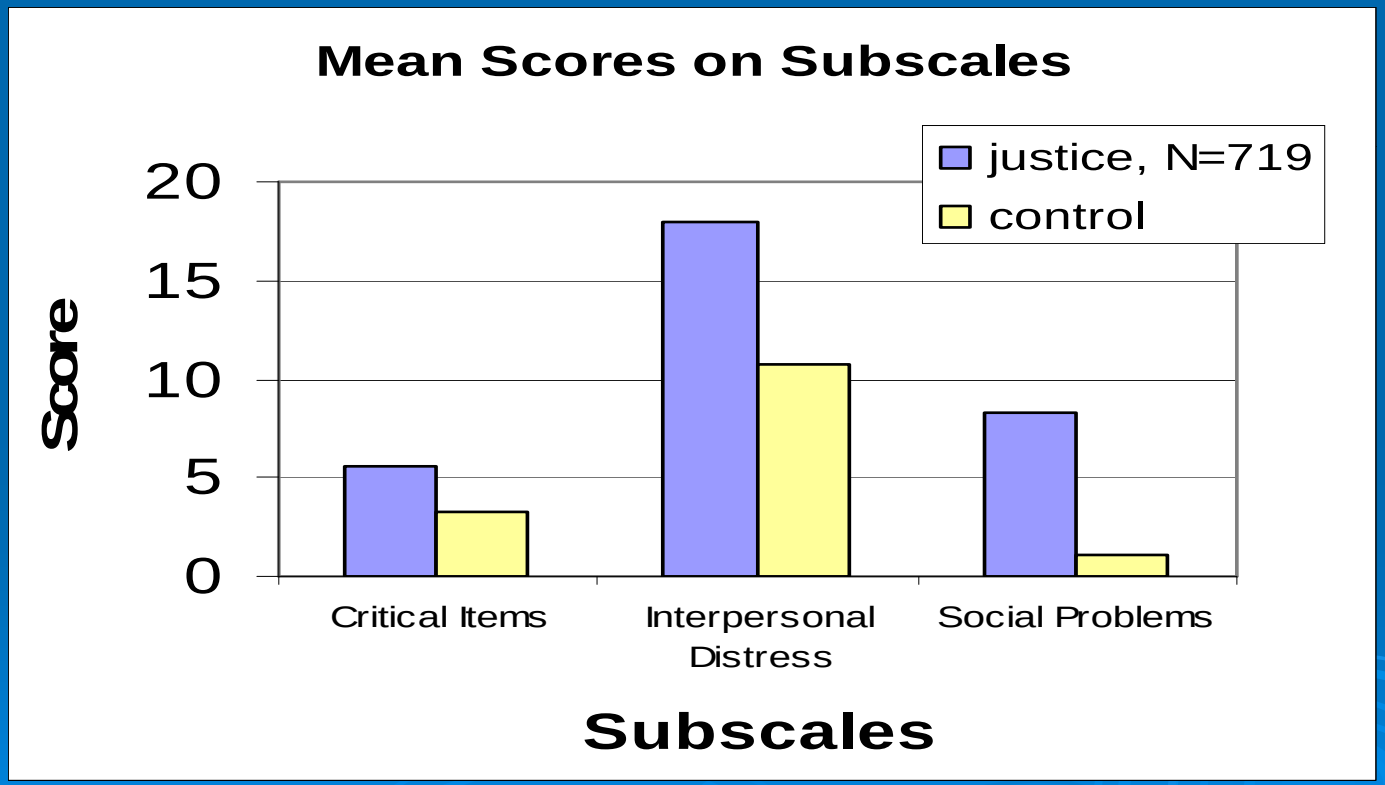
Methods
Phase V

- The Youth Outcome Questionnaire (YOQ) study included Utah residents who were consecutively referred to the statewide Juvenile Court system, for either status or criminal offenses, over a one-month period (N=719).
- The YOQ is a 64 question parent-report screening tool, which assesses distress and dysfunction associated with mental illness for children and adolescents.
- As a psychometric measure, it provides a comparison to scores from youth inpatient and outpatient psychiatric patients.

Results
Percent Above YOQ Clinical Cut-Off



Results
YOQ Subscales

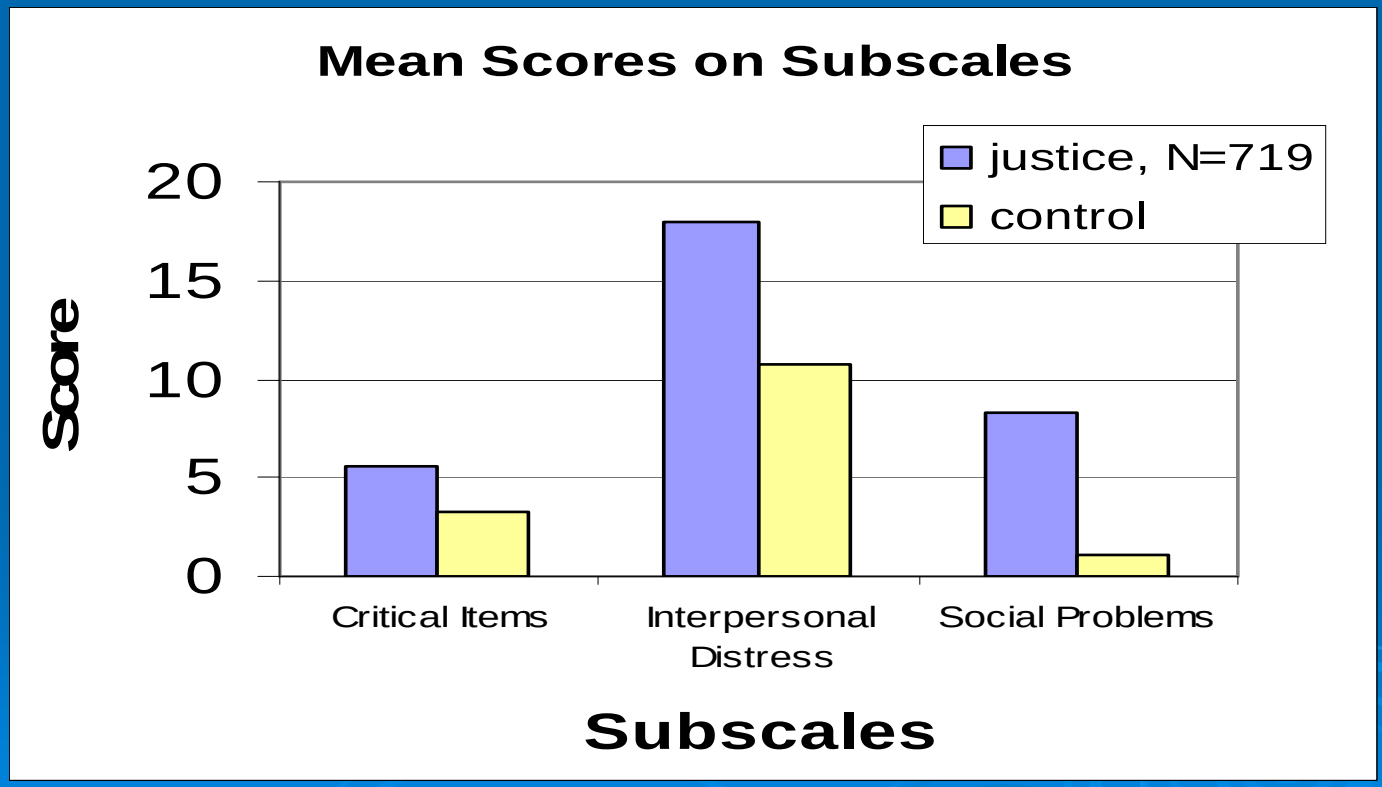


Results

YOQ Subscale Correlates

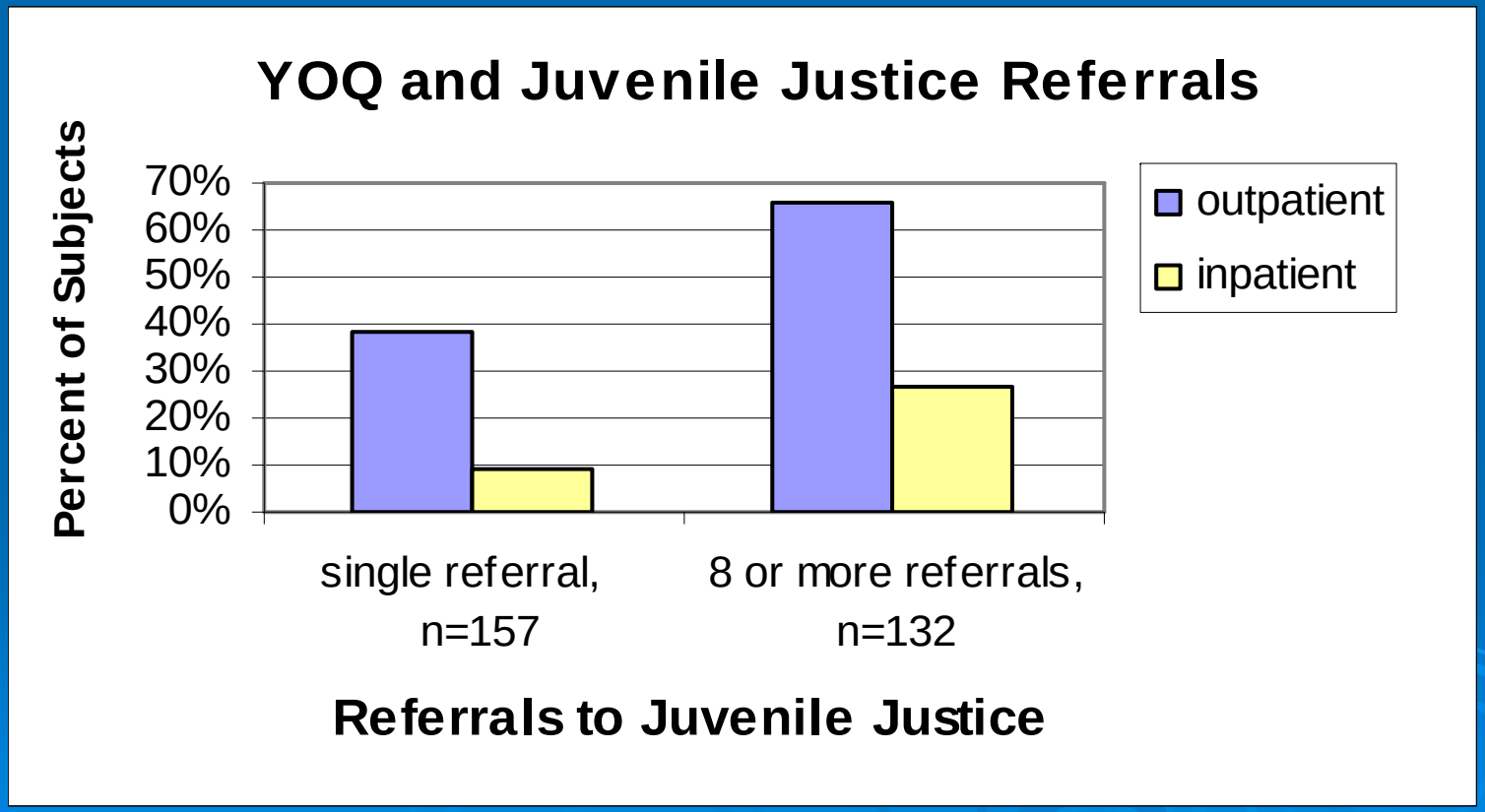
- Critical Items: symptoms requiring immediate intervention, e.g., suicidal ideation or hallucinations.
- Interpersonal Distress: anxiety and depression.
- Social Problems: conduct problems, aggression, and substance abuse.

Results
YOQ Subscales



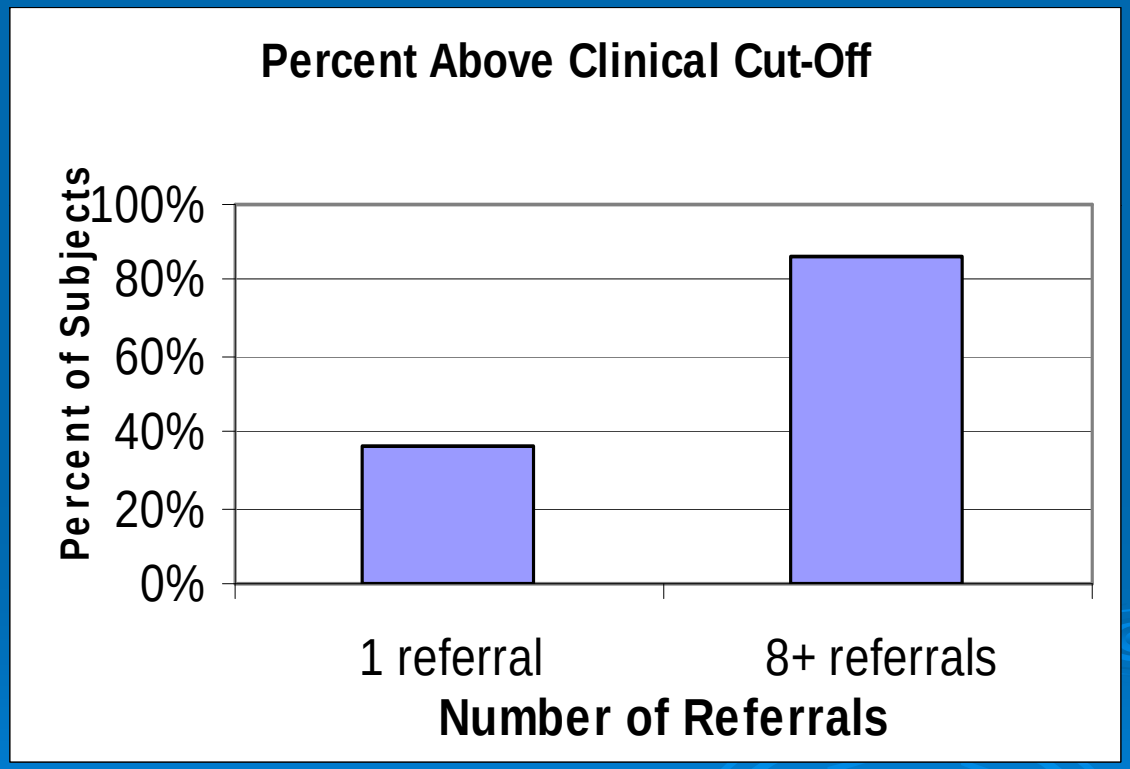
Results

Percent Above YOQ Cut-off Scores



Results:
Interpersonal Distress vs. Recidivism

- Interpersonal Distress (ID) correlates with anxiety and depression.
- ID increased with more referrals.



Conclusions
Phase V

- Sixty-three percent (63%) of youth who suicide in Utah have had contact with Juvenile Court system and any referral to the Juvenile Court system increased the odds of suicide.
- The Juvenile Court population has significant psychiatric problems as demonstrated by elevated YOQ scores, and YOQ subscales which correlate with suicide risk factors.
- YOQ scores are directly related to recidivism.

Recommendations
Phase V

- The Juvenile Court system offers a substantial window of opportunity to screen, identify, and refer high-risk individuals for treatment.
- The YOQ may be an appropriate instrument to identify individuals in the Juvenile Court system who are at risk for psychiatric problems, recidivism, and suicide.

Implications for Courts

- Do Something
  - Suicide Rare Event
  - Mental Illness Prevalent
    - Decrease Caseload
    - Decrease Cost
    - Defer Youth from Placement
- Do Nothing
  - Suicide Rare Event
  - Mental Illness Prevalent
    - Increase Caseload
    - Increase Cost
    - Increase Placements

Utah Youth Suicide Study

WHAT?

Pilot Partnership with Courts

Consent

- Consent increases time decreases "productivity," but pilot with consent may be necessary to convince all entities of procedures for expansion-lack of evidence base practice.
- Without consent parameters of relationship evolves over time--possibly more subjective
- Consent Pilot Study: 1999-2005 (N=44)
- Policy Expansion: 2006-2009 (N=6000+)

Planning Stakeholders

- Team Members-subgroup from Utah Youth Suicide Task Force

  - Researchers (Drs. Moskos & Gray)
  - Court Administrators (Probation)
  - Court Officers (Probation)
  - Public Mental Health Professionals
  - Mental Health Advocates
  - Families (parents and kids)

Keep End in Mind ALWAYS

What do I need to ask today to convince stakeholders tomorrow

Identify your “boogiemen”

PREVENT WITH POLICY!

- Researchers (Drs. Moskos & Gray)
- Court Administrators (Probation)
- Court Officers (Probation)
- Public Mental Health Professionals
- Mental Health Advocates
- Families (parents and kids)

BOOGIEMEN

- Research: IRB language, consent could paralyze if not redefine your efforts—data collected by courts according to court policy, court contract with experts for analyses
- Administrators will answer to legislature or head of funding streams, anticipate challenge, prevent access to data to decrease misuse
- Officers overworked and underpaid, put them to work for you? No you work for them, doughnuts
- PMH professionals fear competition-hello these are the kids you don't cover anymore….
- Parents…. "Don't have time to do this"

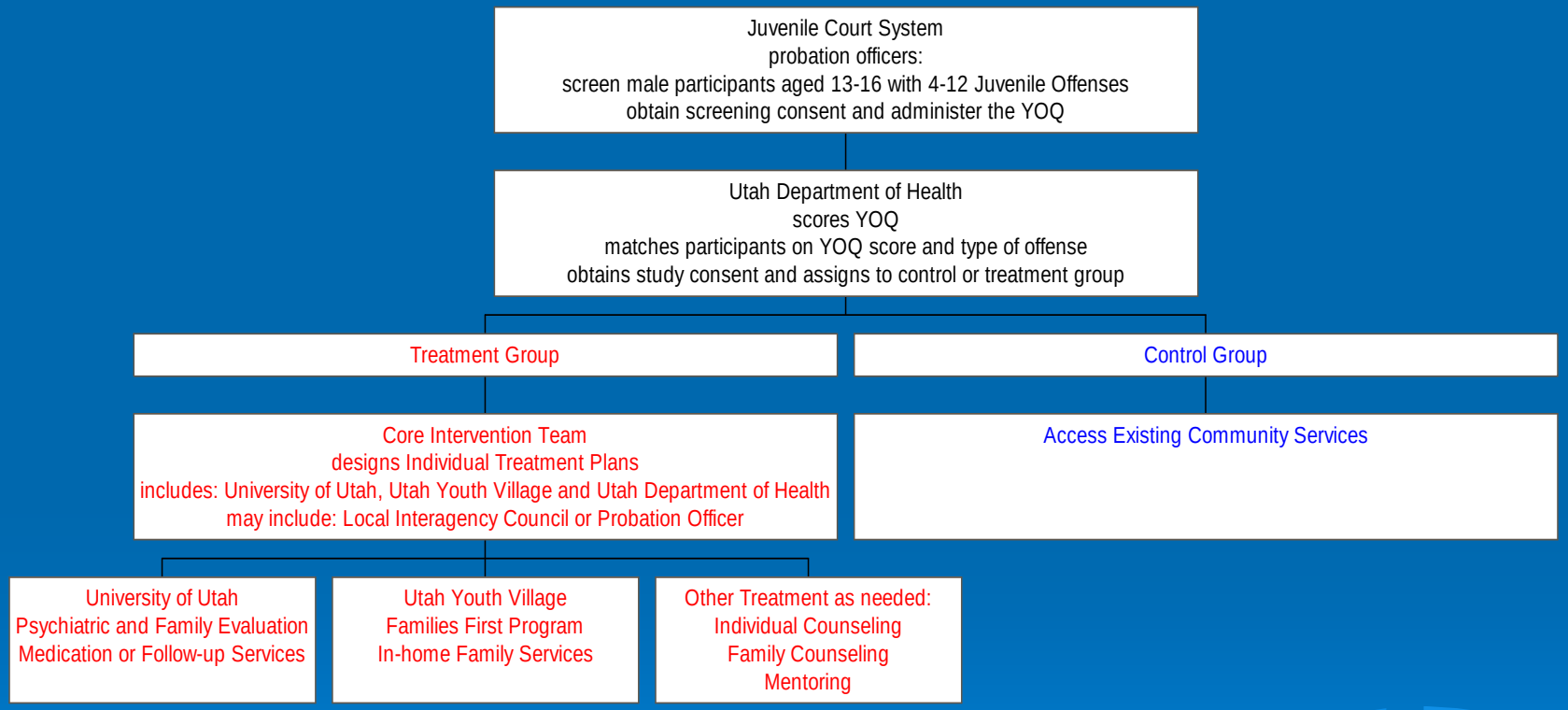
Objectives
Phase VI

- Will the delivery of an Individual Treatment Plan for mental health services:
  - improve mental health status
  - improve school performance
  - decrease recidivism
  - decrease behavioral problems
  - improve family functioning?

Objectives
Phase VI

- Will the systematic identification and earlier intervention, at the secondary prevention level, including more intensive, easily accessible, and coordinated family and mental health services, be more cost-effective than existing community family and mental health services?

Methods
Phase VI



Screening Process

- When a male youth aged 13-16 was referred for their 2th-12th offense, his parents were approached to participate in this study by their Juvenile Justice Court probation officer.
- The Court Officer provided a brief description of the study.
- The Court Officer obtained the informed consent for the screening process.
  - It is important to note that the parent decision to participate, or not to participate in the study, will have no effect on how their child's case is handled by the Juvenile Justice Court System.

Study Description for Parents

- “The additional support services offered in this program may improve your child’s mental health; help with school performance; decrease risk of abusing alcohol or drugs; and, may reduce involvement in future criminal offenses which puts your child in contact the Juvenile Court System.”

Individual Treatment Plan

- a-Psychiatric and Family Evaluation
- b-Utah Youth Village: Families First Program
- c-Completion of the initial questionnaire 5 times by the parents, more specifically, after the Families First Program, and at 3,6,9, and 12 months after his assignment into the treatment group. Juvenile Justice Records will be reviewed at the aforementioned time intervals.

Individual Treatment Plan (PRN)

- d-prescription medications
- e-individual therapy
- f-family therapy
- g-academic tutoring
- h-mentoring
- i-vocational or job training
- j-alcohol and/or other drug treatment

Not Included

- 24 hour crisis intervention
  - except for the six weeks when the family is receiving in-home services
- Emergency room evaluation
- Psychiatric crisis evaluation
- Residential, inpatient, or day treatment hospital services
- Routine medical care

Psychiatric and Family Evaluation

- General information
- Current emotional and behavioral issues
- Family history
- Your son’s medical and social history
- An interview with your son
- A summary
- A diagnosis
- Treatment options

Utah Youth Village
In-home services

- This in-home service program that supports parents and helps the entire family develop skills to improve family relationships such as communication.

- These services teach youth how to be responsible, respectful and accountable. Family consultants spend time in the home with the family, often evenings, afternoons, or weekends–when the family needs them to be there.

Core Team Intervention

- The treatment activities will be “family-centered.” Community professionals from the Core Intervention Team will present treatment recommendations and discuss treatment options with you throughout the study. You will work equally with the community professionals to plan the treatment activities, or “Individual Treatment Plan.” You will approve all the treatment activities for your son. Therefore, if your son is assigned into the treatment group, your family will be asked to help him when he goes to the activities of the Individual Treatment Plan.

Parent: Family History n=22

Depression	**77 %**	**73%**
ADHD	**18%**	**18%**
Medication	**73%**	**68%**
Suicide Ideation	**5%**	**5%**
Suicide Attempt	**9%**	**14%**
Suicide Completion	**9%**	**9%**
Abuse Physical or Sexual)	**5%**	**5%**

Medical Records: Family History n=22

	Attempt	Completed	Self-Attempt
Case One	Aunt; Uncle		
Case Two	Sister		
Case Three	Sister		
Case Four		Great Uncle; Cousin	
Case Five		Uncle	
Case Six	Sister (8)	Brother	1 ideation
Case Seven			2 attempts

Medical Records Diagnoses

- Mood Disorder M
- Substance Use Disorder S
- Conduct Disorder C
- Attention Deficit Hyperactivity Disorder A
- Learning Disability L

Medical Record: Diagnoses n=22

DX	N	Medication	Therapy	M+T	Self-Harm *
MS	4	2**	0	2	Die & Bored
MA	4	1*	0	3*	Die & NS
MSC	2	0	0	2	
CA	2	0	2	0	
M	2	1*	1	0	Bored
A	1	0	0	1	

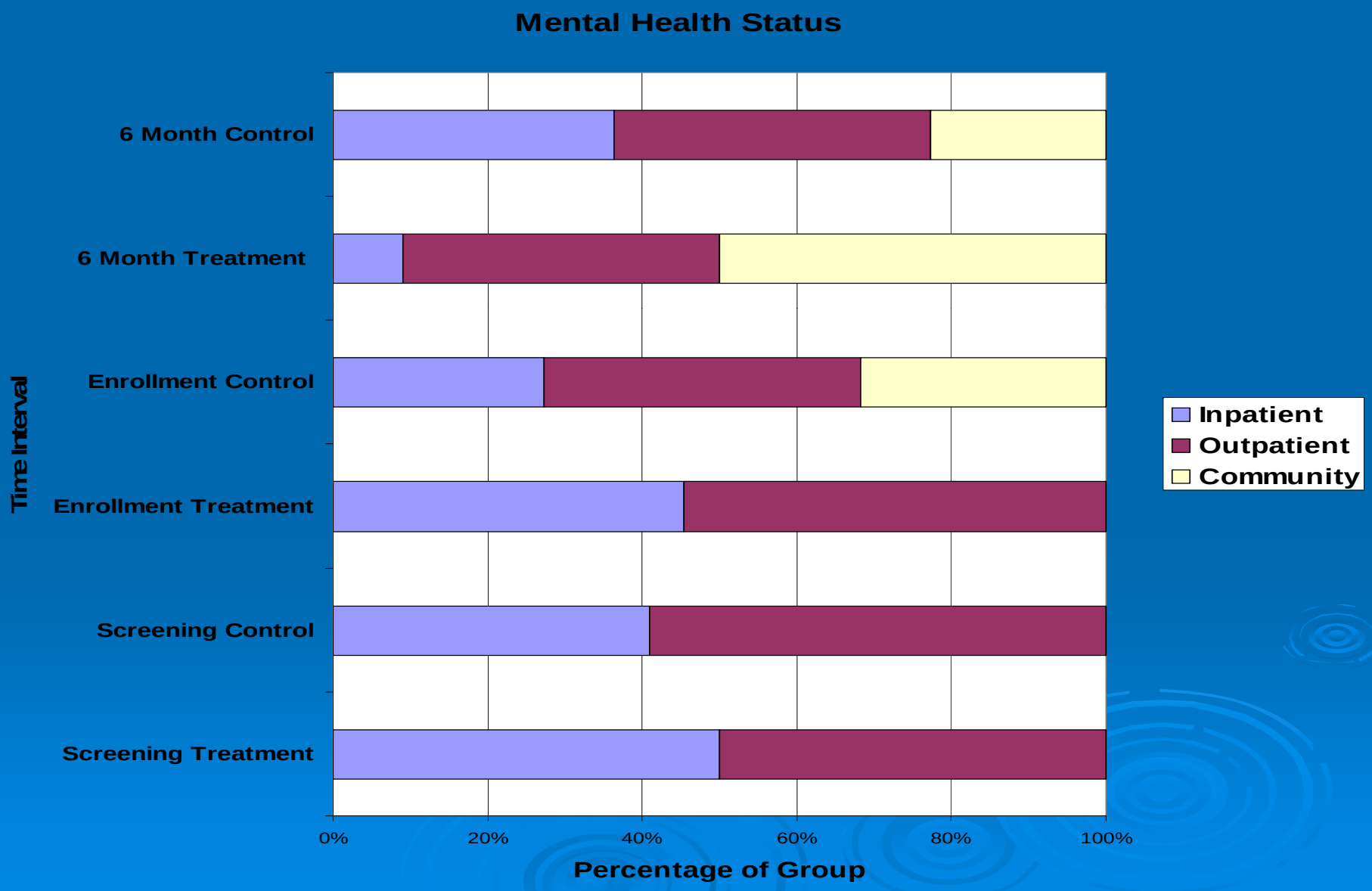
Diagnoses Continued n=22

C	1	0	0	0	
ACL^H	1	1	0	0	
MC	1	0	0	1	
MCA	1	1	0	0	
MCAS	1	0	0	1*	<Anxiety
AS	1	1	0	0	
CAS	1	1	0	0	

Measurement Intervals

- Screening
- Enrollment
- 3 Month
- 6 Month

Mental Health Status



Offenses Definitions

- **Juvenile Court Records**
  - Recidivism
    - Re-offend at same level
    - Re-offend at higher level
  - Suppression
    - Re-offend at lower level
  - No Offenses

Offenses
Outcomes

- Recidivism
  - Treatment: Lower incidence & lower level of offense
  - Control: Higher incidence & higher level of offense
- Court Placement
  - Treatment: fewer days in all court placements
  - Control: several more days in youth corrections and detention centers

Juvenile Court Offenses

	Treatment Pre-Enrollment	n	Control Pre-Enrollment	n
Felonies	Burglary Grow Marijuana	**2** **1**	Theft by Deception Poss. of Stolen Vehicle Poss. of Explosive	**1** **1** **1**
Acts Against People	Assault	**3**	Interfering w/ Arrest Threaten Life/Property	**1** **2**
Acts Against Property	Shoplift / Theft Destruction of Prop Marijuana Possession Burglary Prop	**9** **3** **1** **1**	Shoplift / Theft Destruction of Property	**8** **2**
Acts Against Public Order	Curfew Reckless Driving	**1** **1**	Reckless Driving Alcohol Possession Tobacco Possession Disorderly Conduct Poss. of Drug Paraph	**1** **1** **2** **1** **1**

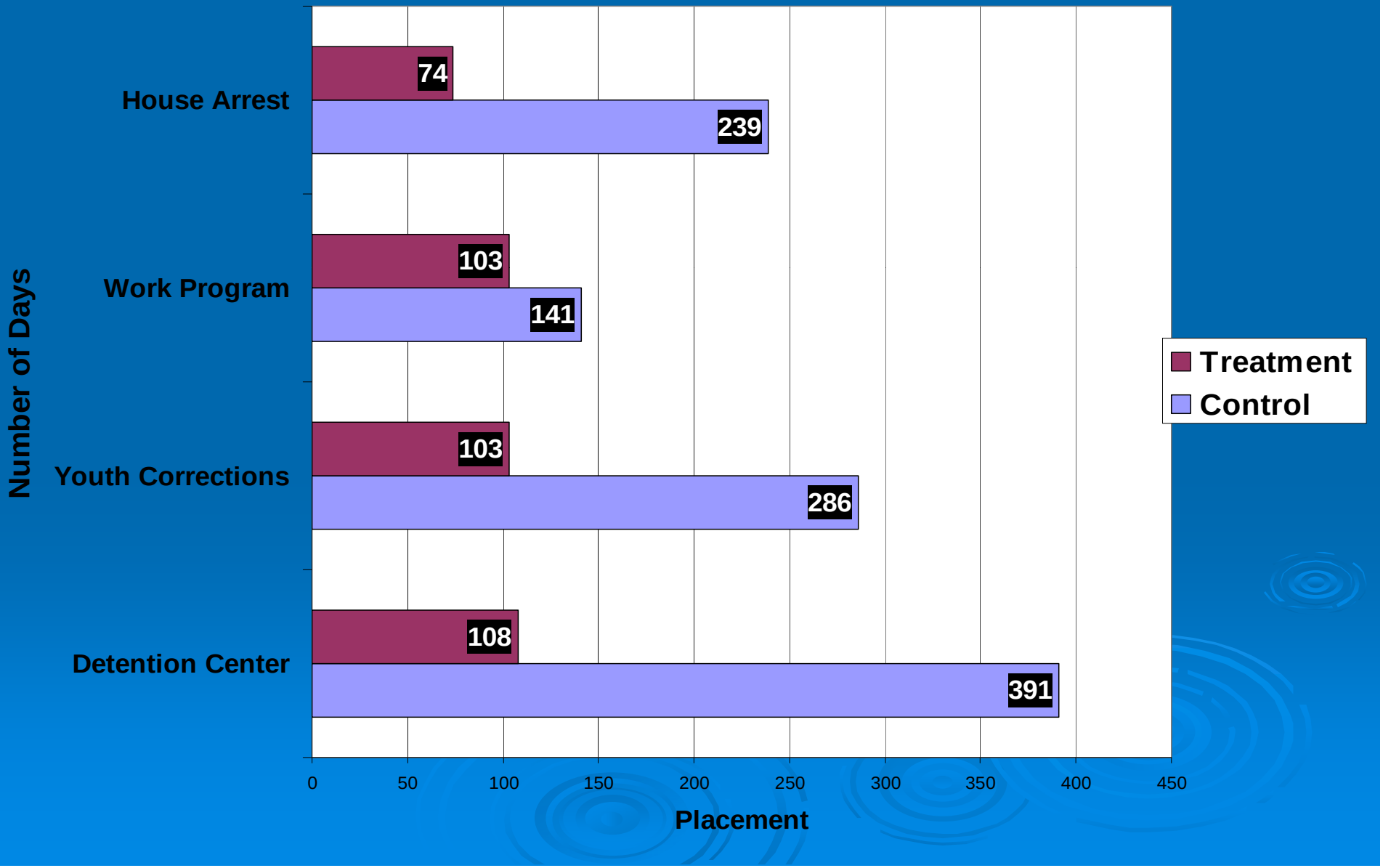
Juvenile Court Offenses

	Treatment Post-Enrollment	n	Control Post-Enrollment	n
Felonies		**0**	Aggravated Assault Assault by Prisoner	**1** **1**
Acts Against People		**0**	Assault Threat to Life/Property	**2** **1**
Acts Against Property	Shoplift / Theft	**3**	Poss. of Marijuana	**1**
Acts Against Public Order	Poss. of Dangerous Weapon/School Probation Violation	**1** **1**	Poss. of Alcohol Poss. of Tobacco Disorderly Conduct Unlicensed Driver Poss. of Drug Paraphernali	**2** **1** **1** **1** **1**
No Offenses		**17**		**10**

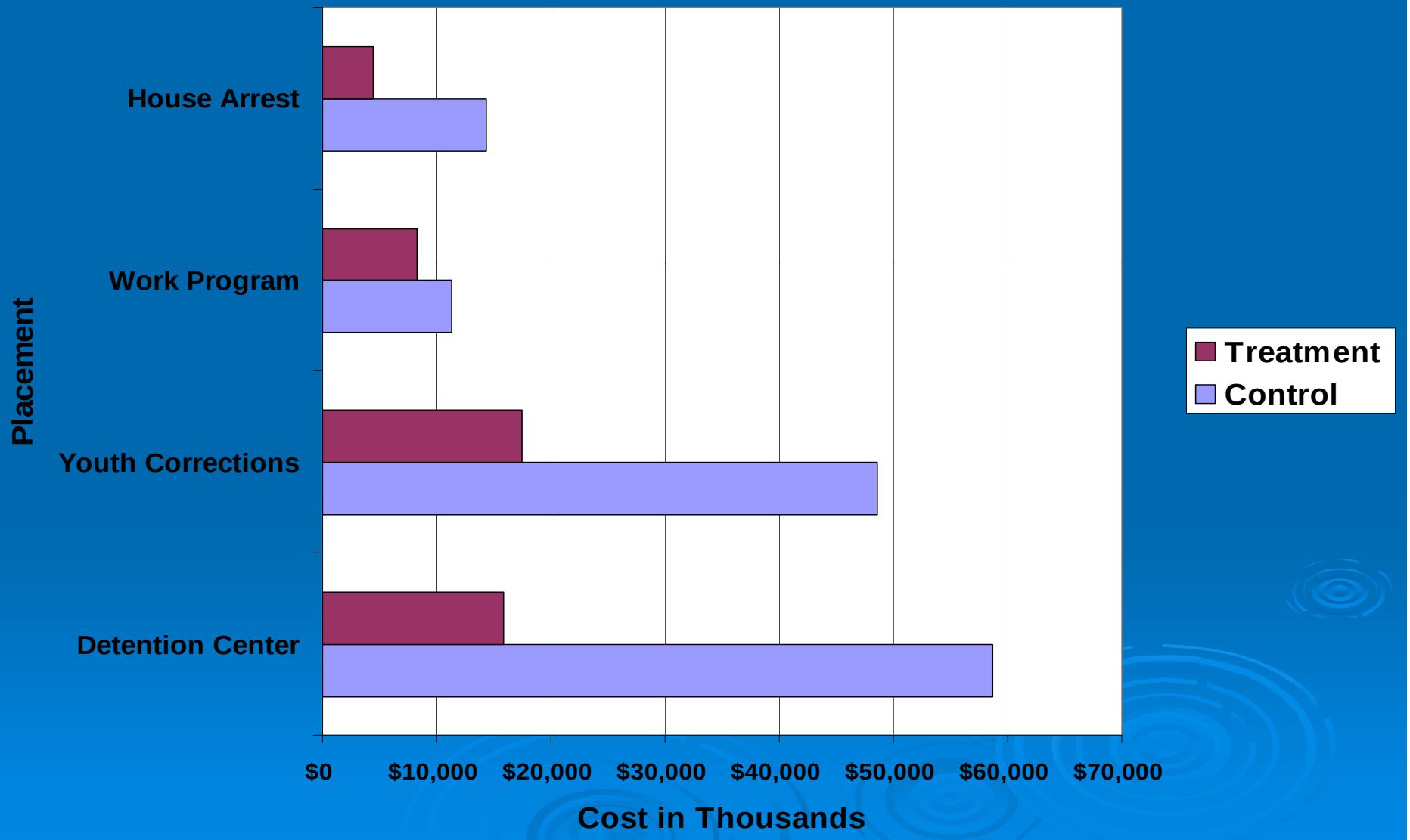
Placements

- Juvenile Court
  - Days in Detention, Corrections, etc.
  - Cost
- Medical Care
  - Emergency Room Visits
  - Primary Care Visits
- Psychiatric Care
  - Residential Treatment
  - Outpatient Treatment

Placement Juvenile Court: Days



Placement Juvenile Court: Cost



Placement
Medical

- Medical Care
  - Treatment: Fewer Emergency Room Visits
  - Control: 3X Higher Emergency Room Visits
  - Treatment: Fewer Primary Care Visits
  - Control: 2X Higher Primary Care Visits

Placement
Psychiatric

- Psychiatric Care-Residential Treatment
  - Treatment: 0 cases = 0 days
  - Control: 1 case = 114 days
- Psychiatric Care-Outpatient
  - Treatment: 8 cases = 155 days
  - Control: 5 cases = 91 days

Medical Care N=44

Medical	Treatment Cases	Days	Control Cases	Days
Emergency Room	4	4	5	13
Hospitalization	0	0	0	0
Primary Care Physician Visits	14	23	18	38

Psychiatric Care N=44

Psychiatric	Treatment Cases	Days	Control Cases	Days
Emergency Room	2	2	2	2
Hospitalization	1	6	0	0
Residential Treatment	0	0	1	114
Day Treatment	1	1	0	0
Outpatient Treatment	8	155	5	91

Additional Data N=44

Other	Treatment Cases	Days	Control Cases	Days
Motor Vehicle Crash	2	-	3	-
Missed Days of Work (parent)	19	73.5	18	81.5

BOOGIEMEN

- Research: IRB language, consent could paralyze if not redefine your efforts—data collected by courts according to court policy, court contract with experts for analyses
- Administrators will answer to legislature or head of funding streams, anticipate challenge, prevent access to data to decrease misuse
- Officers overworked and underpaid, put them to work for you, doughnut contest saved pilot
- PMH professionals fear competition-hello these are the kids you don't cover anymore….

HOW?
SELL IT!

- Data does not speak for itself
- Same data must be reformatted over and over
- KNOW YOUR AUDIENCE!
  - Administrators vs. Officers vs. Judges vs. Grantors vs. Legislature vs. Parents vs. Kids
- Audience determines what you “market”
- Audience determines who does “marketing”
- Some audiences DON’T MIX!!!!

WHEN & WHERE? POLICY!

- Invited by courts? Optimal!
- Identify “win-win” for all entities
- Be clear about compromises always
  - Mutually “protective”
  - Protect Court Officers (liability of mental illness)
  - Provide options, anticipate obstacles
    - Officers know who has mental illness by looking at kid
    - Officers struggling with undiagnosed/untreated

Keep End in Mind ALWAYS

What do I need to ask today to convince stakeholders

Identify your “boogiemen”

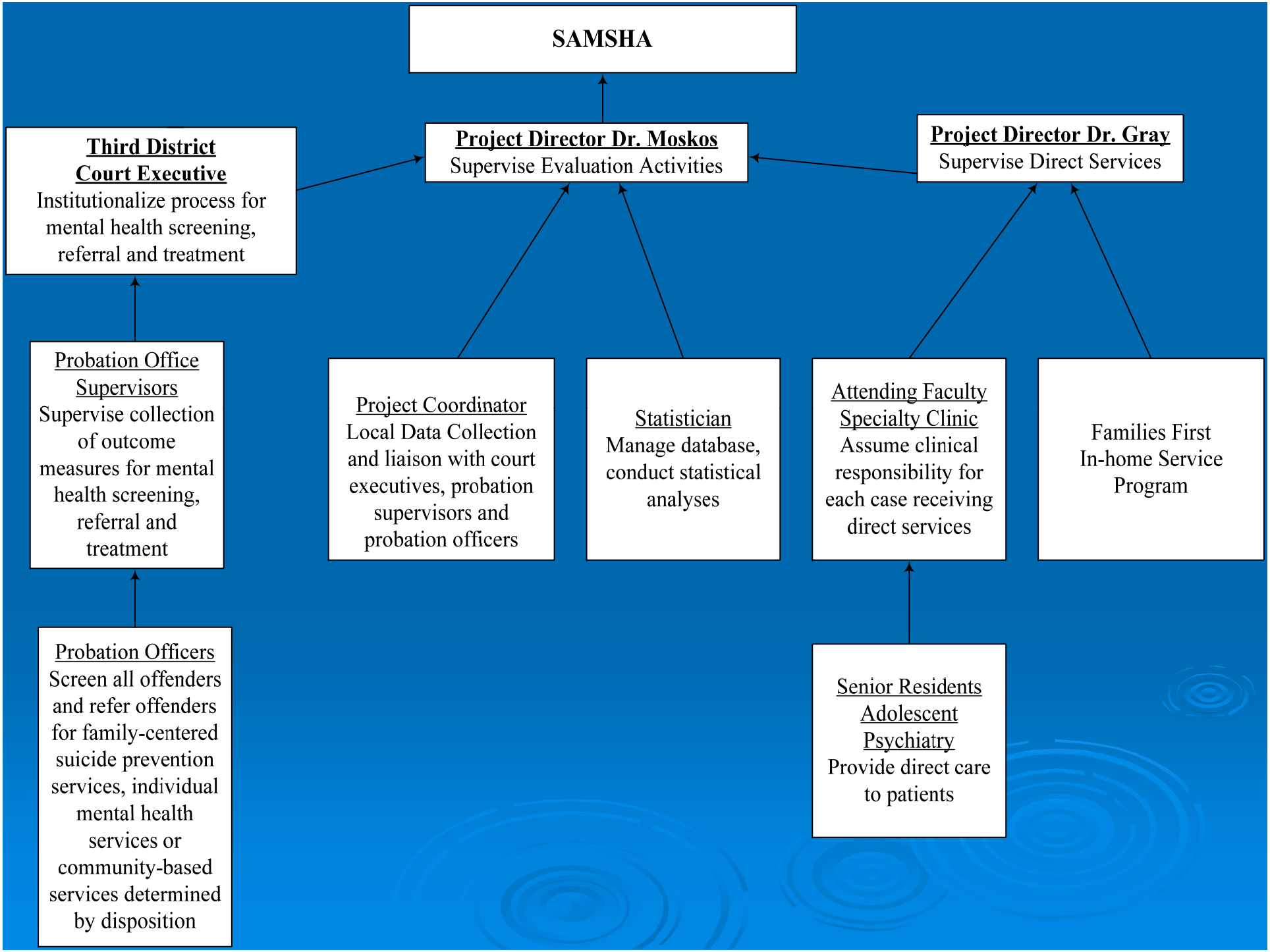
PREVENT WITH POLICY!

- Researchers (Drs. Moskos & Gray)
- Court Administrators (Probation)
- Court Officers (Probation)
- Public Mental Health Professionals
- Mental Health Advocates
- Families (parents and kids)

Policy Document-Sections

- Procedures: Screening, Emergency Referral, Normal Referral, Training, Data Sharing
- Hardware Agreement: who purchases, and who keeps equipment
- Confidentiality and Security: who can access what, how they will access it, how they will use it, who will be accountable to whom for analyses and dissemination, when will it be destroyed, and who will destroy it
- Expungement- Adoption- Case Merge- Case Delete

Do it in a Page or Less!


SAMSHA
Third District Court Executive
Institutionalize process for mental health screening, referral and treatment
Project Director Dr. Moskos
Supervise Evaluation Activities
Project Director Dr. Gray
Supervise Direct Services
Probation Office Supervisors
Supervise collection of outcome measures for mental health screening, referral and treatment
Project Coordinator
Local Data Collection and liaison with court executives, probation supervisors and probation officers
Statistician
Manage database, conduct statistical analyses
Attending Faculty Specialty Clinic
Assume clinical responsibility for each case receiving direct services
Families First In-home Service Program
Probation Officers
Screen all offenders and refer offenders for family-centered suicide prevention services, individual mental health services or community-based services determined by disposition
Senior Residents Adolescent Psychiatry
Provide direct care to patients

PROJECT TIMELINE

Month and Year: October 1, 2005-September 30, 2006

O 05	N 05	D 05	J 06	F 06	M 06	A 06	M 06	J 06	J 06	A 06	S 06

Goal 1-Objective 1-Activity 1: Screen all probation placed youth for signs and symptoms of mental illness using the Y-OQ.
Probation Officers

Goal 1-Objective 1-Activity 2: Assign youth to one of three groups based on age and Y-OQ outcome score.
Project Director/Project Coordinator

Goal 1-Objective 1-Activity 3: Quantify and qualify outcome measures for groups A, B, C.
Project Director/Project Coordinator

Goal 2- Objective 1-Activities 1-3: Obtain juvenile court records monthly and use Juvenile Court's Offense Acronym to determine severity of each offense in order to calculate recidivism.
Project Director/Project Coordinator

Goal 2-Objective 2-Activity 1: Obtain juvenile court records monthly and use Juvenile Court's Offense Acronym to determine severity of each offense in order to calculate suppression.
Project Director/Project Coordinator

Goal 3-Objective 1-Activity 1: Cost of disposition and number of days of service will be used to calculate the total cost of all disposition services. Calculate cost-effectiveness through examination of total cost of disposition services in the context of recidivism and suppression.
Project Director/Project Coordinator

Goal 3-Objective 2-Activity 1: Analyze data and disseminate findings in Utah Outcome Measures Report for Juvenile Offenders Assigned to Probation Status.
Project Director/Project Coordinator/Statistician

Name:	Child, Jayson, R	**ID:**	ABCDE028
Session Date:	1/24/2005	**Session:**	7
Clinician:	Clinician, Bill	**Clinic:**	North Clinic
Diagnosis:	Anxiety		
Completed by:	Mother		

Alert Status:	**White**
Most Recent Score:	40
Initial Score:	110
Change From Initial:	Recovery
Current Distress Level:	Low

Most Recent Critical Item Status:

12.	Obsessive Thoughts	Frequently
20.	Hallucinations	Rarely
21.	Self Injurious Behavior	Never
22.	Substance Abuse	Never
28.	Paranoia	Sometimes
38.	Delusions	Never
41.	Suicidal	Never
44.	Hypomania	Sometimes
46.	Fear of Going Crazy	Rarely
51.	Aggression	Rarely
58.	Eating Disorder	Never

Subscales	Current	Outpat. Norm	Comm. Norm
Intrapers. Distress:	11	26.4	8.9
Somatic:	4	7.8	3.3
Interpers. Relations:	3	10.4	0.6
Social Problems:	4	6.3	0.7
Behavioral Dys.:	8	20.1	6.8
Critical Items:	10	7.7	3.0
Total:	**40**	**78.7**	**23.3**

Graph Label Legend:

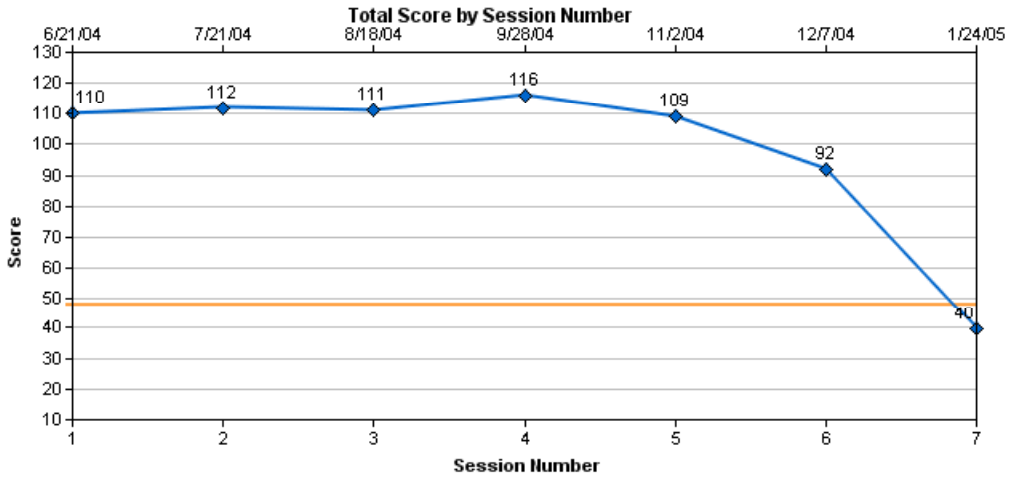
(R) = **Red**: High chance of negative outcome (Y) = **Yellow**: Some chance of negative outcome

(G) = **Green**: Making expected progress (W) = **White**: Functioning in normal range

Session#:	1	2	3	4	5	6	7
Completed By:	Mother	Mother	Mother	Mother	Mother	Mother	Mother

Feedback Message:

The patient is functioning in the normal range. Consider termination.



SUICIDE RISK ASSESSMENT: Y-OQ QUESTION #41

IF

Question #41 on the Y-OQ either:

ALMOST ALWAYS OR ALWAYS TRUE or
FREQUENTLY TRUE or
SOMETIMES TRUE:

THEN

1. Contact parent/guardian immediately when not present
2. Contact the University of Utah Neuropsychiatric Institute (UNI) to speak with a crisis worker (801) 583-2500
3. Have parent/guardian sign the FOLLOW-UP AGREEMENT, place in Supervisor's *RED* file folder
   *if parent/guardian is not present to sign the Follow-Up Agreement, contact parent/guardian and have supervisor sign for them as a witness.

IF

Question #41 on the Y-OQ either:

RARELY TRUE or
ALMOST NEVER OR NEVER TRUE:

THEN

1. Inform parent/guardian of youth's suicide thoughts and encourage them to inquire/talk to youth regarding frequency and seriousness of thoughts.

MENTAL HEALTH ASSESSMENT: Y-OQ RESULTS

IF

1. Y-OQ total score = 46+
2. Youth is 13-16 years of age
3. With 1-12 offenses (regardless if dismissed or adjudicated)

THEN

1. Provide the PARENT INFORMATION SHEET for services through SAMHSA grant, which refers youth for a FREE voluntary psychiatric and family evaluation and follow-up care as needed at the University of Utah Behavioral Health Clinic.
2. Complete MENTAL HEALTH ASSESSMENT CHECKLIST and place in Supervisor's *GREEN* file folder.

IF

1. Y-OQ total score = 46+
2. Youth is 13-18 years of age
3. With 13+ offenses (regardless if dismissed or adjudicated)

THEN

Refer for other general services.

IF

1. Y-OQ total score = 45 or less
2. Youth is 13-18 years of age
3. With 13+ offenses (regardless if dismissed or adjudicated)

THEN

No mental health treatment recommended, refer for existing Juvenile Court programs.

PARENT INFORMATION SHEET

Dear Parent/Guardian,

Based on information from your son or daughter, we would like to offer you and your family additional support services free of charge through the University of Utah Behavioral Health Clinic. Other families who accessed these services found that their child's mental health and school performance improved and that their child's risk of abusing alcohol or drugs, and involvement in future criminal offenses decreased. In fact, parents who chose these services reported fewer missed days of work related to court appearances and other court placements.

All services are family-centered. You and your child will work in partnership with professionals to design his or her Individual Treatment Plan. The plan could include one or more of the following:

1) University of Utah Behavioral Health Clinic:
   First your child will participate in a Family Assessment, and a Psychiatric Assessment. This evaluation includes general information, current emotional, behavioral, developmental and medical history, as well as a mental status examination for your child. The doctor will provide you with a summary of this information, a diagnosis as well as options for treatment. The Treatment Plan may include a variety of options, such as medical treatment for biological depression, designing a behavioral program for the child with help from the parents, a school intervention such as "accommodations," help with how to combat a drug or alcohol problem, etc. In cases where good efforts have been made, but parents still feel their child is not improving, a free in-home service developed by Utah Youth Village may be indicated.

2) Utah Youth Village:
   The "Families First" Program is an in-home service program, which supports parents, and helps the entire family develop skills to improve family relationships such as communication. These services teach youth how to be responsible, respectful and accountable. Family consultants spend time in the home with the family, often evenings, afternoons, or weekends–when the family needs them to be there. This program is accessible through the University of Utah Behavioral Health Clinic after the Family Assessment and Psychiatric Assessment.

The goal of the Juvenile Court and the University of Utah is to team up with parents whose child suffers with mental health problems, so that you feel supported. We want to offer expert clinical assessments of your teenager, and will work closely with you to carry out the treatment plan. If your families needs exceed these two services, then the University of Utah Behavioral Health Clinic will help you find the most appropriate referral. If you would like to make an appointment for services offered through the University of Utah Behavioral Health Clinic please call Dean Weedon at 801-587-3109

If you need more information before you decide you are ready to make an appointment for services, please call our service coordinator Sarah Halbern 801-587-3402. We understand that you may not be sure whether or not you should make an appointment for services. Sarah will be happy to assist you in any way she can to help you decide.

Douglas Gray, MD
Clinical Director, University of Utah Behavioral Health Clinic
Associate Professor, University of Utah Department of Child and Adolescent Psychiatry

* If your child is in mental health crisis, the University Neuropsychiatric Institute (UNI) will provide a free crisis evaluation 24 hours a day, 7 days a week. The UNI crisis phone number is 801-583-2500, please ask to speak to a crisis worker.

FOLLOW-UP AGREEMENT

SUICIDE RISK

_____ Y-OQ #41 Almost Always or Always True
_____ Y-OQ #41 Frequently True
_____ Y-OQ #41 Sometimes True

Dear Parent or Guardian,

According to information from you or your child, we determined that your child may be in mental health crisis that requires immediate attention. Given these responses, we encourage you to seek a crisis assessment for your child.

We highly recommend you call to speak with a crisis worker at UNI (University of Utah Neuropsychiatric Institute) at 801-583-2500, as they will provide free 24-hour crisis help. Your probation officer can help you with making this call. The UNI crisis worker can direct you to the best services available.

Possible Crisis Worker recommendations:

a) Nearest emergency room crisis evaluation with ambulance escort
*intake or probation officer calls 911 as directed.

b) Nearest emergency room crisis evaluation with parent/guardian escort
*intake or probation officer instructs parent/guardian to escort client to nearest emergency room for crisis evaluation and places signed Follow-Up Agreement in file.

c) University Neuropsychiatric Institute (UNI) evaluation with parent/guardian escort
*intake or probation officer instructs parent/guardian to escort client to University Neuropsychiatric Institute for a face-to-face crisis evaluation and places signed Follow-up Agreement in file.

d) No face-to-face crisis evaluation necessary, but needs outpatient mental health services
*intake or probation officer evaluates service criteria to determine type of referral for client and places signed Follow-up Agreement in file.

We respect that you are the parent and ultimately you will take responsibility for your child. We are happy to assist you and to try to help you find mental health services.

Signatures:

_____ _____
Parent/Guardian or Supervisor Date

_____ _____
Intake or Probation Officer Date

MENTAL HEALTH ASSESSMENT CHECKLIST

Mental Health Assessment Checklist

_____ Y-OQ Total Score

_____ Parent Information Sheet Form Provided

Case # _____ Supervisor's Name: _____

_____ _____

Intake or Probation Officer Signature Date

MENTAL HEALTH ASSESSMENT CHECKLIST

Mental Health Assessment Checklist

_____ Y-OQ Total Score

_____ Parent Information Sheet Form Provided

Case # _____ Supervisor's Name: _____

_____ _____

Intake or Probation Officer Signature Date

National Outcome Measures

Choosing A Outcome Tool

Government Performance Results Act

Data Collection Instruments for National Outcome Measures:	Youth Outcome Questionnaire	Juvenile Court Web-based Management Information System	Psychiatric Charts	In-home Service Case-logs
	Groups A, B, C	**Groups A, B, C**	**Group A**	**Group A**
1. Improved functioning	Primary Source	Secondary Source	Additional Source	Additional Source
2. Increased or retained employment and school enrollment		Primary Source	Additional Source	Additional Source
3. Decreased involvement with the criminal justice system		Primary Source	Additional Source	Additional Source
4. Increased stability in family and living conditions	Primary Source	Secondary Source	Additional Source	Additional Source
5. Increased access to services/number of person served by age, gender, race, and ethnicity		Primary Source	Secondary Source	Additional Source
6. Decreased utilization of psychiatric inpatient beds		Primary Source	Secondary Source	Additional Source
7. Increased social support/social connectedness	Primary Source	Secondary Source	Additional Source	Additional Source
8.Client reporting positively about outcomes			Primary Source	Secondary Source
9. Cost-effectiveness		Primary Source	Secondary Source	Additional Source
10. Use of evidence-based practices	Primary Source	Primary Source	Primary Source	Primary Source

Outcomes:

(Three dominant models of evidence-based treatment)

1. Empirically supported treatments
2. Practice guidelines
3. Patient-focused treatments

“Outcomes” Ability

- Outcomes Questionnaire (OQ)
- Youth Outcomes Questionnaire (Y-OQ)

- Mental Health Status Change or Outcome
  - Treatment: greater % in Community Range
  - Control: greater % in Inpatient Range

Patient focused treatment requires:

- Using an outcome measure that is sensitive to patient change
- Repeated patient assessment—preferably every session
- Ability to graph patient change and calibrate to “typical” profiles
- Immediate feedback on patient status

Implications For Practice

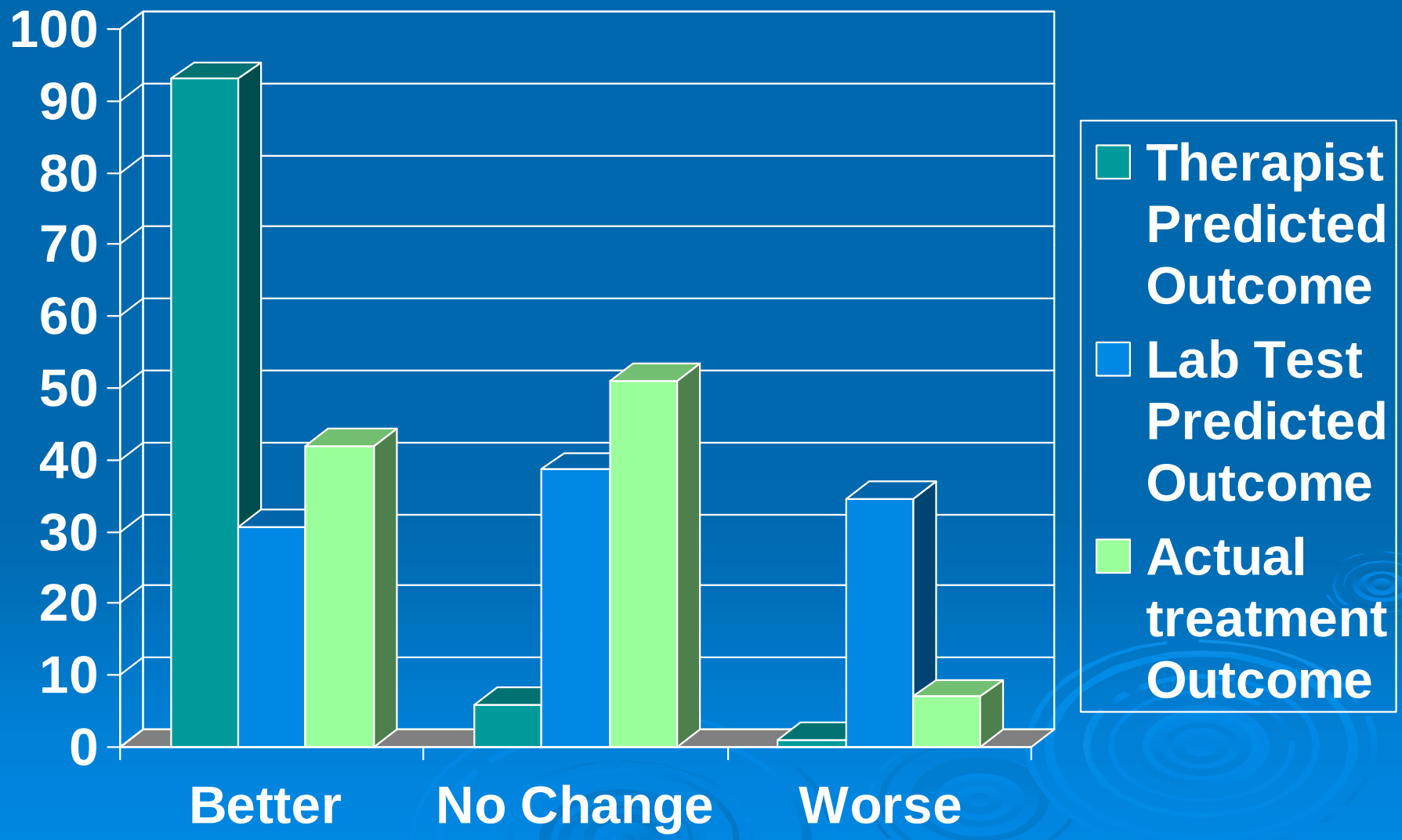
- Practitioners are overly optimistic about the positive benefits of therapy they offer
- 90% of clinicians report that their outcomes are above the 75th percentile.
- Therapists are unable to predict which of their patients will deteriorate (Hit rate less than 1%).
- Monitoring patient treatment response with instantaneous feedback to clinicians about a patient's treatment response should become a part of routine care.

From lab to clinical practice

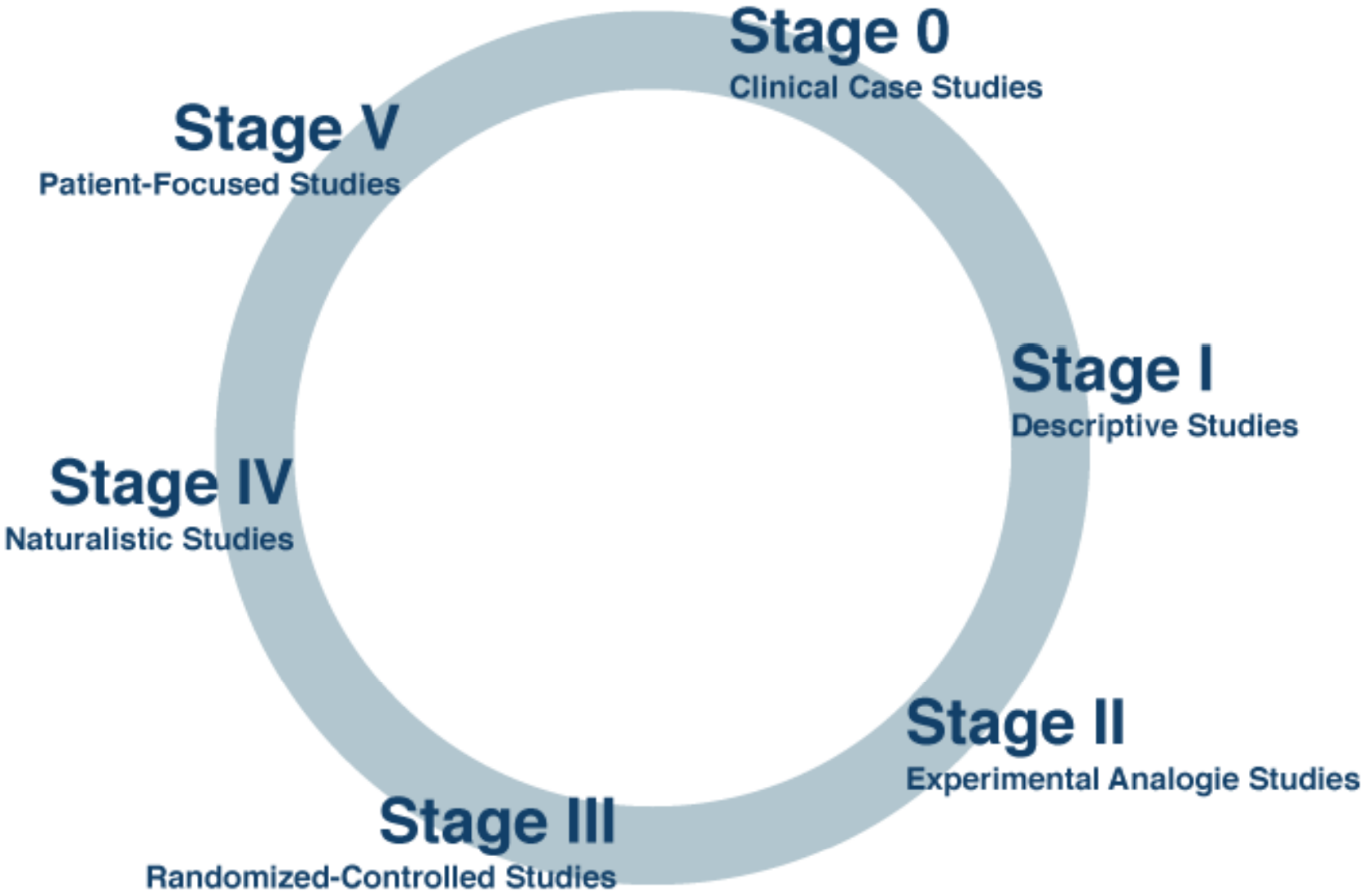
OQ-Analyst Features

- Patient-based outcome reduces burden on clinical and support staff: paper or PDA
- Incorporates clinician and patient feedback reports tested in 6 randomized clinical trials
- Mental health lab results available within 3 seconds of patient completing Y/OQ
- Provides alerts on critical and unanswered items as well as trajectory of change
- Includes rational & empirical algorithms—tied to dynamic research program

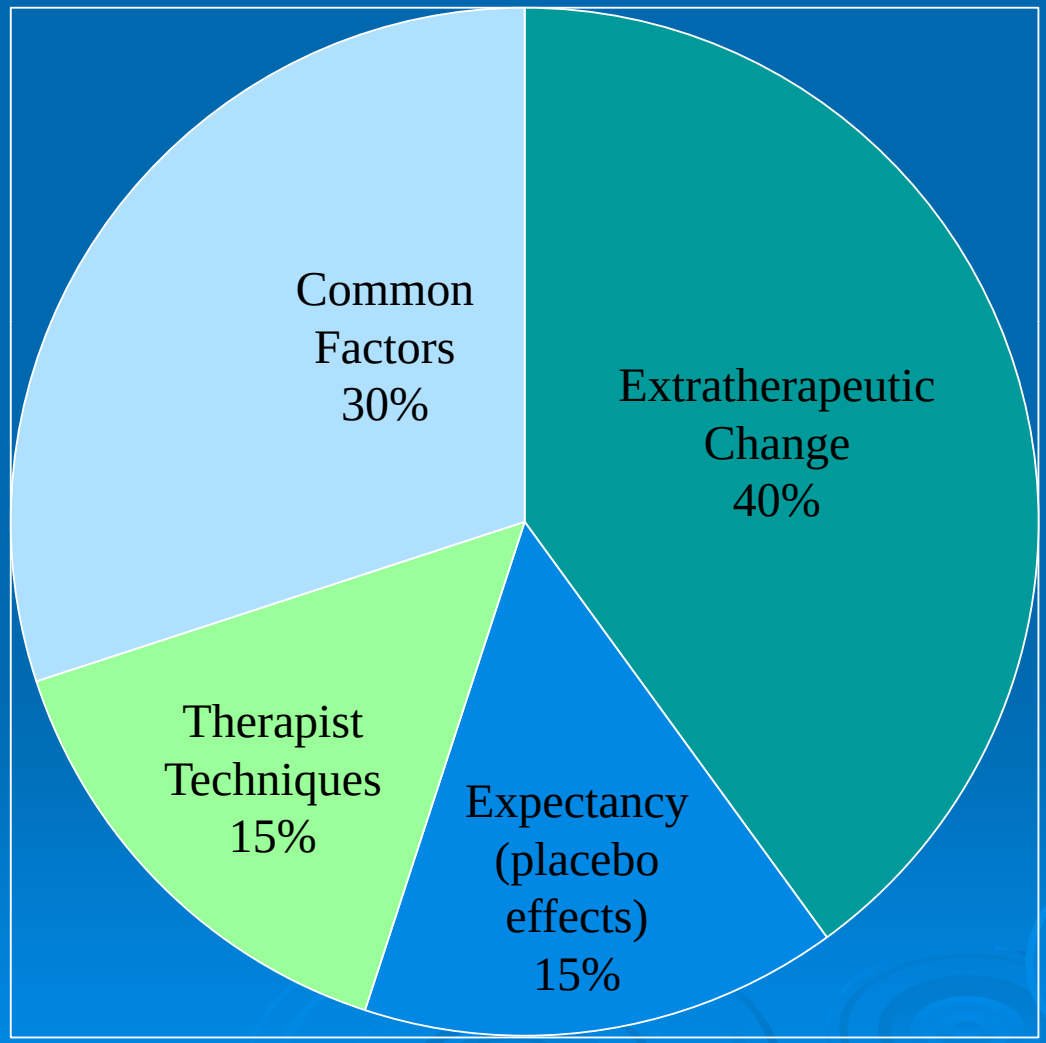
3. Lab test vs Clinician Predictions



Stages of treatment research



Explaining patient outcome X model

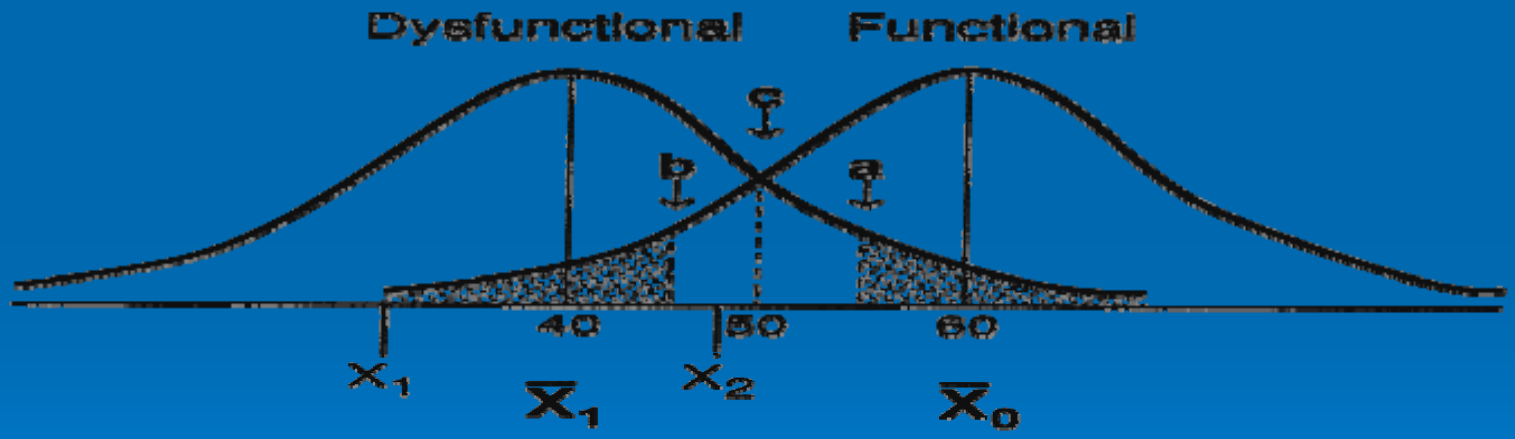


1. Is the treatment working for a particular patient?

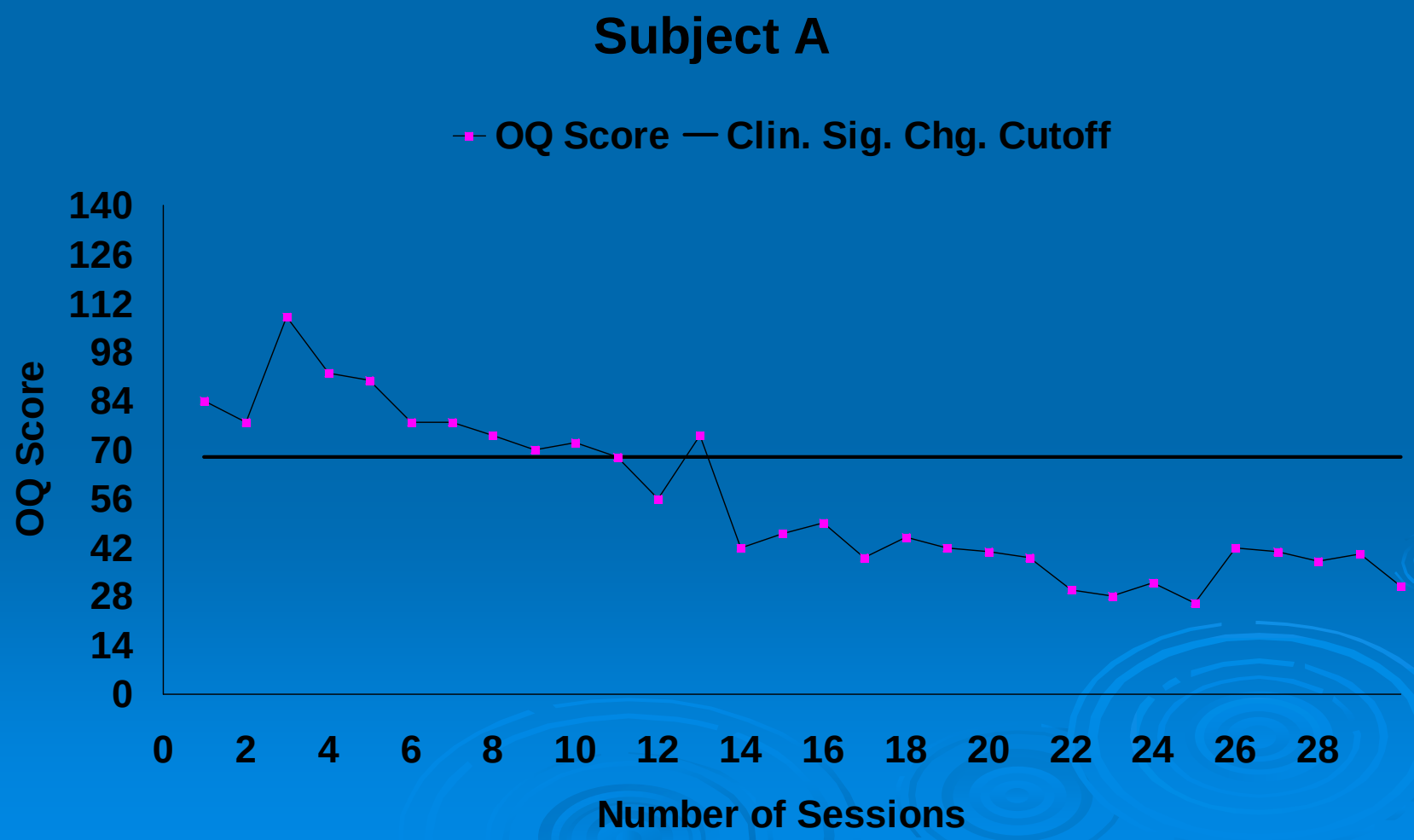
Answering this requires:

1. Definition of how much change is required before patient can be considered improved—reliable change index (RCI)
2. Definition of success and failure—clinically significant change

Recovery or “Success” is Movement into Functional Distribution



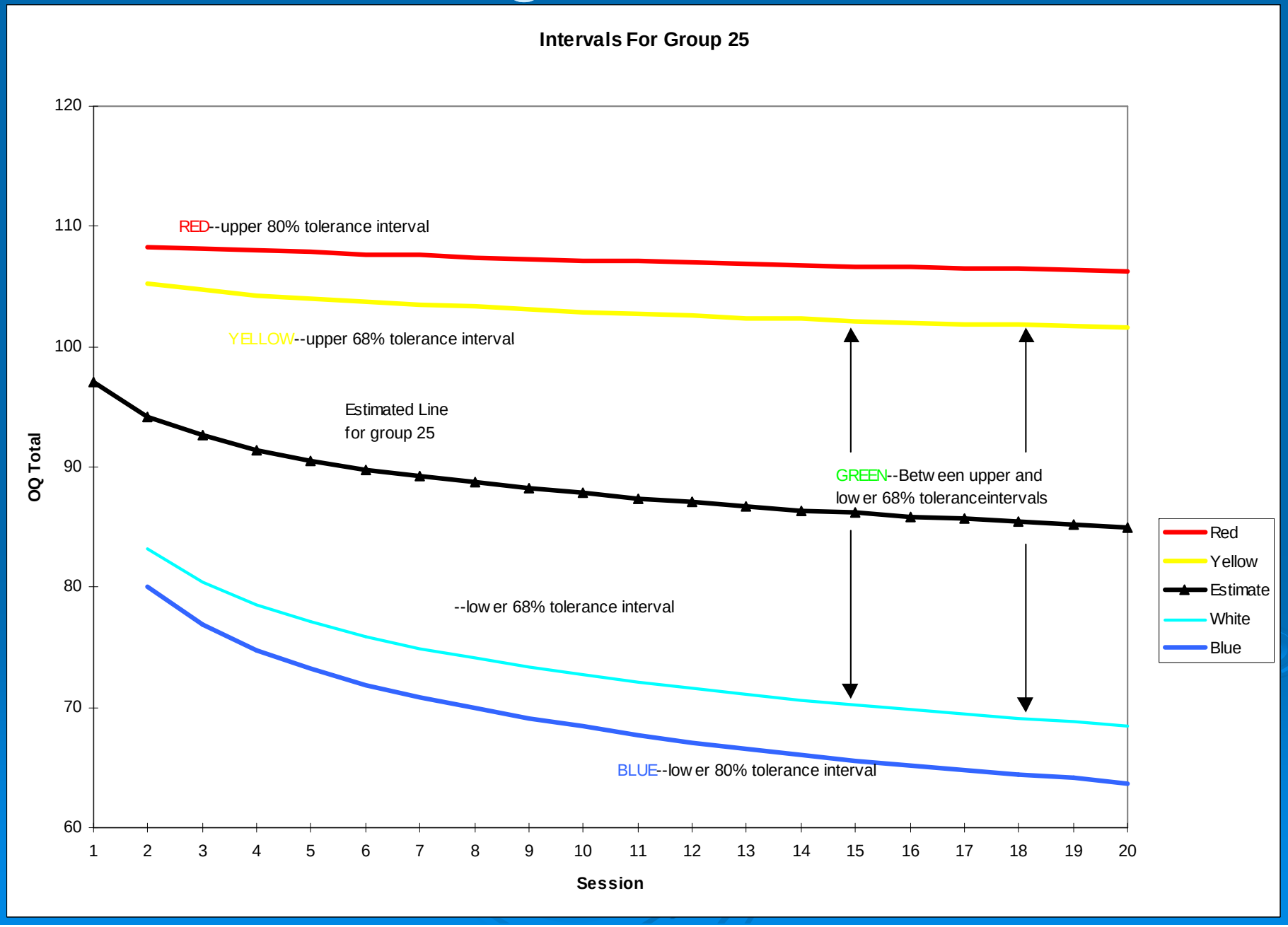
Putting RCI & cut scores together to track individual patient change



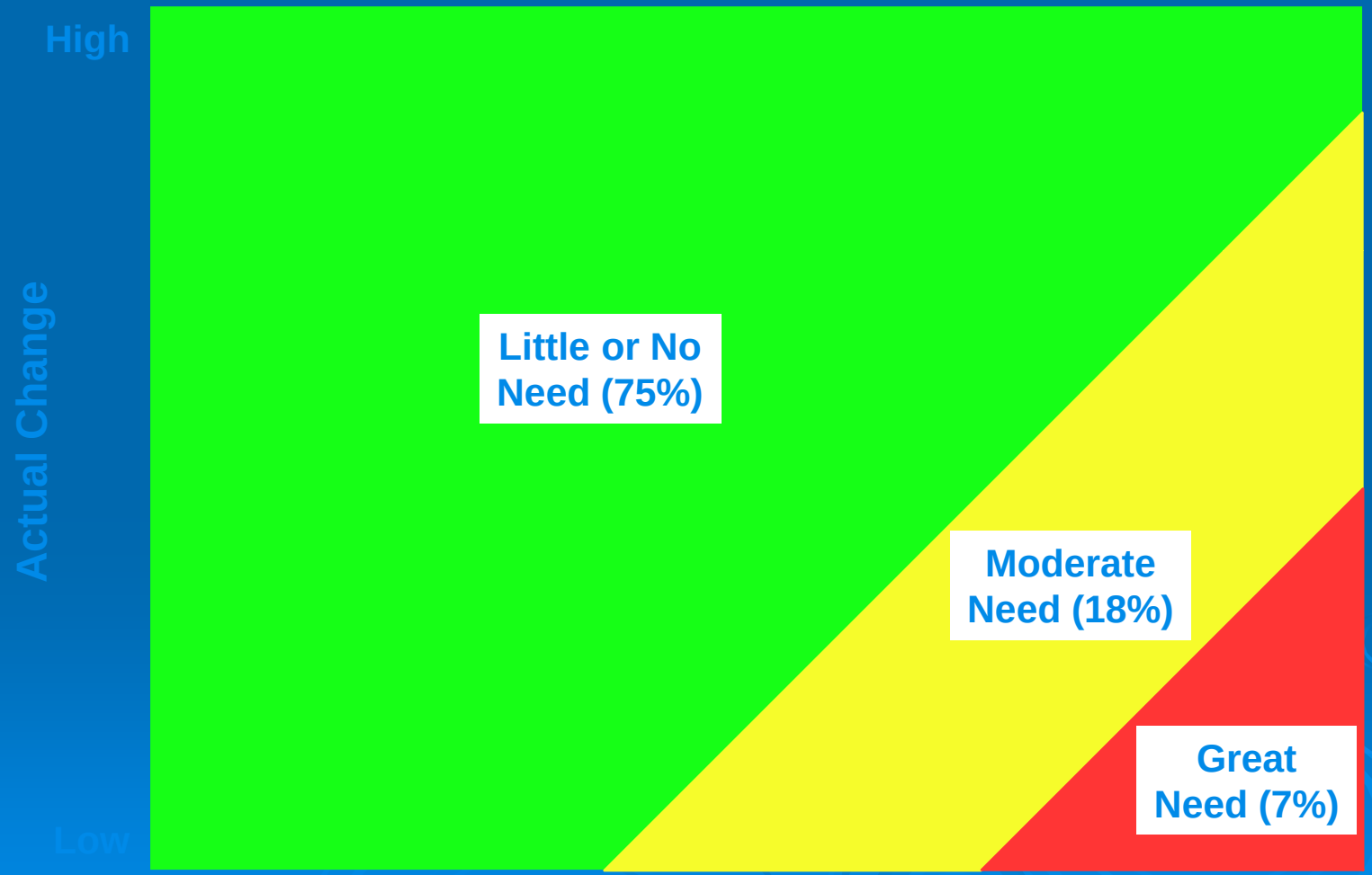
2. Rules for detecting Tx failure?

- **Red Rule:** The patient is not making the expected level of progress and is likely to drop out or have a negative outcome.
- **Yellow Rule:** Rate of change less than expected.
- **Green Rule:** The rate of change the patient is making is in the adequate range.
- **White Rule:** The patient is functioning in the normal range. Consider termination of treatment activities (not medications).

2. Predicting Treatment Failure



2. Interface between treatment failure rules and utilization review



3. Effects of predicting Tx failure

	Recovered or Improved	No Change	Deteriorated
No Feedback to therapists	60 (21%)	165 (58%)	61 (21%)
Feedback to therapists	104 (35%)	154 (52%)	40 (13%)
Feedback with clinical support tools	29 (49%)	25 (42%)	5 (8%)

3. How Well do Practitioners Predict Treatment Failure?

- Final Outcome predicted for 550 Clients
- Therapists predicted that 3 patients would have a negative outcome
- 26 had an ACTUAL negative outcome
- Therapists were accurate 1 time—4%
- Algorithms predicted 55 to have a negative outcome and were correct 20/26—77% accurate