Published in final edited form as:

Int J Ment Health Promot. 2016 ; 18(1): 19–63. doi:10.1080/14623730.2015.1079429.

Student Perceptions of the Acceptability and Utility of Standardized and Idiographic Assessment in School Mental Health

Mylien T. Duong,

Department of Psychiatry and Behavioral Sciences, University of Washington

Aaron R. Lyon,

Department of Psychiatry and Behavioral Sciences, University of Washington

Kristy Ludwig,

Department of Psychiatry and Behavioral Sciences, University of Washington

Jessica Knaster Wasse, and

Public Health – Seattle and King County

Elizabeth McCauley

Department of Psychiatry and Behavioral Sciences, University of Washington

Abstract

Evidence-based assessment (EBA) comprises the use of research and theory to select methods and processes that have demonstrated reliability, validity, and clinical usefulness for prescribed populations. EBA can lead to positive clinical change, and recent work has suggested that it is perceived to be useful by school mental health providers. However, virtually nothing is known about student perceptions of assessment use. Semi-structured interviews were conducted with 31 ethnically diverse middle and high school students (71% female) receiving mental health services in school-based health centers. Findings indicated that the majority of students found assessments to be useful, and perceived three primary functions of assessments: structuring the therapy session, increasing students' self-awareness, and improving communication with the provider. Barriers to acceptability were also found for a minority of respondents. Some students found the nature of standardized assessments to be confining, and others expressed that they wanted more feedback from their counselors about their responses. Idiographic assessments demonstrated especially high acceptability in this sample, with students reporting that tracking idiographic outcomes increased self-awareness, spurred problem-solving, and helped them to reach behavioral goals. Implications for school mental health service improvements are discussed.

Keywords

assessment; school mental health; acceptability

Despite increased attention to evidence-based practices in the last 40 years, the focus continues to be on evidence-based treatment manuals and has largely neglected evidence-based assessment (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008). Evidence-based assessment (EBA) comprises *methods* and *processes* that have demonstrated reliability, validity, and clinical usefulness for prescribed populations (Mash & Hunsley, 2005). In regards to *methods*, EBA includes (a) standardized assessment tools with strong reliability, validity, and clinical utility, and (b) idiographic assessment approaches, defined as strategies that are at least partially unstandardized and designed to maximize relevance for a particular individual. Idiographic targets may include a subset of items from a standardized questionnaire; individually selected thoughts, behaviors, emotions, or functional outcomes; as well approaches to goal-based outcome assessment, including Goal Attainment Scaling (Michalak & Holtforth, 2006) and “top problems” assessments (Weisz et al., 2011). EBA *processes* may include initial assessment for the purposes of problem identification/diagnosis, and treatment planning, progress monitoring over the course of intervention, and/or feedback to clinicians or clients about the results of assessments. Although these methods and processes represent the “gold standard” for assessment use, clinicians in actual practice rarely employ all EBA principles, and the current project focuses on student perception of assessment-as-usual.

EBA is particularly applicable to school mental health (SMH) for a variety of reasons. It is cost-effective and easily scalable; it can be implemented independent of, or in combination with, more complex evidence-based intervention packages (Glasgow et al., 2014; Scott & Lewis, 2014); it is efficient and can be implemented in only a few minutes (Lambert, 2012); and it improves client outcomes regardless of the specific treatment approach (Bickman et al. 2011; Lambert & Shimokowa, 2011). A meta-analysis found that simply providing clinicians with outcome ratings for their clients, based on how they compared to normative data, produced an effect size of 0.39 for reliable and clinically-significant change (Lambert et al., 2003). This effect size exceeds those found in meta-analyses of community implementations of evidence-based practices for youth (Weisz et al., 2006; Weisz et al., 2013).

Perceptions of Assessment Use among Clinicians

To be truly useful and sustainable, practices need to be *acceptable* among relevant stakeholders. Acceptability is defined as the perception that the practice is “agreeable, palatable, or satisfactory” (Proctor et al., 2011). In a mixed-methods investigation, Connors and colleagues (Connors, Arora, Curtis, & Stephan, 2015) showed that SMH providers have neutral attitudes to assessment use. Clinicians perceive assessments to serve a number of functions, including tracking clinical progress and communicating with other health care providers. At the same time, all clinicians endorsed at least one barrier, or disadvantage, to assessment use. The most commonly endorsed barriers were the lack of follow-through from parents, teachers, and students in completing questionnaires; and a preference for clinical judgment over assessment findings. In a recent study, our research team found that SMH clinicians collected assessment information on less than half of their caseload, and more commonly relied on clinical interviews and impressions to determine diagnoses and monitor

treatment progress (Lyon et al., 2015). Thus, although clinicians perceive some utility to EBA, many barriers to its use exists and actual use is low.

Perceptions of Assessment Use among Consumers

Acceptability

Although recent research has focused on attitudes towards EBA among mental health clinicians, significantly less attention has been paid to the perspectives of the recipients of mental health service. Consumer preferences and attitudes have been shown to predict engagement with, and benefit from, mental health treatment. In a sample of 144 children and families referred for outpatient mental health treatment for externalizing behavior, Kazdin (2000) found that treatment acceptability was related to behavioral change over the course of therapy. The same appears to be true for other presenting problems. Among children receiving therapy for anxiety disorders, the extent to which youth reported that they felt the treatment would be helpful predicted their dropout (Wergeland et al., 2015). Given that utilization of SMH is frequently brief and/or irregular (Lyon et al., 2014), it may be especially important for SMH practices to be acceptable in order to engage and retain students in treatment.

Studies of assessment acceptability among adult consumers give reason to be optimistic about potential acceptability of assessment use among youth. Adults generally value assessments in the services they receive (Gordon et al., 2004; Graham et al., 2001; Guthrie, McIntosh, Callaly, Trauer, & Coombs, 2008; Stedman, Yellowlees, Mellsop, Clarke, & Drake, 1997). Focus groups conducted with 183 adult receiving mental health service in Australia indicated that they perceived assessments to be *reasonably useful* or *very useful*. In interviews with 50 adults, Guthrie and colleagues (2008) found that 76% of those who had completed assessments believed that it resulted in their provider having a better understanding of them and 66% believed it had resulted in them receiving better care.

Utility

Qualitative data collected with adults indicate that they perceive standardized assessments to have a number of positive functions. These include: increasing self-awareness (Graham et al., 2001; Stedman et al., 1997), improving communication with providers (Guthrie et al., 2008), helping to structure therapy sessions (Guthrie et al., 2008; Gordon et al., 2004; Stedman et al., 1997), and providing aggregated data that may facilitate public understanding of mental health.

Regarding the role of assessment in increasing self-awareness, prior reports indicate that adults see assessments as useful in providing feedback about their progress and areas in which to improve (Graham et al., 2001); helping to compensate for their own poor memory by providing a record of change over time (Graham et al., 2001); empowering consumers to reflect on their own experience (Graham et al., 2001); and building insight about situational factors affecting mental health symptoms (Stedman et al., 1997). Assessments results have the potential to guide individuals in deciding whether to access treatment, what treatment to seek, and whether to stay in treatment (Stedman et al., 1997). The utility of standardized

assessments in increasing client self-awareness (Stedman et al., 1997) is consistent with evidence that self-monitoring is a common element of many evidence-based practices (Chorpita, Becker, & Daleiden, 2007) and may contribute directly to client improvement. Research has shown that self-monitoring leads to favorable changes in behavior (Abueg, Coletti, & Kopel, 1985), even above and beyond other therapeutic techniques (Kazantzis, 2000).

A second function of EBA is improved communication between mental health providers and recipients (Guthrie et al., 2008). A recent clinical trial found that computer-generated feedback to clinicians about client outcomes resulted in faster improvement (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011). A dose-response relationship was found, such that more feedback resulted in a greater client benefits (Bickman et al., 2011). EBA can also be useful for identifying client deterioration or therapy non-response (Carlier et al., 2012; Lambert et al., 2003). Adult consumers of mental health service are aware of this function of standardized assessment. They note that clinicians and clients can jointly use assessment results to make changes to the treatment plan, evaluate the effectiveness of a particular intervention, and generate options for further intervention. Written questionnaires help some clients to put words to their experiences (Stedman et al., 1997).

EBA may also help to structure therapy sessions. Focus groups with adults indicate that some clients see questionnaires as an opportunity to express themselves “more comprehensively” (Stedman et al., 1997, p. 62) and to report issues that may not be addressed during a clinical session. Others stress that therapy sessions, particularly initial encounters, may be disorienting, and questionnaire results provide a grounding for their conversation with the provider: “it’s hard to get across just how really bad you felt, I feel, just in words...Perhaps it’s [questionnaires] something that you could have, like a number of them, and you fill it out regularly yourself, and then it’s something that your doctor could browse through at a later date” (Stedman et al., 1997, p. 54).

A final function of assessments reported by adults is the provision of aggregated data that can lead to increased public understanding of mental health. This understanding, in turn, may guide resource allocations by both the service agency and larger government. In a study of consumer perceptions of EBA in the Australian mental health system, one focus group member stated: “I think that it is very important to provide some feedback...to the bureaucrats, on how to divide the cake up. Like, if they’ve got no information there on the degree of mental disorders and illnesses within society, they’re just not going to give any dollars to it” (Stedman et al., 1997, p. 57).

Barriers to acceptability

Adult consumers of mental health also identified a number of concerns with EBA. They expressed a preference for highly-personalized and relevant measures, open-ended questions and alternative response modalities, expanding EBA beyond symptom measures to include living skills and general functioning as well as life circumstances that may be impacting adjustment, and a debriefing following the EBA administration where feedback can be provided (Stedman et al., 1997). Consumers were also concerned about confidentiality, and

some express that completing standardized measures can be distressing (Stedman et al., 1997).

Idiographic assessments

As far as we are aware, there has been no systematic investigation of the acceptability of standardized tools versus idiographic assessments among mental health service recipients. Multiple studies, however, indicate a consumer preference for assessments to be individualized (Gordon 2004; Graham et al., 2001), to assess a wide range of domains beyond symptoms, including relationships, quality of life, and functioning in various domains (Stedman et al., 1997). We would expect, then, that idiographic assessment, because of its individualized nature, might be more acceptable to service recipients than use of standardized assessment tools.

The Current Study

To our knowledge, this is the first study to examine the perceived acceptability and utility of EBA among youth receiving mental health services. The project represents one component of an initiative to enhance services provided by mental health clinicians working in school-based health centers (SBHCs), which are primary care clinics based on school campuses in the United States. Participants were recruited from SBHCs located on middle and high school campuses in a large urban district in the Pacific Northwest. This study was designed to address the following research questions: (1) To what extent is EBA perceived to be acceptable by student recipients of school-based mental health services? (2) What are the perceived functions of EBA? (3) Are there differences in perceived acceptability and utility of idiographic versus standardized assessment tools?

Method

Participants and Setting

The sample included 31 middle and high school students (mean age = 16.3, range = 12.8 to 19.9) who presented to the SBHC for mental health services. Students were majority female (71%), and racially/ethnically diverse (48.4% Caucasian, 29.0% Hispanic/Latino, 22.6% Asian American, 16.1% African American, 6.5% American Indian, and 6.5% multiethnic). Participants were primarily lower-middle class, with 71.0% of students coming from homes with household incomes \$50,000.

Procedures

SMH clinicians were trained to identify potential student participants and introduce the study. Clinicians completed the Children's Global Assessment Scale (CGAS; Shaffer et al., 1983) on all new students entering their caseloads. Youth receiving a CGAS score 70, indicative of some difficulty in a single area or greater impairment, were asked by clinicians for permission to contact their guardians about research participation. Those who agreed to participate provided clinicians with contact information, which clinicians forwarded to research staff. Because the age of consent for mental health services is 13 years in the state in which the project occurred, the institutional review board granted an exception to allow

participants 13 years and older to choose whether they wanted project staff to contact their parents. After transmitting contact information, SBHC clinicians had no further role in the study and were blind to each youth's study enrollment status.

Students and/or their parents/guardians were contacted by phone. Project staff described the project and obtained assent for all students, and parental consent for 16 of 30 students over age 13. Although in-person interviews were offered, all participants elected to complete study measures over the phone. Other than participant demographics, data reported the current study were collected four weeks after recruitment in order to ensure that youth had the opportunity to receive some mental health service.

Measures

Children's Global Assessment Scale (CGAS; Shaffer et al., 1983)—The CGAS is a clinician-rated measure of youth functioning. Scores range 1–100 (higher = better functioning). Scores ≥ 70 have been used to identify clinical “caseness.” Previous research has demonstrated the ability of the CGAS to identify youth with clinically relevant mental health symptoms (Shaffer et al., 1983).

Student demographics—Demographic information was collected from all participants including age, grade in school, gender, race/ethnicity, and household income.

Semi-structured interview protocol—Questions evaluated in the current study focused on the use of EBA in therapy, both with standardized assessment tools (e.g., “Did the counselor ever give you a questionnaire or survey that asked you about your emotions or how you were feeling?”) and idiographic assessments (e.g., “Did you and your counselor track anything else over time?”), and the impact of EBA on therapy (e.g., “How helpful did the questionnaire make your meetings?”).

Data Analysis

Interviews were audio recorded, transcribed, and coded using conventional content analysis (Hsieh & Shannon, 2005) with ATLAS.ti (Muhr, 2004). Four coders reviewed the transcripts initially and then met to identify potential codes. An initial codebook was developed, trialed, and revised through discussion over subsequent transcript reviews. Then, two reviewers independently coded each transcript and met to compare their coding using a consensus dialogue (Hill, Knox, Thompson, Nutt Williams, & Hess, 2005). Consensus coding is designed to circumvent some researcher biases while capturing data complexity, avoiding errors, and reducing groupthink. This process yielded six codes related to the function of EBA; two codes related to barriers to acceptability; four codes related to idiographic assessments; as well as other categories of responses, including comments about specific assessment tools and idiographic targets, provision of feedback about EBA, and how EBA was administered.

Results

Table 1 summarizes the descriptive statistics for student-reported EBA use in their SMH services. It should be noted that these statistics reflect frequency of EBA use in the context

of a quality improvement effort that included ongoing training for SMH providers on EBA. In this sample, the vast majority (87%) of students reported that their counselor had administered a standardized questionnaire. When it was administered, it was most frequently administered *sometimes* (35%) or *in every session* (42%). Seventy-three percent received feedback about the questionnaire at least some of the time. The use of idiographic assessment was much less frequent (40%), with grades (43%) and attendance (33%) most frequently tracked. Overall, nearly all students (93%) reported that their counselor engaged in standardized and/or idiographic assessment.

Acceptability of EBA

With regard to standardized assessment tools, students most commonly perceived that standardized questionnaires made their counseling sessions *a little bit more helpful* (37%). Some students felt that standardized questionnaires made their counseling sessions *much more helpful* (23%) and some felt that standardized questionnaires did not impact their sessions (23%).

Utility of EBA

As shown in Figure 1, the majority of students (57%) were able to identify a function of EBA in their mental health counseling, and 30% identified two or more functions. Among those who identified a function, a large majority (76%) stated that it helped to structure their therapy sessions. For instance, one student stated that completing standardized questionnaires was “a great way to start off with what you want to talk about.” It also helped to structure therapy sessions by providing a quick snapshot of a student’s current functioning, guiding the counselor to follow up. Eighteen percent of students who identified a function of EBA appreciated that the assessment made their care more efficient: “It gave us kind of a schedule and maybe even saved us some time because I had already answered it so she kind of knew how I was feeling and she kind of knew how severe I was feeling without having to ask it.”

Increasing self-awareness was also a common identified function of EBA. Of those who endorsed a function, 58% reported that completing assessments helped them to gain insight or track their symptoms over time: “I had been going through a lot and didn’t notice I had Major Depression Disorder. It was very big eye-opener.” For this student, the information was validating and normalizing: “It’s okay to feel those ways. It’s just mental illness.” For some, the process of completing the questionnaire was an opportunity for self-reflection that was not available elsewhere: “When I saw it all written down and realized how many yeses I had checked, it made me realize how I was feeling and I don’t think I would have been able to put that all together in my brain before.” Students also appreciated being able to track their progress in therapy over time: “It’s pretty cool when it [the score] actually goes up. Or is it down? I don’t remember.” Seeing this improvement helped to engage students in therapy: “It made me want to go see my counselor more to know that I was making that improvement.”

Thirty-five percent of students who endorsed a function of EBA stated that it helped improve communication with their counselor. These students stated that standardized tools at intake

helped their counselor to understand their diagnoses better. EBA was also useful on an ongoing basis: “It’s an easy way for us to kind of have a check-in.” One student reported that communicating some of her struggles via the questionnaire was more comfortable for her: “I might not have had the confidence to say that stuff to her, but it was easier for me to write it down.”

Barriers to the Acceptability of EBA

Only a small percentage (13%) of students reported disliking completing standardized questionnaires. Two of these students felt confined by the standardized questions and response options: “It made me feel kind of like there was only a few options of how I could be feeling at that moment.” One student disliked the process generally: “they [the questionnaires] are whatever. They’re, like, they’re pitiful. I don’t like people asking me questions. [addressing the interviewer] Like, don’t take offense to that. It really is irritating.” As is typical in assessment-as-usual practices, not all EBA processes were followed and students were not always provided feedback about their responses. Two students expressed that they disliked not receiving this feedback: “It kind of makes me feel like I filled out that paper for nothing, if we’re not going to talk about it.”

Acceptability of Idiographic Assessment

Most students (75%) whose counselors tracked a specific idiographic outcome found the assessment to be helpful. In half of these responses, students stated that tracking an idiographic outcome helped to increase self-awareness. Tracking sleep, for example, helped one student to understand the relationship between sleep and her mood. Often, this increased awareness would lend to problem-solving: “It helps me to sort out what needs to be done.” One student, whose counselor looked at her grades while in session, stated that this helped her “so I know what I need to do extra credit for.” Forty-two percent of students whose counselor tracked an idiographic outcome directly stated that it was helpful in helping them reach their goals. These successes included coming to school on time more often, going to bed at a set hour, and reducing smoking. In one student’s words: “I feel like when you have certain goals and you’ve accomplished even partially what the goals you made, I feel like it helps. It helps me make more goals and helps me want to achieve more to actually get where I want to be.” No students reported any dislikes about idiographic assessments.

Discussion

To the best of our knowledge, this is the first project that examined the perceived acceptability and utility of assessment use among youth mental health service recipients. The current results indicated that the majority of students found EBA to be useful, and the perceived functions mirrored those identified by adult mental health consumers (Gordon et al., 2004; Guthrie et al., 2008; Graham et al., 2001; Stedman et al., 1997). These included structuring the therapy session, increasing students’ self-awareness, and improving communication with the provider. Unlike adult mental health service recipients, no students identified improving public understanding of mental health as a function of assessments.

Barriers to acceptability were endorsed by a minority of respondents. Some found the nature of standardized assessments to be confining, and others expressed that they wanted more feedback from their counselors about their responses. Idiographic assessments demonstrated especially high acceptability in this sample, with students reporting that tracking idiographic outcomes increased their self-awareness, spurred problem-solving, and helped them to reach behavioral goals.

Increasing Acceptability of Assessments

The pattern of findings in the current study suggests that assessments are most acceptable to students when it is individualized, relevant to identified treatment goals, and discussed with the clients. When assessments were individualized, they were most acceptable to youth, consistent with findings from research with adults (Gordon et al., 2004; Guthrie et al., 2008; Graham et al., 2001; Stedman et al., 1997). Clinicians or clinics may choose, at intake, to administer a broadband assessment (that measures a student's functioning in multiple domains) or multiple narrowband scales (that provide more detailed information about a student's functioning within a particular domain or with respect to a specific problem). Such assessments may aid diagnosis, but are necessarily not tailored to individual need or presenting problems if they are administered prior to the intake interview. Despite this, acceptability of intake assessments may be maximized by explaining the rationale for their use (i.e., standardized measures provide data that can help to compare students to their peers across domains and facilitate treatment planning; standardized measures save session time by providing a snapshot of functioning, etc.). When monitoring progress, acceptability can be optimized if the process of selecting an assessment target is collaborative. Structured tools for identifying monitoring targets, such as the top problems assessment (Weisz et al., 2011) may be helpful in guiding students and providers through this process. The rationale for using idiographic and/or standardized tools to monitor progress also needs to be clearly communicated to students.

Relevance, or "fit" with identified treatment goals was a strong determinant of acceptability of EBA in this study, consistent with feedback from adult clients and clinicians. Connors and colleagues (2015) found that assessments were highly regarded when they tracked student progress with specific treatment goals over time and when their results can be easily integrated into treatment planning. Our prior work indicates SMH clinicians, on average, feel only *moderately* skillful in selecting standardized assessments, setting treatment goals based on assessment results, and using assessments to monitor progress (Lyon et al., 2015). In focus groups, many reported minimal prior training in EBA, and some expressed a desire to learn these skills (Lyon et al., 2015). Further, clinicians often reported a lack of assessment-related supervision as a key barrier to EBA use (Lyon et al., 2015; Connors et al., 2015). To address these barriers, our team piloted a training and consultation program focused on assessment principles and use of specific tools. The results were promising: We found that participating clinicians administered standardized tools to 62.2% of their caseload (compared to the less than 50% found in some SMH settings; Lyon et al., 2015).

A significant percentage of students (27%) reported never receiving feedback about the standardized forms they completed, and students specifically mentioned this as problematic.

A prior study of adult mental health services showed that 65% percent of providers who administered assessments did not provide feedback or debrief assessments with their clients (Guthrie et al., 2008). This low rate of feedback stands in contrast with the positive attitudes about feedback endorsed by clinicians. In prior work, we found that most clinicians indicated strong beliefs that providing feedback to youth gave assessment tools added value (Lyon et al., 2015). For example, one provider who worked primarily with middle school students indicated the importance of graphs and visual feedback in motivating students to stay in therapy. Others stated that assessment results can validate students' experiences (Lyon et al., 2015). Some of the discrepancy between attitudes and behavior may have to do with clinician skill and comfort in discussing assessment results. SMH clinicians in our prior study reported being *moderately* skilled in interpreting assessment results and providing feedback to clients (Lyon et al., 2015). Relative to other evidence-based practices, EBA is relatively low in complexity and can be taught via a brief training. Thus, EBA may be an especially appropriate target for training of SMH clinicians, especially given that SMH clinicians perpetually contend with limited time and resources (Evans & Weist, 2004).

Consumer preference for individualized and relevant assessments needs to be balanced with mandates to use assessments from some national funders of health services and from provider organizations. Many provider organizations in the U.S. and the U.K., for example, mandate the use of specific measures in all cases regardless of clinical relevance (Connors et al., 2015; Wolpert, 2013). On the one hand, organizational support has been cited as a potential strategy for increasing EBA use in mental health (Bickman et al., in press), and our previous work indicates that EBA use in schools can be facilitated by organizational expectations, informal culture of EBA use, and embedding of assessment tools in health record systems (Lyon et al., 2015). At the same time, clinicians may perceive external mandates as bureaucratic burden and patients may experience irrelevant measures as undermining the clinical encounter (Wolpert, 2013). Strategies that increase the use of individualized and relevant assessments, consistent with the principles of EBA, have yet to be developed. Wolpert (2013) argued for encouraging and training providers in assessments, but leaving some freedom for clinical judgment in what assessments to use.

Idiographic Assessments

In this sample, students uniformly perceived idiographic assessment to be helpful and no students in the study reported disliking idiographic assessment. It may be that idiographic targets are more individualized because they are more likely to derive from conversation with students regarding presenting problems and treatment goals that may not be captured by standardized assessments. Prior research suggests that many students presenting for SMH services do not meet criteria for clinical diagnosis, and SMH clinicians are less likely to use standardized assessment tools with subclinical cases (Lyon et al., 2015). Because they focus on outcomes that are not necessarily bound by symptoms of psychopathology, idiographic assessments may therefore be particularly useful in SMH. As students noted in this study, tracking idiographic outcomes may also shed light on causal relations (e.g., situational factors that impact behavior) and effectiveness of interventions (Haynes, Mumma, & Pinson, 2009). Relative to the decades of research about standardized tools, however, the conversation about reliable and valid idiographic assessments has only recently begun (see

Haynes et al., 2009). Haynes and colleagues (2009) outline a procedure for developing idiographic targets, which includes generating a potential array of items, specifying response format and scale, selecting targets that are maximally sensitive and congruent with the treatment goal, specifying times and/or settings for tracking, developing instructions, and establishing methods for monitoring adherence. In other words, idiographic assessment done well is no easy task. For a student working on improving sleep, for example, idiographic targets that can be tracked include time to bed nightly, numbers of hours slept, minutes awake in bed before falling asleep, subjective alertness during the day, whether naps are taken, or a variety of other sleep-relevant variables. Clearly, thorough information gathering is needed to effectively conduct an idiographic assessment. Given the high acceptability and utility of idiographic assessments among students and clinicians alike, our research team is increasingly integrating idiographic assessment into our trainings for SMH providers. Our experience doing this work suggests that idiographic assessment requires more intensive training and support than standardized assessment.

Academic indicators were the most frequently tracked idiographic outcomes. Academic concerns are among the top reasons why youth receive mental health services (Walker et al., 2010). Perhaps for this reason, our prior work showed widespread support for the use of academic data in clinical practice (Kelly & Lueck, 2011). Connors and colleagues (2015) found that SMH clinicians rated academic targets to be more useful than other types of assessment information, including standardized questionnaires. Although clinicians in that study reported using academic indicators more frequently than standardized tools, we have also found that school providers in the district participating in this study often experience barriers to accessing educational data (Lyon et al., 2015). In our prior interviews with providers, many spoke at length about the national and local policies that sometimes interfered with their access to student educational data. In this district, many (but not all) SMH providers are located in SBHCs and are employed by health agencies, not by school districts. Thus, they are unable to access educational data under the Family Educational Rights and Privacy Act (FERPA) of 1974 without parental authorization. Students in the current sample whose counselors tracked academic indicators had positive perceptions of the process and reported that it helped to improve those idiographic outcomes. Thus, problem-solving barriers to enable providers easy access to educational data and training them to integrate these data into their decision-making, seem of paramount importance in improving SMH. Although relatively little is known about effective ways to integrate academic data into mental health service delivery, Lyon and colleagues (2013) recently applied a model of data-driven clinical decision making (Daleiden & Chorpita, 2005) to the use of educational data in SMH. The authors concluded that the successful application of such a model requires significant training and that uptake of such practices is unlikely to occur without structured, ongoing support.

Conclusion, Limitations, and Directions for Future Research

In order to contribute to the nascent literature and inform future quality improvement efforts, the current project was designed to assess student perceptions of EBA in SMH. EBA consists of using theory and research to select assessment methods (i.e., relevant standardized tools or individualized, idiographic targets), and using such methods to

establish diagnosis, differentiate between diagnoses, formulate treatment plans, monitor progress, and, by providing feedback, enable the client and provider to collaboratively engage in data-based decision making. The majority of students in this study found use of assessments to be helpful in structuring therapy, increasing self-awareness, and improving communication with the provider. Idiographic assessments demonstrated especially high acceptability. Barriers were also documented, with some students reporting that standardized assessments were confining, and others expressing a desire for more feedback from their counselors about their responses.

Although current findings are promising, it should be noted that this project was conducted in one type of SMH delivery model in a single urban area. Perceptions of assessment use may vary across settings, and across stakeholders. For example, little is known about how best to obtain standardized assessments from parents and teachers (Connors et al., 2015). In addition, provider behavior is likely to significantly impact student perceptions of assessments. Our initial findings suggests that how the clinician explains the rationale for assessments, selects the assessment target, and communicates results to students is likely to predict students' engagement with assessments. Identifying the clinician behaviors that optimize the utility and effectiveness of EBA – and developing trainings to enhance clinician mastery of these strategies – can help to maximize the benefit of assessments.

Given consistent evidence that providers and consumers alike favor assessments that are individualized, relevant to treatment goals, and discussed in treatment, future research should develop and test specific strategies to overcome barriers to implementing EBA. Our current work focuses on training and consultation. Other strategies that have been suggested as potential helpful include building in organizational supports (e.g., making questionnaires easily accessible). Providing consumer feedback to clinicians and provider organizations about assessment use, including the findings in the current study, may also help to facilitate change.

Acknowledgments

This publication was made possible in part by funding from grant K08MH095939, awarded to the second author from the National Institute of Mental Health (NIMH). The authors would also like to thank the participating students, Seattle Children's Hospital, and Public Health of Seattle and King County for their support of this project.

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Figure 1.
Percent of students identifying functions of EBA

Figure 2.
Among students who identified a function, percent of students endorsing each function.

Table 1

Descriptive Statistics for Evidence-Based Assessment Administration

Ever administered SA	%
Yes	87
No	13
If ever administered, frequency of administration	
Sometimes	35
Half the time	8
Usually	15
In every session	42
If ever administered, received feedback	
Yes	73
No	27
Ever tracked idiographic outcome	
No	60
Yes	40
If idiographic outcome tracked, type of outcome	
Grades	43
Attendance	33
Mood	18
Sleep	8