In Response

MHSPY: Intentional Integrated System of Care Associated with Improved Youth Outcomes

We have reviewed the comments offered by Drs. Bickman and Lambert and definitely agree that the funding and government authorization they had 15 years ago to collect both study and comparison group data was a fortunate, if uncommon, opportunity. The current reality of applied clinical research, which lacks the millions of dollars available to them, is that consent decrees have more impact on delivery systems than scientific recommendations, and few efforts are made to measure the results of anything. We were unable to retain our randomized design for our study[1] due to concerns from the federal Center for Medicaid and Medicare about the potential for inequity in service delivery.* Recognizing that financial and policy barriers require real-world research designs, we proceeded with a revised study. We urge others to continue to measure and report, even when randomized controlled trials are not possible. Standardized, transparent measurement methodologies applied to innovations and "usual care" alike can add to the collective knowledge base on effectiveness. Despite his ostensible rigor regarding comparison groups, Dr. Bickman suggests that the Massachusetts Mental Health Services Program for Youth (MHSPY) Medicaid data from 2002 can be usefully compared to his Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) data from 10 years earlier in North Carolina. Dr. Bickman has reported elsewhere[2] that the Fort Bragg study and control populations, in addition to being employed and insured, were made up of predominantly white, educated, middle-class, two-parent families. The Stark County population reportedly included children with severe emotional disorders (SED), but only 10% were racial or ethnic minorities, and only 16% were at or below the poverty level.[3] By contrast, the MHSPY study population is predominantly nonwhite, all are below poverty level, and all the children meet criteria for SED. The parents/caregivers are mostly single with little education and impaired physical and mental health. Over 80% of the enrolled youth have histories of involvement with protective services. The relevance of comparing these two very different populations, from different geographies and different decades, is not evident. Yet, Bickman and Lambert indicate they did "16 [undisclosed] comparisons" of Child Behavior Check List (CBCL) and Youth Self Report (YSR) scores between MHSPY children and samples selected from their files. It is not clear what the comparisons were regarding the two out of five measures the authors chose to report on, so their statement that something was "insidious" remains a mystery. Putting aside the legitimacy of such comparisons, two questions come to mind: Why were only two instruments compared when we

*Ironically, despite this precaution, the state Medicaid office in Massachusetts was successfully sued last year, in the well-known "Rosie D." case, for failure to meet federal early and periodic screening, diagnosis, and treatment (EPSDT) schedule guidelines on screening and treatment for children with serious emotional disturbance, or SED.

Journal of Behavioral Health Services & Research, 2007

actually have five instruments in common, and is it a coincidence that one of the two they chose to compare (the CBCL) provides the least favorable comparison for the MHSPY data? The CBCL is a parent or caregiver report of a child's symptoms. Many researchers note that factors such as parent income and education, parental mental illness, substance abuse, and cognitive functioning particularly influence the reliability of this measure, with more challenged families less likely to report high levels of symptoms at baseline, thereby limiting the range of subsequent symptom reduction. Although MHSPY families do report improvement at 6, 12, and 18 months, as displayed in our article, we presume that the smaller change scores on this measure compared to the Fort Bragg populations might be impacted by some of the already described differences between the two groups. It is also unclear what Dr. Bickman intends to communicate regarding the YSR. A comparison between his published data[3] and ours indicates that the MHSPY youth show a greater degree of improvement (14 vs. 4%) than both the study and control groups Bickman reports on. The absence of specifics of the 16 comparisons using CBCL and YSR leaves little more to discuss about them. However, there is no doubt that MHSPY youth show improvements at 6, 12, and 18 months on the two standard child functional measures: the child and adolescent functional assessment scale (CAFAS) and the child global assessment scale (CGAS). MHSPY youth improve by 20 or more points, consistent with reliable clinical change, according to CAFAS norms developed by Dr. Kay Hodges.[4] On the CGAS, MHSPY youth improved 23% at 18 months, in contrast to the −1 and −2%, respectively, that Dr. Bickman reports for his control and study groups.[3] Lastly, in response to the collection of dismissive remarks at the close of their letter, we can assure Drs. Bickman and Lambert that the program's attrition rate is remarkable only for its negligibility: MHSPY has a 97% retention rate. As to the question of maturation, the average length of stay is 16 months; eligibility requirements for both symptom severity and duration make the passage of little more than a year unlikely as an explanatory factor in the observed changes. The possibility of regression to the mean is always a good point to consider; however, we note the opposite in the MHSPY data, where those children with scores farthest from the mean appear to improve the least. As to the possibility that an "inferior" service is being masked, the consistent finding that the complex MHSPY study subjects with SED spend at least 80% of their days at home would suggest otherwise.

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