Meadows Mental Health Policy Institute

Best Practices Summary – December 2014 Care

Overarching Framework: Quality Improvement and Health Care

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of their "Crossing the Quality Chasm"[1] report, which became the first in a series of subsequent IOM publications that have helped shape our understanding of the need for a fundamental shift in operational priorities and health care delivery organization commitment to ongoing quality improvement. The premise of the report is in many ways quite simple – the health care industry must move from a traditional command and control model to a continuous quality improvement model. These are lessons that the U.S. manufacturing sector had to learn and apply in the 1980s and 1990s, building on the work of pioneers such as Edward Deming and leading to a variety of standards and frameworks now widely used across industry (e.g., ISO 9001:2008[2]).

The Quality Chasm series built upon prior reports in the late 1990s demonstrating the serious quality gaps in the U.S. health care system, many associated with the shift in treatment to greater numbers of chronic illnesses (vs. acute illnesses), an important subset of which includes addictions, serious mental illnesses for adults, and serious emotional disturbances for children. The series focuses on applying the broader framework of performance and quality improvement to the delivery of health care services. The report argues convincingly that these quality gaps cost the U.S. upwards of $750 billion in 2009 in poor, inefficient, wasteful, and ineffective care. The need for systematic change is clear and stark.

In 2006, the Quality Chasm series focused its attention on mental health (MH) and substance use disorders (SUD),[3] documenting severe system level quality gaps and describing a framework for improving them. The report was quite explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most MH/SUD delivery systems in effectively promoting it:

> *Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences—for people who have the conditions; for their*

[1] Institute of Medicine (IOM). 2001. Crossing the quality chasm: A new health system for the 21st Century. Washington, DC: The National Academies Press.

[2] For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf.

[3] Institute of Medicine (IOM). 2006. Improving the quality of health care for mental and substance-use conditions. Washington, DC: The National Academies Press.

> *loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.*

The report goes on to note that the challenges facing MH/SUD systems are in many ways more severe than those facing the broader health system due to ". . . a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace." (page 2) Nonetheless, the IOM recommended clearly that the advised shift from "command and control" models of quality assurance to customer-oriented quality improvement was not only necessary but possible within behavioral health systems, with similar capacity as in health care to produce better outcomes with lower costs.

The implications of the IOM's recommended shift from command and control models to continuous quality improvement is not just about improving the quality of care delivery – it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm series.[4] The report states the matter in the series' characteristically direct manner, as quoted below:

> *Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:*
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> - *If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.*
> - *If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.*
> - *If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.*
> - *If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.*
> - *If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.*
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> *The point is not that health care can or should function in precisely the same way as all other sectors of people's lives – each is very different from the others, and every industry has room for improvement. Yet if some of the transferable best practices from banking, construction,*

[4] Institute of Medicine (IOM). 2012. Best care at lower cost: The path to continuously learning health care in America. Washington, DC: The National Academies Press.

retailing, automobile manufacturing, flight safety, public utilities, and personal services were adopted as standard best practices in health care, the nation could see patient care in which:

- *records were immediately updated and available for use by patients;*
- *care delivered was care proven reliable at the core and tailored at the margins;*
- *patient and family needs and preferences were a central part of the decision process;*
- *all team members were fully informed in real time about each other's activities;*
- *prices and total costs were fully transparent to all participants;*
- *payment incentives were structured to reward outcomes and value, not volume; errors were promptly identified and corrected; and*
- *results were routinely captured and used for continuous improvement.*

National Best Practices

There are hundreds of evidence-based practices available for mental health (MH) and substance use disorder (SUD) treatment, and the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP).[5] The NREPP includes MH and SUD treatment approaches ranging from prevention through treatment. While the NREPP is, in its own description, "not exhaustive," it is the most complete source on evidence-based practices of which we are aware. The NREPP refers to all practices in the registry as "evidence-based," using the following definition: "Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation." The NREPP then rates each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention. Thus, many approaches formerly termed "promising" are now included in the NREPP, albeit with lower scores in some domains.

Successful best practice promotion also requires understanding of the real world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. This process is sometimes called "using practice-based evidence" to inform implementation and is a core feature of continuous quality improvement. The reasons for stakeholder concerns at the "front line" implementation level are well documented and significant.[6] One major issue is that the literature prioritizes randomized clinical trials (RCTs) that address **efficacy** in controlled research

[5] The NREPP's searchable database can be found at: http://www.nrepp.samhsa.gov/.

[6] Waddell, C. & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. *Evidence-Based Mental Health, 8*, 60-62.

settings, whereas practitioners require research evidence on **effectiveness** in typical practice settings. This "efficacy-effectiveness gap" was clearly defined in the 1999 U.S. Surgeon General's report on mental health services in America[7] and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships.[8] Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between individuals and their environments over time, and is inextricably linked to natural contexts, the efficacy research literature is largely silent on these relationships.[9] Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about best practices – and one that is certainly highly relevant for a state as diverse as Texas – involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base with regard to diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their communities and the situations they encounter on a daily basis. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across culture.[10] Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that best practices be implemented within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an

[7] U.S. Surgeon General. (1999). Mental health: A report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[8] Hoagwood, K., Burns, B.J., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52, 1179–89.

[9] Hoagwood K., Burns B.J., Kiser L., et al. (2001).

[10] U.S. Surgeon General. (2001). Mental health: Culture, race, and ethnicity – A supplement to mental health. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

analysis regarding the cross-cultural applications of major best practices.[11] There is also increasing recognition of best practices for refugee and immigrant communities.[12]

It is also therefore critical to ground best practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of ethnic minority groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)[13] were adopted in 2001 by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) with the goals of "equitable and effective treatment in a culturally and linguistically appropriate manner" and "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers" in order "to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available,[14] but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American / Pacific Islander, Hispanic / Latino, and Native American / American Indian groups is also available.[15] Guidance for multicultural applications is also available.[16]

Major Evidence-Based Practices for Children and Families

In this section we describe evidence-based practices (EBPs) at three levels – prevention approaches, office and community-based interventions, and out-of-home treatment options. We also try to differentiate approaches by age group, where applicable.

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[11] See http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx.

[12] American Psychological Association, Presidential Task Force on Immigration. (2012). Crossroads: The psychology of immigration in the new century.

[13] U.S. Department of Health and Human Services (USDHHS), Office of Minority Health. (March 2001). National Standards for Cultural and Linguistically Appropriate Services in Health Care. Washington, DC: Author.

[14] The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf.

[15] USDHHS, Substance Abuse and Mental Health Services Administration. (2001). Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Rockville, MD: Author.

[16] See http://www.cimh.org/Services/Multicultural.aspx for the overall site and http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx for specific best practices demonstrated in California.

Prevention

Many EBPs are available to increase parenting skills, with an emphasis on early childhood (on up to age 12). These include:

- ***The Incredible Years*[17]*:*** The Incredible Years program focuses on preventing conduct problems from developing and intervening early in the onset of these behaviors in children, targeting infancy to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and teaching of social skills). This curriculum particularly targets risk factors for conduct disorder, and promotes a positive environment for the child both in the home and at school.
- ***Positive Parenting Program (Triple-P)*[18]*:*** This program is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems. It includes five levels of varying intensity (from the dissemination of printed materials, to 8-10 session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theory, in combination with studies of risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues.

Prevention efforts shift as children enter school (ages 6 – 12) to increase positive social interactions, decrease aggression and bullying, and increase academic motivation. School-wide initiatives such as Positive Behavioral Interventions and Supports (PBIS) have significantly decreased aggressive incidents among students and increased the comfort and confidence of school staff within the school environment. PBIS is a school-based application of a behaviorally-based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant, and desired

[17] Webster-Stratton, C. (1984). A randomized trial of two parent-training programs for families with conduct-disordered children, *Journal of Consulting and Clinical Psychology, 52(4),* 666-678.

[18] Sanders, M.R., Markie-Dadds, C., Tully, L.A., & Bor, W. (2000). The triple-P positive parenting program. A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68 (4),* 624-640.

behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment, (2) comprehensive intervention, and (3) lifestyle enhancement.[19]

The value of school-wide PBIS integrated with mental health, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent of students fall into the first tier. For them, school-wide PBIS creates "a social environment that reinforces positive behavior and discourages unacceptable behaviors."[20] A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it "easier to identify students who require early intervention to keep problem behaviors from becoming habitual" and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can be provided intensive services through partnerships between the school, the mental health system, other child-serving agencies, and the child's family.

Office and Community-Based Interventions

There is growing evidence that, in most situations, children can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that, with the exception of youth with highly complex needs or dangerous behaviors, such as fire setting or repeated sexual offenses, programs in community settings are more effective than those in institutional settings, with intensive, community-based and family-centered interventions the most promising. Even children and adolescents with SEDs and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and adolescents has rapidly developed in recent years. The ideal system would have treatment protocols offered in clinics, schools or homes with the objective of: 1) decreasing problematic symptoms and behaviors, 2) increasing youth's and parents' skills and coping and/or 3)

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[19] Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. Educational Psychologist, 33, 135-152.

Horner, R.H., & Carr, E.G. (1997). Behavioral support for students with severe disabilities: Functional assessment and comprehensive intervention. Journal of Special Education, 31, 84-104.

Koegel, L.K., Koegel, R.L. & Dunlap, G. (Eds.). (1996). Positive behavioral support: Including people with difficult behavior in the community. Baltimore, MD: Paul H. Brookes.

Positive Behavior Interventions and Supports website: http://www.pbis.org/main.htm.

[20] Bazelon Center. (2006). Way to Go: School Success for Children with Mental Health Care Needs. Available at www.bazelon.org

preventing out-of-home placement. Core components of some of these interventions should also be used as part of an individualized treatment plan for a child of any age who is receiving intensive intervention in a day treatment program. The following examples of evidence-based and other best practice treatments are offered as examples of the types of services needed in the ideal system and are not intended to be an exhaustive inventory of potential community-based interventions and EBPs.

During the preschool years, parent/caregiver participation in treatment is an essential part of success. An ideal service array should include interventions, such as the following:

- **Parent-Child Interaction Therapy (PCIT)** has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders or other problems.[21] PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting. In order to improve the parent-child attachment through behavior management, the PCIT program uses structural play and specific communication skills to teach parents and children constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while the interaction is occurring. In addition, parents learn how to give their child direction towards positive behavior. The therapist guides parents through education and skill building sessions and oversees practicing sessions with the child. PCIT has been adapted for use with Hispanic and Native American families.
- **Early Childhood Mental Health Consultation** in early childhood settings, such as child care centers, emphasizes problem-solving and capacity-building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.[22] Early childhood mental health consultation aims to build the capacity

[21] Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., et al. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. Journal of Consulting and Clinical Psychology 72(3), 500-510.

Eyberg, S.M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) Encyclopedia of Clinical child and Pediatric Psychology. New York: Plenum.

Querido, J.G., Eyberg, S.M., & Boggs, S. (2001). Revisiting the accuracy hypothesis in families of conduct-disordered children. Journal of Clinical Child Psychology, 20, 253-261.

[22] Brennan, E.M., Bradley, J.R., Allen, M.D., Perry, D.F., & Tsega, A. (2006, February). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. Presented at the 19th Annual Research Conference, A System of Care for Children's Mental Health, Tampa, FL.

Child Health and Development Institute of Connecticut, Inc. (2005, April). Creating a statewide system of multi-disciplinary consultation for early care and education in Connecticut. Farmington, CT.

(improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six, and their families. Two types of early childhood mental health consultation are generally discussed, program level and child/family level. The goals of program level mental health consultation seek to improve a program's overall quality and address problems that affect more than one child, family or staff member. Consultants may assist the setting in creating an overall approach to enhance the social and emotional development of all children. Child/family-centered consultation seeks to address a specific child or family's difficulties in the setting. The consultant provides assistance to the staff in developing a plan to address the child's needs, and may participate in observation, meet with the parents of the child, and in some cases refer the child and family for mental health services.

- **Applied Behavior Analysis (ABA)** has good support for the treatment of autism in young children in particular.[23] ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for two weeks to 11 months. ABA is one of the most widely used approaches with this population. The ABA approach teaches social, motor, and verbal behaviors, as well as reasoning skills. ABA teaches skills through use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training of the therapists, extensive time spent in ABA therapy (20-40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be the source for the generalization of skills outside of school. In the ABA approach, developing and maintaining a structured working

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Cohen, E. & Kaufmann, R. (2005). Early Childhood Mental Health Consultation. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Gilliam, W. (2005, May). Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Programs. Foundation for Child Development Policy Brief Series No. 3. New York: Foundation for Child Development.

[23] Harris, S.L.P., and L.P. Delmolino. (2002). "Applied Behavior Analysis: Its Application in the Treatment of Autism and Related Disorders in Young Children". Infants and Young Children, 14(3):11-17.

Smith, T., Groen, A.D. & Wynn, J.W. (2000). Randomized Trial of Intensive Early Intervention for Children with Pervasive Developmental Disorder. American Journal on Mental Retardation, 105 (4), 269-285.

McConachie, H. & Diggl, T. (2006). Parent implemented early intervention for young children with autism spectrum disorder: a systematic review. Journal of Evaluation in Clinical Practice. (early release).

Sallows, G.O. & Graupner, T. D. (2005). Intensive Behavioral Treatment for Children with Autism: Four-Year Outcome and Predictors. American Journal on Mental Retardation, 110 (2), 417-438.

Eikeseth, S., Smith, T., Jahr, E. & Eldevik, E. (2002). Intensive Behavioral Treatment at School for 4- to 7-Year-Old Children with Autism: A 1-Year Comparison Controlled Study. Behavior Modification, 26 (1), 49-68.

Shook, G.L. & Neisworth, J.T. (2005). Ensuring Appropriate Qualifications for Applied Behavior Analyst Professionals: The Behavior Analyst Certification Board. Exceptionality, 13(1), 3-10.

relationship between parents and professionals is essential to ensure consistency of training and maximum benefit.

- **Preschool Post-Traumatic Stress Disorder Treatment** is an approach adapted from trauma-focused cognitive behavioral therapy (TF-CBT – see below) and trauma-focused coping to help young children recover from traumatic events with support from their parents throughout the treatment process.

For latency-aged children, individual cognitive behavioral techniques are effective, parent work is still important and some group therapy can begin. Examples include:

- **Behavior Therapy** has support for the treatment of attention and hyperactivity disorders; substance abuse; depression; and conduct problems. Typically, behavior therapy features behavior management techniques taught to teachers / parents to aid the child in replacing negative behaviors with more positive ones.[24]
- **Brief Strategic Family Therapy (BSFT)** is a problem-focused, family-based approach to the elimination of substance abuse risk factors. It targets problem behaviors in children and adolescents six to 17 years of age, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building strategies that strengthen families. It targets conduct problems, associations with anti-social peers, early substance use and problematic family relations.[25]
- **Cognitive Behavior Therapy (CBT)** is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.[26] It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For children and youth, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder. CBT can be used for anxious and avoidant disorders, depression, substance abuse, disruptive behavior, and ADHD. It can be used with family

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[24] Pelham, W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for ADHD. Journal of Clinical Child Psychology, 27, 190-205.

[25] Szapocznik J. & Williams R.A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. Clinical Child and Family Psychology Review, 3(2), 117-135.

Szapocznik J. & Hervis O.E. (2001). Brief Strategic Family Therapy: A revised manual. In National Institute on Drug Abuse Treatment Manual Rockville, MD: NIDA. BSFT has support for use with Hispanic families.

[26] Hoagwood, Kimberly, Burns, Barbara, Kiser, Laurel, et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52:9, 1179-1189.

Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. Annual Review of Psychology, 56, 337–363.

intervention. Specific pediatric examples include Coping Cat and the Friends Program. CBT works with the individual to understand their behaviors in the context of their environment, thoughts and feelings. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** has strong support for efficacy with children and youth aged three to 18 years old, and their parents.[27] It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem and other symptoms related to traumatic experiences. TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies, in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as: intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and some of its assessment instruments are available in Spanish.

For adolescents, the same EBPs as above should be available in outpatient and school-based clinics, as should the following programs for teens with severe difficulties, including those that may be at risk for out-of-home placement:

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[27] Cohen, J.A. & Mannarino, A.P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. Journal of the American Academy of Child & Adolescent Psychiatry 35(1), 42-50.

King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. Journal of the American Academy of Child & Adolescent Psychiatry 39(11), 1347-1355.

Mannarino, A.P., & Cohen, J.A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. Child Maltreatment 1(3), 246-260.

Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trail. Journal of the American Medical Association 290(5), 603-611.

- **Wraparound Service Coordination** (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children involved with multiple systems and at the highest risk for out-of-home placement.[28] Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family (for additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf).
- **Dialectical Behavior Therapy (DBT) Approaches for Adolescents** is well supported for adults, but also has moderate support for helping youth to develop new skills to deal

[28] Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). The Comparative Costs and Benefits of Programs to Reduce Crime. Olympia: Washington State Institute for Public Policy.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services. 52:9, 1179-1189.

with emotional reaction and to use what they learn in their daily lives.[29] DBT for youth often includes parents or other caregivers in the skills-training group so that they can coach the adolescent in skills and so they can improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week. There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions. It needs to help consumers develop new skills, address motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment: group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

- **Functional Family Therapy (FFT)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at risk adolescents and their families, targeting youth between the ages of 11 and 18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change, and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.[30] FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities, and aims for obtainable change with specific and individualized intervention that focuses on both risk and protective factors.

[29] Miller, A. L., Wyman, S.E., Huppert, J.D., Glassman, S.L. & Rathus, J.H. (2000). Analysis of behavioral skills utilized by suicidal adolescents receiving DBT. Cognitive & Behavioral Practice 7, 183-187.

Rathus, J.H. & Miller, A.L. (2002). Dialectical Behavior Therapy adapted for suicidal adolescents. Suicide and Life-Threatening Behavior 32, 146-157.

Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. Child and Adolescent Mental Health 7(3), 121-127.

[30] Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., et al. (1998). Blueprints for Violence Prevention Series, Book Three: Functional Family Therapy (FFT), Boulder, CO: Center for the Study and Prevention of Violence.

Intervention incorporates community resources for maintaining, generalizing and supporting family change.[31]

- **Multidimensional Family Therapy (MDFT)** is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban and rural settings.[32] Treatment usually lasts between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including: adolescent and parents individually, family as an interacting system, and individuals in the family, relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent's development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.
- **Multisystemic Therapy (MST)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.[33] In addition, the developers are currently working to develop specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive home-based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with low caseloads and varying frequency, duration, and

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[31] Rowland, M., Johnson-Erickson, C., Sexton, T., & Phelps, D. (2001). A Statewide Evidence Based System of Care. Paper presented at the 19th Annual System of Care Meeting. Research and Training Center for Children's Mental Health.

[32] Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services. 52:9, 1179-1189.

Hogue, A.T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high risk young adolescents: Immediate outcomes. Journal of Community Psychology, 30(1), 1-22.

Liddle H.A., Dakof G.A., Parker K., Diamond G.S., Barrett K., Tejeda M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. American Journal of Drug and Alcohol Abuse, 27, 651-687.

[33] Huey, S.J. Jr., Henggeler, S.W., Brondino, M.J. & , Pickrel, S.G. (2000). Mechanisms of Change in Multisystemic Therapy: Reducing Delinquent Behavior Through Therapist Adherence and Improved Family and Peer Functioning. Journal of Consulting and Clinical Psychology, 68 (3), 451-467.

Schoenwald S.K., Henggeler S.W., Pickrel S.G., & Cunningham P.B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), Model programs in child and family mental health, (pp. 317-332). Mahwah, NJ: Lawrence.

intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of youth anti-social behavior.[34] At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and a reduction in association with "deviant" peers, primarily through parental mediation.[35] **MST-Psychiatric (MST-P)** is an approach similar to MST, but adapted for teens with serious emotional disorders.

- **Assertive Community Treatment (ACT) for Transition-Age Youth** uses a recovery/resilience orientation, which offers community-based intensive case management and skills-building in various life domains, as well medication management and substance abuse services for youth ages 18 – 21, with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. The majority of ACT services are delivered to the consumer within his or her home and community, rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or to provide assistance. The most recent conceptualizations of ACT include peer specialists as

[34] Henggeler S.W., Weiss, J., Rowland M.D., Halliday-Boykins C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. Journal of the American Academy of Child & Adolescent Psychiatry 42(5), 543-551.

[35] Huey, S.J. Jr., Henggeler, S.W., Rowland, M.D, Halliday-Boykins, C.A., Cunningham, P.B., Pickrel, S.G., Edwards, J. (2004) Multisystemic Therapy Effects on Attempted Suicide by Youths Presenting Psychiatric Emergencies. Journal of the American Academy of Child & Adolescent Psychiatry. 43(2):183-190.

integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).[36, 37]

Out-of-Home Intervention Options

Treatment of youth in residential facilities is no longer thought to be the most beneficial way to treat those with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states: "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence."

Residential treatment represents a necessary component of the continuum of care for children and adolescent youth whose behavior is not managed effectively in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors, such as fire setting, that may not respond to intensive, nonresidential service approaches (Stroul, 2007). Yet, on a national basis children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

Nevertheless, youth do sometimes need to be placed outside of their homes for their own safety and/or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the situation is temporary, due to a crisis or for longer term care, the ideal service system should include an array of safe places for children and youth.

[36] Allness, D.J. & Knoedler, W.H. (2003). A manual for ACT start-up. Arlington, VA: National Alliance for the Mentally Ill.

[37] Morse, G., & McKasson, M. (2005). Assertive Community Treatment. In R.E. Drake, M. R. Merrens, & D.W. Lynde (eds.). Evidence-based mental health practice: A textbook.

A family-driven, youth-guided, community-based plan should follow the child or youth across all levels of care (including out-of-home placements, as applicable) and help him/her return to home as quickly as possible, knitting together an individualized mix from among the following array of services.

A full continuum of crisis response, with mobile supports and short- to intermediate-term, local out-of-home options, including respite, psychosocial and behavioral health interventions for youth and their families should include:

- A mobile crisis team for children and families, with the capacity to provide limited ongoing in-home supports, case management and direct access to out-of-home crisis supports (for a national example, Wraparound Milwaukee's Mobile Urgent Treatment Team / MUTT[38] is offered).
- A bio-psychosocial assessment, supported by protocols to communicate assessment results across professionals and to determine the appropriate level of services.
- An array of crisis supports tailored to the needs and resources of the local system of care, including an array of options such as:
  - Crisis foster care (a few days up to 30 days),
  - Crisis group home (up to 14 days),
  - Crisis respite (up to three days),
  - Crisis runaway shelter (15 days),
  - Crisis stabilization (30 – 90 days) with capacity for 1:1 mental health crisis intervention,
  - Crisis supervision (30 – 90 days) to maintain safety in the community,
  - Placement stabilization center, providing out-of-home respite,
  - Acute inpatient care,
  - Consultation, and
  - Linkages to a full continuum of empirically supported practices.

A residential continuum of placement types, grounded in continued connections and accountability to the home community, with a focus on specialized programming, including treatment foster care (Multidimensional Treatment Foster Care is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African American and American Indian youth

[38] For more information, see: http://county.milwaukee.gov/MobileUrgentTreatmen10109.htm. While the MUTT model has not been demonstrated at the level of an EBP, it is widely cited as a best practice and has been the basis of EPSDT settlements in Massachusetts (Rosie D.) and many other positive systems reforms for children's systems of care nationally.

and families[39]), gender-responsive services that go beyond just a willingness to serve female youth and that include a continuum of out-of-home treatment options for young women with behavioral health needs (including histories of sexual maltreatment) and specialized residential programming for youth with gender-identity issues, and residential placement options that vary by intensity of service provided, primary clinical needs addressed, and targeted length of stay, emphasizing , acute-oriented programs to serve as an inpatient alternative, in which children and youth can have behaviors that require longer than a typical acute inpatient stay to be stabilized, complex needs evaluated, and treatment begun while transition planning back to a more natural environment takes place.

When residential treatment is provided, there should be extensive involvement of the family. Residential (and community-based) services and supports must be thoroughly integrated and coordinated, and residential treatment and support interventions must work to maintain, restore, repair or establish youths' relationships with family and community.

Family involvement is essential throughout the course of residential treatment, especially at admission, in the development of the treatment plan, when milestones are reached, and in discharge planning.

Best Practices for Adults and Older Adults

Best practices for adults and older adults with severe needs are emphasized, differentiating between interventions that are **well established** and those that are **promising:**

a) **Well established** interventions may be characterized by their support from randomized controlled studies, as well as evidence from real-world care settings. Further, well established interventions are sufficiently documented to allow tracking of fidelity to established standards.
b) **Promising interventions** are supported by methodologically sound studies in either controlled or routine care settings and are sufficiently documented to allow at least limited fidelity tracking.

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[39] Chamberlain P, Reid J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. Journal of Community Psychology, 19, 266-276.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services. 52:9, 1179-1189.

Kazdin, A.E., & Weisz, J.R. (Eds.) (2003). Evidence-based psychotherapies for children and adolescents. New York: Guilford Press.

Weisz, J.R., Doss, J.R., Jensen, A., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. Annual Review of Psychology, 56, 337–363.

Well Established Practices for Adults and Older Adults

Assertive Community Treatment (ACT). ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. The majority of ACT services are delivered to the consumer within his or her home and community, rather than provided in hospital or outpatient clinic settings, and services are available round the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or to provide assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).[40]

The Substance Abuse and Mental Health Services Administration (SAMHSA) also developed an ACT Implementation Kit (often referred to as a "toolkit") to provide guidance for program implementation.[41] More recent ACT promotion efforts seeking to systematically promote consistent outcomes across programs over time in the states of Washington, Indiana, North Carolina, and elsewhere have focused on supporting ACT service development through a comprehensive process of interactive, qualitative fidelity monitoring of clinical services using best practice measures such as the Tool for Measurement of Assertive Community Treatment (TMACT). This is the current standard in the field and represents the best currently known way to broadly develop high quality teams system wide building on the lessons of best practice implementation science.[42] Such an approach is particularly critical because high fidelity

[40] Morse, G., & McKasson, M. (2005). Assertive Community Treatment. In R.E. Drake, M. R. Merrens, & D.W. Lynde (eds.). Evidence-based mental health practice: A textbook.

[41] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Assertive Community Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS ACT Resource Kit).

[42] Fixen, D.L. et al. (2005). Implementation research: A synthesis of the literature. Tampa: University of South Florida. Monroe-DeVita, M., Teague, G.B., & Moser, L.L. (2011). The TMACT: A new tool for measuring fidelity to Assertive Community Treatment. *Journal of the American Psychiatric Nurses Association, 17*(1), 17-29.

implementation of programs like ACT is a predictor of good outcomes[43] and of system wide cost savings.[44] Rigorous fidelity assessment also provides a basis for needed service delivery enhancements within a continuous quality improvement (CQI) process. In effect, qualitative clinical services monitoring will help ensure fidelity to the ACT model, evaluate whether settlement stipulations are being met, and contribute to a continuous quality improvement process.

ACT is one of the most well-studied service approaches for persons with SPMI, with over 50 published studies demonstrating its success[45], 25 of which are randomized clinical trials (RCTs).[46] Research studies indicate that when compared to treatment as usual (typically standard case management), ACT substantially reduces inpatient psychiatric hospital use and increases housing stability, while moderately improving psychiatric symptoms and subjective quality of life for people with serious mental illnesses.[47] Studies also show that consumers and their family members find ACT more satisfactory than comparable interventions and that ACT promotes continuity.

This intervention is most appropriate and cost-effective for people who experience the most serious symptoms of mental illness, have the greatest impairments in functioning, and have not benefited from traditional approaches to treatment. It is often used as an alternative to restrictive placements in inpatient or correctional settings.

Cognitive Behavior Therapy (CBT). CBT is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.[48] It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some

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[43] Teague & Monroe-DeVita (in press). Not by outcomes along: Using peer evaluation to ensure fidelity to evidence-based Assertive Community Treatment (ACT) practice. In J. L. Magnabosco & R. W. Manderscheid (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods* (2nd ed.). Washington, DC: National Association of Social Workers Press.

[44] See for example, Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. *Canadian Journal of Psychiatry, 44*, 443-454.

[45] The Lewin Group. (2000). Assertive community treatment literature review. from SAMHSA Implementation Toolkits website: http://media.shs.net/ken/pdf/toolkits/community/13.ACT_Tips_PMHA_Pt2.pdf

[46] Bond, G. R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. Disease Management & Health Outcomes, 9, 141-159.

[47] Bond, G. R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. Disease Management & Health Outcomes, 9, 141-159.

[48] Chambless et al. (1998). Update on empirically validated therapies II. *The Clinical Psychologist, 51 (1),* 3-21.
Gatz, M., Fiske, A., Fox, L. S., Kaskie, B., Kasl-Godley, J. E., McCallum, T. J., & Wetherell, J. L. (1998). Empirically-validated psychological treatments for older adults. *Journal of Mental Health and Aging, 4,* 9-46.

common elements. For adults and older adults, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder.

CBT can also be used for Substance Abuse, Eating Disorders, and ADHD. It can be used with family intervention. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

Collaborative Care. Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.[49]

Two key principles form the basis of the Collaborative Care model:

1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and
2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of the Collaborative Care model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels.[50]

Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,[51] depression in adults,[52] and depression in older adults.[53] For

[49] Unutzer, J., Katon, W. Hogg Foundation Integrated Care Initiative (2006). Training presentation retrieved at: http://www.hogg.utexas.edu/programs_ihc_program.html.

[50] Unutzer, J., Katon, W., Sullivan, M., and Miranda, J. (1999). Treating Depressed Older Adults in Primary Care: Narrowing the Gap between Efficacy and Effectiveness. The Milbank Quarterly, 77, 2.

[51] Katon, W.J., Roy-Byrne, P., Russo, J. and Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. Archives of General Psychiatry, 59, 1098-1104.

[52] Katon, W., Von Korff, M., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. Archives of General Psychiatry, 56, 1109-1115.

[53] Unutzer, J., Katon, W., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. Journal of American Medical Association, 288, 2836-2845.

example, a study of IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression) – a multi-state Collaborative Care program with study sites in multiple states – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care. The 2003 Final Report of the President's New Freedom Commission on Mental Health suggested that collaborative care models should be widely implemented in primary health care settings and reimbursed by public and private insurers.

Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy (DBT) is a modification of cognitive behavioral therapy in which an ongoing focus on behavioral change is balanced with acceptance, compassion, and validation of the consumer. [54] Services are delivered through individual therapy, skills group sessions, and telephonic coaching.

Randomized studies have shown that DBT reduces severe dysfunctional behaviors that are targeted for intervention, increases treatment retention, and reduces psychiatric hospitalization. Although published follow-up data are limited, the available data indicate that improvements may remain up to one year after treatment.[55] DBT is specifically designed to address the particular needs of people who have borderline personality disorder and/or self-harming behaviors.

Family Psychoeducation. Family psychoeducation is a method of working in partnership with families to provide current information about mental illness and to help families develop increasingly sophisticated coping skills for handling problems posed by mental illness in one member of the family.[56] They last from nine months to five years, are usually diagnosis specific, and focus primarily on consumer outcomes, although the well-being of the family is an essential intermediate outcome.[57] Under this approach, the practitioner, consumer, and family work

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See also President's New Freedom Commission on Mental Health Final Report at 66.

[54] Swenson, C.R., Torrey, W.C., and Koerner, K. (2002). Implementing Dialectical Behavior Therapy. Psychiatry Serv 53:171-178.

[55] Swenson, et al. (2002), citing Linehan MM, Heard HL, Armstrong HE 1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Archives of General Psychiatry 50:971-974. See also Comtois, K.A. (2002). A Review of Interventions to Reduce the Prevalence of Parasuicide. Psychiatr Serv, 53, 1138-1144.

[56] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Family Psychoeducation Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS Family Psychoeducation Resource Kit).

[57] Dixon. L., McFarlane, W., Lefley, H., et al. (2001). Evidence-Based Practices for Services to Families of People With Psychiatric Disabilities. 52 Psychiatric Services, 7, 903-910.

together to support recovery, incorporating individual, family, and cultural realities and perspectives.

Family psychoeducation can be used in a single family or multi-family group format and can vary in terms of the duration of treatment, consumer participation, and treatment setting, depending on the consumers and family's wishes, as well as empirical indications. Although several treatment models exist, the following are essential elements of any evidence-based program:[58]

1. The intervention should span at least nine months.
2. The intervention should include education about mental illness, family support, crisis intervention, and problem solving.
3. Families should participate in education and support programs.
4. Family members should be engaged in the treatment and rehabilitation of consumers who are mentally ill.
5. The information should be accompanied by skills training, ongoing guidance about management of mental illness, and emotional support for family members.
6. Optimal medication management should be provided.

Extensive research demonstrates that family psychoeducation significantly reduces rates of relapse and re-hospitalization. When compared to consumers who received standard individual services, differences ranged from 20-50% over two years. Recent studies have shown employment rate gains of two to four times baseline levels, especially when combined with supported employment, another best practice. Families report a decrease in feeling confused, stressed, and isolated and also experience reduced medical care costs. In addition, studies consistently indicate a very favorable cost-benefit ratio, especially in savings from reduced hospital admissions, reduction in hospital days, and in crisis intervention contacts.

The SAMHSA/CMHS Family Psychoeducation Resource Kit suggests that family psychoeducation is most beneficial for people with the most severe mental illnesses and their families. Although most research involves consumers with schizophrenia, improved outcomes have been found with other psychiatric disorders, including bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa, and borderline personality disorder.

Gatekeeper Program. The Gatekeeper Program engages and trains a range of community members who have frequent contact with older adults – such as utility, cable telephone, bank,

[58] See literature review provided in McFarlane, W., Dixon, L., Lukens, E., and Lucksted, A. (2003). Family Psychoeducation and Schizophrenia: A Review of the Literature. 29 Journal of Marital and Family Therapy, 2, 223-245.

housing, and postal workers – as well as emergency medical technicians, firefighters, police officers, and other first responders to identify older adults who may need mental health services and report them to a central information and referral office.[59]

After referral, a clinical case manager and nurse visit the individual at his or her home, making repeat visits as needed to overcome the individual's suspicion and promote engagement. An interdisciplinary team, usually including a psychiatrist and physician, develop a plan of care and, if appropriate, meets with the individual's family with a goal of providing community-based rather than institutional services.

Research suggests that the Gatekeeper Program is effective in reaching older adults with mental illnesses who are more likely to be economically and socially isolated than older adults referred by a medical provider or other traditional referral source.[60] Some studies found that Gatekeeper referrals were no more likely to be placed out-of-home than those referred by other sources.[61] Although there is limited data regarding specific clinical outcomes associated with the Gatekeeper Program, a recent literature review suggests that multidisciplinary approaches to serving older adults in their homes may be effective in reducing symptom severity.

Illness Management and Recovery. Illness Management and Recovery (IMR) is a set of specific evidence-based practices for teaching people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals. These practices include: (1) psychoeducation; (2) behavioral tailoring to improve medication adherence; (3) relapse prevention training; (4) increasing coping skills; and (5) social skills training. IMR involves a series of weekly sessions in which specially trained professionals use these practices to help people who have experienced psychiatric symptoms in developing personal strategies for coping with mental illness and moving forward in their lives.[62]

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[59] Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. (2005). Community Integration of Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities. DHHS Pub. No. (SMA) 05-4018. Rockville, MD: Author.

[60] Van Citters, A.D. and Bartels, S.J. (2004). A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach Services for Older Adults. Psychiatric Services, 55,1237-1249.

[61] U.S. Administration on Aging. (2001). Older adults and mental health: Issues and opportunities. Rockville, MD: U.S. Department of Health and Human Services.

[62] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Illness Management and Recovery Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS IMR Resource Kit).

Practitioners educate consumers on nine topic areas, ranging from recovery strategies and illness information, to coping with stress and finding help in the mental health system. IMR practitioners combine motivational, educational, and cognitive-behavioral strategies aimed at helping consumers make progress towards personal recovery goals. The program can be provided in an individual or group format and generally lasts between three and six months.

Research has demonstrated that IMR can increase an individual's knowledge about mental illness, reduce relapses and hospitalizations, help consumers cope more effectively, reduce distress from symptoms, and assist consumers in using medications more effectively.[63] In addition, when using IMR practitioners often report a high rate of job satisfaction as consumers learn to reduce relapses, avoid hospitalization, and make steady progress toward personalized recovery goals.

This intervention is most appropriate for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression at various stages of the recovery process. Emerging research suggests that this intervention may also be effective for people with serious mental illnesses in the criminal justice system.[64]

Integrated Dual Disorder Treatment (IDDT) for Co-Occurring Mental Illness and Substance Use Disorders. Integrated Dual Disorder Treatment (IDDT) provides mental health and substance abuse services through one practitioner or treatment team and co-locates all services in a single agency (or team) so that the consumer is not excluded from or confused by multiple programs.[65] IDDT encompasses 14 components, each of which is evidence-based, including but not limited to: (1) screening and assessments that emphasize a "no wrong door" approach; (2) "blended" treatment to ensure compatibility in treatment approaches; (3) stage-wise treatment that recognizes that different services are helpful at different stages of the recovery process; and (4) motivational interviewing and treatment, using specific listening and counseling skills to develop consumer awareness, hopefulness, and motivation for recovery. Combined mental health and substance abuse treatment is effective at engaging people with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing

[63] See also review of the literature provided by Mueser, K., Corrigan, P., Hilton, D., Tanzman, B. et al. (2002). Illness Management and Recovery: A Review of the Research. 53 Psychiatric Services 10, 1272–1284.

[64] Mueser, K. and MacKain, S. (2006). Illness Management and Recovery. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, The National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness.

[65] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS IDDT Resource Kit).

hospitalization, and decreasing substance abuse, while at the same time improving social functioning.[66] Integrated treatment also reduces symptoms of mental disorders and overall treatment costs.[67] Fidelity to the components of IDDT is clearly tied to better clinical outcomes.[68]

This intervention is appropriate for individuals with co-occurring mental illness and substance use disorders. A "conceptual framework" developed jointly by the National Association of State Mental Health Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) suggests that mental health and substance abuse treatment should be provided along a continuum of coordination, collaboration, and integration among service systems, depending on the severity of the mental illness and substance abuse disorder.[69]

Motivational Interviewing. People with substance use disorders or co-occurring mental illness and substance use often are not ready to attempt to make changes in their use of substances. Clinical leaders and researchers argue that if people have not moved beyond the stage of preparing for or becoming determined to make changes in their behavior, then the focus needs to be not on changing behavior but on increasing motivation so that the person is ready to take action toward making these changes.[70]

Motivational Interviewing (MI) is an EBP that was developed to help increase motivation to

[66] U.S. Surgeon General's Report, (1999). p. 288, citing Miner, C.R., Rosenthal, R.N., Hellerstein, D.J. & Muenz, L.R. (1997). Predictions of compliance with outpatient referral in patients with schizophrenia and psychoactive substance use disorders. Archives of General Psychiatry, 54, 706-712 and Mueser, K.T., Drake, R.D., and Miles, K.M. (1997). The course and treatment of substance use disorders in persons with severe mental illnesses. NIDA Research Monograph, 172, 86-109.

[67] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (IDDT Resource Kit).

[68] Drake, R., Essock, S., et al. (2001). Implementing Dual Diagnosis Services for Clients with Mental Illness. Psychiatric Services 52, 469-476.

[69] The National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors. (2005). The Evolving Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders: Developing Strategies for Systems Change. Final Report of the NASMHPD-NASADAD Task Force on Co-Occurring Disorders. Authors: Washington, DC & Alexandria, VA.

[70] Corrigan, P.W., McCracken, S.G., & McNeilly, C. (2005). Evidence-based practices for people with serious mental illness and substance abuse disorders. In C. Stout, & R Hayes (Eds.), *The Evidence-based practice: Methods, models and tools for mental health professionals*. Hoboken, NJ: John Wiley & Sons. (pp. 153-176).

reduce use of substances and to recover from substance use disorders.[71] Motivational Interviewing combines principles of empathic responding with elements of behavioral analysis, including careful identification of the unique set of rewards and punishments that influence a given person's behavior. The clinician helps the person clarify his or her most important goals and the advantages and disadvantages associated with achieving those goals. Clinicians adopt an objective, nonjudgmental stance in their work with consumers. Reviews of studies generally find MI to be an effective substance abuse intervention, with some indication that it is particularly effective in ethnic minority study samples.[72] Although the evidence base for MI with adolescents may not yet be quite as strong as for adults,[73], MI is widely used in the juvenile justice system as a behavior change intervention.

In a review of studies, Apodaca and Longabaugh (2009) found that certain aspects of MI were associated with better outcomes and that when therapists' behavior was inconsistent with MI principles outcomes were worse.[74] Core principles of MI include the following (Corrigan et al., 2005):

- *Express Empathy* – Use reflective listening to help consumers clarify the advantages and disadvantages associated with behavior change. It promotes honest discussion of the person's reluctance and concerns about reducing use.
- *Develop Discrepancy* – Clinicians help clarify, in a non-confrontational manner, the ways in which not changing substance use and other behaviors associated with it are interfering with the attainment of consumers' most important goals.
- *Avoid Argumentation* – Clinicians avoid direct confrontation of the person and slipping into an argumentative style of relating.
- *Roll with Resistance* – Motivational Interviewing clinicians view clients' resistance as an indication that they (the clinicians) are not addressing issues the consumer believes are important or relevant; they use resistance as a way to try to help the person focus on actual barriers to change.
- *Support Self-Efficacy* –The Motivational Interviewing approach assumes that consumers are responsible for change. Clinicians attempt to convey confidence in the consumers—that she or he will decide to change and begin to reduce substance use when they are ready to do so.

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[71]Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* (2nd ed.) New York: Guilford Press.

[72]Hettema, J., Steele, J., & Miller, W.R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, *1*, 91-111.

[73]Jensen, C.D., et al. (2011). Effectiveness of motivational interviewing interventions for adolescent substance use behavior change: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 79*(4), 433-440.

[74]Apodaca, T.R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: a review and preliminary evaluation of the evidence. *Addiction, 104*(5), 705-715.

Supported Employment. Supported Employment promotes rehabilitation and a return to mainstream employment for persons with serious mental illnesses and co-occurring disorders. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. Employment specialists are responsible for carrying out vocational services while all members of the treatment team understand and promote employment. All Supported Employment programs are based on the following principles:

1. Eligibility is based on consumer choice. Individuals interested in employment are not screened for job readiness.
2. Supported employment is integrated with treatment. Employment specialists coordinate plans with the treatment team, including the case manager, therapist, psychiatrist, and others.
3. Competitive employment is the goal. The focus is on community jobs in integrated settings that anyone can apply for that pay at least minimum wage, including both part-time and full-time work.
4. Job search starts soon after a consumer expresses interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like transitional employment or sheltered workshops). Follow-along supports are continuous.
5. Individualized supports to maintain employment continue as long as consumers want the assistance.
6. Consumer preferences are important.
7. Vocational Specialists collaborate with the person's natural support networks and with employers (when the consumer wants his or her status as a mental health consumer disclosed to the employer).

A considerable body of research indicates that Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among consumers.[75] A seven-state, multi-site study supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that Supported Employment participants were significantly more likely (55%) than comparison participants (34%) to achieve competitive employment.[76] A review of three randomized controlled trials found that, in

[75] Drake, R.E., Becker, D.R., Clark, R.E. & Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. Psychiatric Quarterly, 70, 289-301.

[76] Cook, J. Executive Summary of Findings from the Employment Intervention Demonstration Program. Retrieved at www.psych.uic.edu/eidp/EIDPexecsum.pdf.

general, 60-80% of people served by a Supported Employment model obtain at least one competitive job.[77]

In addition, the research consistently shows that specific consumer factors such as diagnosis, age, gender, disability status, prior hospitalization, co-occurring substance abuse disorder, and education are not strong or consistent predictors of an individual's work outcomes.[78] Supported employment remains more effective than traditional vocational services for consumers with both good and poor work histories. This intervention should be offered to all individuals with mental illnesses and/or co-occurring disorders who want to work, regardless of prior work history, housing status, or other population characteristics.[79]

Promising Practices for Adults and Older Adults

Case Management. The primary purpose of case management is to coordinate service delivery and to ensure continuity and integration of services.[80] There are many models of case management for people with mental illnesses. Clinical case management and targeted case management generally include at least five integrated functions: (1) assessing consumers' needs; (2) planning service strategies to respond to identified needs; (3) linking consumers to appropriate services, including non-mental health specialty services such as housing, employment supports, or other social services; (4) monitoring consumers' progress to detect changing needs; and (5) providing follow up and ongoing evaluation.[81] Some models may also include limited skills building techniques.

In addition, intensive case management may also involve the actual delivery of service. ACT is sometimes thought of as a model of intensive case management, although many distinguish

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[77] New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 41, *citing* Drake, R.E., Becker, D.R., Clark, R.E., and Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. Psychiatric Quarterly, 70, 289-301.

[78] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Supported Employment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (Supported Employment Resource Kit).

[79] North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Mental Health Systems Transformation: Supported Employment Toolkit. Retrieved at: http://www.governorsinstitute.org/index.php?option=com_content&task=view&id=32&Itemid=61&PHPSESSID=c0381139b8ae1fb19764f80bd8d57992.

[80] U.S. Surgeon General's Report, (1999). p. 286.

[81] Taube, C., Goldman, H., and Salkever, D. (1990) Medicaid Coverage for Mental Illness: Balancing Access and Costs. Health Affairs, Spring 1990.

intensive case management as usually relying less on a team approach to service delivery, likely involving more brokering than delivery of services, and focusing more on facilitating participation by consumers in treatment decisions.

Considerable research suggests the effectiveness of intensive case management models, including ACT, in reducing inpatient use among high-risk consumers. Several studies also suggest improvements in clinical and social outcomes over conventional case management approaches.[82] However, at least one recent study has suggested that intensive case management programs are effective only in community settings where there is an ample supply of treatment and support services.[83]

There is less of a research base to support more traditional clinical and targeted case management approaches. One review of the research found that clinical case management was as effective as ACT in reducing symptoms of illness, improving social functioning, and increasing consumer and family satisfaction with services. However, that review also found that clinical case management increased hospitalizations and the proportion of consumers hospitalized.[84]

Comprehensive Crisis Services. In general, crisis services involve short-term, round-the-clock help provided in a non-hospital setting during a crisis with the purposes of stabilizing the individual, avoiding hospitalization or other high-cost services, and helping individuals return to pre-crisis functioning as quickly as possible. Crisis services can also help assure that emergency room, ambulance, law officer, and jail resources are not inappropriately utilized for behavioral health crises.[85]

Best practice components of comprehensive crisis services include but are not limited to:

1. A 24-hour telephone response system staffed by qualified mental health professionals with immediate capacity for face-to-face assessment and on-call consultation with a psychiatrist.
2. Mobile services capacity with transportation to assist individuals in getting to stabilization facilities.

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[82] The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations. (1998). Agency for Healthcare Quality and Research, Rockville, MD. Retrieved at: http://www.ahrq.gov/clinic/schzrec.htm. Citing Scott J.E., Dixon L.B. (1995). Assertive community treatment and case management for schizophrenia. Schizophrenia Bulletin 21(4), 657-68.

[83] Meyer, P.S., and Morrissey, J.P. (2007). A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. Psychiatric Services 58, 121-127.

[84] Ziguras, S.J., Stuart, G.W., and Jackson, A.C. (2002). Assessing the evidence on case management. The British Journal of Psychiatry 181, 17-21.

[85] St. Luke's Health Initiatives. (2001). Into the Light: A Search for Excellence in the Arizona Public Behavioral Health System, Volume II.

3. Access to short-term intensive residential treatment resources for stabilization and hospital diversion.
4. Cultural and linguistic competency to facilitate assessment.
5. Access to appropriate linkages with other healthcare resources.

Research suggests that when crisis services are provided in non-hospital settings, the likelihood of inpatient admission is reduced.[86] At least one study has found that, for individuals with serious mental illness in need of hospital level care and willing to accept voluntary treatment, residential crisis centers provided the same outcomes as inpatient hospitals for significantly less cost.[87]

Comprehensive crisis services are appropriate for individuals with an acute mental illness experiencing a crisis that puts them at risk of hospitalization or other high-cost care.

Peer Support. Peer Support is a service through which consumers can: (1) direct their own recovery and advocacy process and (2) teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community.[88] This service typically provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, often under the direct supervision of a mental health professional. Peer Support can also encompass a range of supports delivered by consumers, including informal services or as part of a consumer-operated service.

An innovative Georgia model, which receives Medicaid reimbursement for Peer Support and which has been replicated in several states, emphasizes the role of Certified Peer Specialists, who provide direct services to assist consumers in developing the perspective and skills to facilitate recovery and who also model the possibility of recovery through their own experiences as consumers engaged in self-directed recovery. A job description defines specific support activities, including helping consumers create a wellness recovery action plan and supporting vocational choices.

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[86] Mercer Government Human Services Consulting. (2006). Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices. Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services, p. 58.

[87] Fenton, W.S., Hoch, J.S., Herrrell, J.M., Mosher, L., Dixon, L. (2002). Cost and cost-effectiveness of hospital vs. residential crisis care for patients who have serious mental illness. Archives of General Psychiatry, 59 (4), 357-64.

[88] Georgia Medicaid Guidelines – Peer Supports for Adults. Retrieved at: www.gacps.org/files/peer_supports_guidelines2_3.doc.

The Georgia certification process includes two required weeklong trainings followed by a written and oral examination, as well as periodic continuing education seminars and workshops. Certified Peer Specialists are paid employees of public and private providers and operate as part of a clinical team, which can be integrated into a range of emergency, outpatient (including ACT), or inpatient settings. A Georgia-model Peer Support service reimbursable under Medicaid must be operated at least 12 hours a week, at least four hours per day for at least three days per week.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.[89]

Under the Medicaid-reimbursable model implemented in Georgia, peer support services are geared toward consumers with severe and persistent mental illness. These consumers may have co-occurring mental retardation or substance abuse disorders.[90]

Respite Care. Respite care is designed to provide community-based, planned or emergency short-term relief to family caregivers, alleviating the pressures of ongoing care and enabling individuals with disabilities to remain in their homes and communities.[91] Respite care frequently is provided in the family home. Without respite care, many family caregivers experience significant stress, loss of employment, financial burdens, and marital difficulties.

Little existing research is available regarding the effectiveness of this intervention either for family caregivers or mental health consumers. The majority of family caregiving studies identify a need for greater quality, quantity, variety, and flexibility in respite provision.[92]

Standardized Screening for Substance Abuse Disorders. Effective treatment for co-occurring disorders begins with accurate screening and assessment in settings where individuals present

[89] Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E. and Brown, C. (1995). Consumers as peer specialist on intensive case management teams: Impact on client outcomes. Psychiatric Services, 46, 1037-1044.
[90] Georgia Medicaid Guidelines – Peer Supports for Adults. Retrieved at: www.gacps.org/files/peer_supports_guidelines2_3.doc.
[91] New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 40.
[92] Jeon, Y.H., Brodaty, H., and Chesterson, J. (2005). Respite care for caregivers and people with severe mental illness: literature eview. Journal of Advanced Nursing, 49(3), 297–306.

for treatment.[93] Failure to detect substance abuse disorders can result in a misdiagnosis of mental disorders, sub-optimal pharmacological treatments, neglect of appropriate substance abuse interventions, and inappropriate treatment planning and referral.[94] In addition, since use of even limited amounts of alcohol or other drugs can be associated with negative outcomes among people with mental illnesses,[95] routine screening is an important component of mental health prevention and treatment.

The clinical screening process enables a service provider to assess if an individual demonstrates signs of substance abuse or is at risk of substance abuse. Screening is a formal process that is typically brief and occurs soon after the consumer presents for services.[96] The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment.

A broad range of effective screening tools exist for specific populations. Many are brief self-report screens that can be completed as part of an initial intake interview for an individual with a severe mental illness.[97] For example, Washington State is currently using the Global Appraisal of Individual Needs – Short Screener (GAIN-SS), a shortened version of a leading tool for a broad range of substance use.[98] In addition, the Michigan Alcoholism Screening Test (MAST) is considered reliable and valid as a screening tool for persons with primary alcoholism, but includes items that are irrelevant or confusing for people with severe mental illness.[99] Research suggests that the Dartmouth Assessment of Life Style Instrument (DALI) is effective for individuals with acute mental illness.

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[93] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2002). Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.

[94] Drake, R.E., Mueser, K.T., Clark, R.E., et al. (1996). The course, treatment and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry 66: 42-51.

[95] RachBeisel, J., Scott, J. and Dixon, L. (1999). Co-Occurring Mental Illness and Substance Use Disorders: A Review of Recent Research. Psychiatric Services, 50, 1427-1434.

[96] Center for Substance Abuse Treatment. (2006). Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders. COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services.

[97] RachBeisel, et al. (1999).

[98] Dennis, M.L., Chan, Y-.F., & Funk, R.R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. The American Journal on Addictions, 15 (supplement 1), 80-91. Downloaded on April 11, 2007 at http://www.chestnut.org/LI/gain/GAIN_SS/Dennis_et_al_2006_Development_and_validation_of_the_GAIN_Short_Screener.pdf.

[99] Rosenberg, S., Drake, R., et al. (1998). Dartmouth Assessment of Lifestyle Instrument (DALI): A Substance Use Disorder Screen for People with Severe Mental Illness. Am J. Psychiatry, 155, 232-238.

Prevention and both early identification and intervention of substance abuse disorders are appropriate for individuals of all ages, but are especially critical for young people and individuals whose substance use problems have not risen to the level of seriousness to require treatment.

Supportive Housing. Supportive housing (sometimes called supported housing) is a term used to describe a wide range of approaches and implementation strategies to effectively meet the housing needs of people with disabilities, including people with mental illnesses. Supportive housing may include supervised apartment programs, scattered site rental assistance, and other residential options. NASMHPD has identified supportive housing as a best practice in the field,[100] and SAMHSA's Center for Mental Health Services is in the process of developing an Evidence-Based Practice Implementation Resource Kit for this approach.

The overall goal of supportive housing is to help consumers find permanent housing that is integrated socially, reflects their personal preferences, and encourages empowerment and skills development.[101] Program staff provide an individualized, flexible, and responsive array of services, supports, and linkages to community resources, which may include such services as employment support, educational opportunities, integrated treatment for co-occurring disorders, recovery planning, and assistance in building living skills. The level of support is expected to fluctuate over time.[102]

Numerous studies of consumer preferences agree that mental health consumers generally prefer normal housing and supports over congregate residential living. Furthermore, people tend to want to live alone or with another person of their choice, rather than with groups of people who have psychiatric disabilities.[103] Residential stability and life satisfaction are increased when consumers perceive they have choices and when their housing and support preferences are honored.[104]

All supportive housing models should maximize, to the extent possible, the following components of an ideal model of supportive housing: (1) choice of housing; (2) separation of

[100] Housing for persons with psychiatric disabilities: Best practices for a changing environment. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.
[101] U.S. Surgeon General's Report, (1999). p. 293.
[102] U.S. Surgeon General's Report, (1999). p. 293.
[103] Schutt, R.K. & Goldfinger, S.M. (1996). Housing preferences and perceptions of and health and functioning among homeless mentally ill persons. Psychiatric Services. 47, 381-386.
[104] Srebnick, Debra S. (1992). Perceived choice and success in community living for people with psychiatric disabilities. Unpublished doctoral dissertation. Burlington, VT: University of Vermont, Department of Psychology.

housing and services; (3) decent, safe, and affordable housing; (4) housing integration; (5) access to housing; and (6) flexible, voluntary services.[105]

A significant body of research demonstrates that people in supportive housing experience reduced homelessness, increased residential stability, reduced recidivism to hospitalization and shorter lengths of stay, and reduced time spent incarcerated.[106] A few studies relate supported housing to reductions in psychiatric symptoms, increased social functioning, and improved quality of life.[107]

Supportive housing program models have been successfully adapted and implemented to meet the needs of people with serious mental illnesses and co-occurring substance abuse and developmental disabilities, including those with special needs such as veterans, people who are homeless, families with children, transition-age youth, people who have histories of trauma, people with HIV/AIDS, and offenders leaving prisons or jails.

Telepsychiatry. Telepsychiatry is a method of providing expert psychiatric treatment to consumers at a distance from the source of care. Its use has been suggested for the treatment of consumers in remote locations or in areas where psychiatric expertise is scarce.[108] Telepsychiatry sometimes includes educational initiatives for providers and other non-clinical uses.

Psychiatric interviews conducted by telepsychiatry appear to be generally reliable, and consumers and clinicians generally report high levels of satisfaction with telepsychiatry.[109] Current technologies make telepsychiatry feasible, increases access to care, and enables specialty consultation.[110] There is little evidence to date regarding clinical outcomes or cost-effectiveness of telepsychiatry as compared to in-person treatment. However, at least one randomized, controlled study has found that remote treatment of depression by means of

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[105] Fidelity Scale for Ideal Permanent Supportive Housing (2007). Draft in progress for inclusion in SAMHSA Supportive Housing Implementation Resource Kit.

[106] Ridgeway, P. and Marzilli, A. (2006). Supported Housing and Psychiatric Disability: A Literature Review and Synthesis: Prepared for the Development of an Implementation Toolkit. (unpublished document)

[107] Ridgeway, P. and Mazilli, A. (2006). Citing Hough, R., Harmon, S., et al. (1994). The San Diego project: providing independent housing and support services. In Center for Mental Health Services (eds.). Making a difference: Interim status report on the McKinney research demonstration program for mentally ill adults, at 91-110.

[108] Ruskin, P.E., Silver-Aylaian, M., et al. (2004). Treatment Outcomes in Depression: Comparison of Remote Treatment Through Telepsychiatry to In-Person Treatment. Am J Psychiatry 161, 1471-1476.

[109] Frueh, B.C., Deitsch, S.E., Santos, A.B., et al. (2000). Procedural and Methodological Issues in Telepsychiatry Research and Program Development. Psychiatric Services 51, 1522-1527.

[110] Hilty, D.M., Marks, S.L., Urness, D., Yellowlees, P.M., Nesbitt, T.S. (2004). Clinical and educational telepsychiatry applications: a review. Can J Psychiatry 49(1):12-23.

telepsychiatry and in-person treatment of depression have comparable outcomes and equivalent levels of consumer adherence and satisfaction.[111] In that study, telepsychiatry was found to be more expensive per treatment session, but this difference disappeared if the costs of psychiatrists' travel to remote clinics more than 22 miles away from the medical center were considered.

Wellness Recovery Action Plan (WRAP). The Wellness Recovery Action Plan (WRAP) approach is a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. Under the WRAP model developed and disseminated by Mary Ellen Copeland,[112] WRAP services are provided by facilitators who have developed and used their own WRAP and who are trained and certified through participation in a five-day seminar.

A WRAP includes the following six main components: (1) developing a Daily Maintenance Plan, including a description of oneself when well and tools needed on a daily basis to maintain wellness such as maintaining a healthy diet, exercise, or stable sleep patterns; (2) identifying triggers to illness; (3) identifying early warning signs of symptom exacerbation or crisis; (4) identifying signs that symptoms are more severe; (5) developing a crisis plan or advance directive; and (6) developing a post-crisis plan.

The WRAP model includes a pre-test/post-test tool to measure the impact of the intervention. At least one study using this tool found significant increases in consumers' self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.[113] Another widely-cited study found increases in consumers' self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.[114]

The WRAP model has been integrated into MHD's current peer counseling training curriculum, and federal block grant funds have been used to support training in the last fiscal year.

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[111] Ruskin, P.E., et al. (2004).

[112] Copeland, ME., WRAP-Wellness Recovery Action Plan. Retrieved at www.mentalhealthrecovery.com/art_aboutwrap.html.

[113] Vermont Recovery Education Project, cited in Cook, J., Mental Illness Self-Management through Wellness Recovery Action Planning (n.d.), retrieved at www.copelandcenter.com.

[114] Buffington E., (2003). Wellness Recovery Action Plan: WRAP evaluation, State of Minnesota. Minneapolis, MN: Mental Health Consumer/Survivor Network of Minnesota.

Cultural Brokers. To supplement the lack of diversity in the health care workforce, standards have also been developed regarding the strategy of employing cultural brokers. The potential utility of cultural brokers in mental health settings has been described,[115] and the National Center for Cultural Competence (NCCC) at the Georgetown University School of Medicine has developed a guide to promote the development of cultural broker programs.[116] The NCCC guidelines take a broad view of culture, including factors related to sexual orientation, age, disabilities, social economic status, religion, political beliefs, and education. The guide defines a cultural broker broadly as an advocate between groups of differing cultural backgrounds; it defines the role more specifically for health care settings as a particular intervention to engage a range of individuals with diverse backgrounds to help span the boundaries between the culture of health care delivery and the cultures of the people served. These individuals range in their roles within the health care delivery system from consumers to providers to leaders. Singh and his colleagues (1999) describe the broker as acculturated in the mainstream health care delivery culture and one or more minority cultures. The NCCC guidelines note that, while cultural brokers generally achieve acculturation in a particular minority culture through their own experience as a member of that culture, membership is neither a sufficient nor a necessary requirement. The guidelines instead center on the person's

> *. . . history and experience with cultural groups for which they serve as a broker including the trust and respect of the community; knowledge of values, beliefs, and health practices of cultural groups; an understanding of traditional and indigenous wellness and healing networks within diverse communities; and experience navigating health care delivery and supportive systems within communities.* (page 5)

The NCCC guidelines focus on the development of programs within health care organizations to expand the availability of cultural brokers for the specific communities served by those organizations. The guidelines include the following:

1. "Cultural brokering honors and respects cultural differences within communities," recognizing that diversity within specific communities is as important a factor as diversity across communities.
2. "Cultural brokering is community driven," building on the principle that community engagement and respect for the need for communities to determine their own needs is essential.

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[115] Singh, N.N., McKay, J.D., and Singh, A.N. (1999). The need for cultural brokers in mental health services. Journal of Child and Family Studies, Vol. 8, No. 1, 1-10.

[116] National Center for Cultural Competence, Georgetown University Medical Center (2004). Bridging the cultural divide in health care settings: The essential role of the cultural broker programs. Washington, DC: Author. Downloaded at: http://nccc.georgetown.edu/documents/Cultural_Broker_Guide_English.pdf.

3. "Cultural brokering is provided in a safe, non-judgmental, and confidential manner," underscoring the professional responsibilities of the cultural broker to provide the service responsibly.
4. "Cultural brokering involves delivering services in settings that are accessible and tailored to the unique needs of the communities served," emphasizing the importance of flexibility in the implementation of cultural brokering programs.
5. "Cultural brokering acknowledges the reciprocity and transfer of assets between the community and health care settings," acknowledging that skills and knowledge must be built both within the health care organization and the broader community being served.

It should be noted that, while membership in a specific cultural group is not necessary to serve as a cultural broker, a high level of acculturation is necessary. In order for a person to bridge two cultures, a level of acculturation in both cultures is needed. While a successful cultural brokering program can also promote awareness and skills that build cross-cultural competence (related to CLAS Standard 1, emphasizing the cultural competence of the entire health care workforce), the specific mechanism of the cultural broker focuses on their ability to bridge cultures they know well (related to CLAS Standard 2, emphasizing the match between the diversity of the health care workforce and the communities served).

A cultural broker does not have knowledge of how to work with "all cultures" or even "all members of a specific culture," as such a standard is simply not attainable. They instead have sufficient knowledge and skill to be viewed as credible by a sufficient number of the members of the specific communities being served to function as a bridge. This poses challenges to regulations and systematic efforts to require cultural competence, as will be seen below. While mental health specialists are regulated in terms of a minimum level of competence, the broader array of potential cultural brokers are not. In addition, cultural brokers typically are paraprofessionals, whose skills are vital but do not include the level of mental health expertise to deliver services or consult independently.

The tradeoff between ensuring a minimum level of competency and access to a broader array of skills is one that the health care workforce is continually seeking to balance, whether it be between prescribers and prescriber extenders, licensed mental health professionals and unlicensed mental health workers, or professional and peer support. While regulation can ensure that a set of minimum defined standards are met, it can be problematic when misconstrued as an endorsement of high quality or expert status or as a barrier to a broader array of resources.

Promotores de Salude. Promotores de salud (health promoters) provide culturally competent assistance to people in accessing and utilizing a range of health and/or mental health services in the community, including prevention and early intervention services. Promotores are from the

communities they serve, they speak the primary languages of the communities they serve, and they understand the culture. They also know the service systems that they help people navigate. Because of their unique knowledge of culture and systems, and because of their credibility within the communities they serve, promotores are especially well positioned to enhance access to and optimize utilization of services. Promotores assist people by providing health (and/or mental health) education to community members and they assist both community members and providers in identifying and overcoming barriers to services, such as language, stigma, mistrust, transportation, and others.[117]

[117] Summary was based on a description of the role of Promotores de Salud found on the California Institute for Mental Health Website. See http://www.cimh.org/LinkClick.aspx?fileticket=Qw5mqcEahTI%3d&tabid=568 for the CiMH report.