A GUIDE TO EVIDENCE-BASED PRACTICES

for **ADULTS WITH MENTAL ILLNESS**

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

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FORWARD

This is one of a series of reports on evidence-based practices. It was produced in response to the Saginaw County Community Mental Health Authority's interest in applying those services and supports that have proven ability to produce beneficial outcomes for consumers served under the auspices of the organization and was instigated by the organization's desire to ensure that state of art services and supports are available to the community. The timing of this endeavor coincides with federal and state initiatives that call for the dissemination and implementation of evidence-based practices in everyday mental health care settings.

This document constitutes a review of empirically based services and supports for adults with mental illness that was complied in an effort to provide an overview of practices that can be implemented by the Saginaw County Community Mental Health Authority. Relevant peer-reviewed journal articles, expert consensus guidelines, algorithms, reports, and other documents from the literature were consulted for relevance and applicability. The research was conducted using sources of information that are in the public domain – i.e., they are available to the public without charge. While individual sources are cited in the reference section, no attempt was made to produce a report in accordance with established standards for publication as this document is intended for use by the Saginaw Community Mental Health Authority as a guide to its own evidence-based practice development and implementation initiatives. As such, this paper is the sole property of the Authority and may be cited or reproduced only with SCCMHA's express permission. It should be noted that this is a "living" document; as evidence-based practices evolve and new ones are introduced, subsequent iterations may be produced. The electronic version contains active hyperlinks (underlined in blue text) to the various web sites and web-based resources listed.

This paper represents the culmination of hundreds of hours of a meticulous review of research that was conducted by combing through hundreds of articles, manuals, reports, guidelines, and web sites. What emerged from this examination was a vast collection of relevant material that had to be condensed and organized into a coherent and cohesive framework. This challenge resulted in the organization of information into sections based on approaches rather than on diagnoses as originally intended. It is hoped that the reader will find this structure comprehensible.

The topics covered are those deemed timely and relevant to public mental health services and supports (given federal and state initiatives), those specifically requested by the Saginaw County Community Mental Health Authority, and those that became apparent to the writer through the research process. While there is a tremendous amount of material available, an effort was made to offer an overview of each subject. Thus, the reader may find less depth in certain areas than might be desired, or lack of mention of areas of personal interest. Such a reader can refer to the references and resources sections for more information.

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EXECUTIVE SUMMARY

This report is a review of the literature on evidence-based practices that was compiled at the behest of the Saginaw County Community Mental Health Authority. It seeks to define what an evidence base constitutes and the rationale for using practices that are empirically supported and have practical use in everyday practice. It also includes approaches that do not yet have as strong an evidence base or do not yet represent a single evidence-based model of practice (e.g., faith-based, criminal justice and primary care collaborative models) but are readily applicable and are national and/or state priorities.

The first section provides an overview on key concepts and definitions of the elements of evidence-based practice and is designed to give the reader the requisite tools for understanding the difference between "usual" practices and those that are considered evidence-based. The goal is provide useful information that can be used to analyze various practices, approaches, and interventions found in the literature.

Evidence-based practices are provided in the context of recovery. Recovery is an empowerment concept that is inextricably linked to person-centered planning, consumer-directed and peer support models, as well self-determination. The section on consumer empowerment reviews the literature on this subject.

The next section is comprised of a brief discussion of prevention followed by key systems that an adult with a mental illness and/or co-occurring substance use disorder interfaces with, including primary care, criminal justice, and faith-based organizations. Collaboration efforts with these systems are federal and state priorities.

The section on education and employment covers supported education and supported employment, two models that have been demonstrated to improve outcomes for consumers. Housing is covered in the following section and focuses on affordability issues and the supported housing paradigm.

The importance of collaborating with family members in supporting recovery is an important element of evidence-based practices. This is clear in all of the SAMHSA (Substance Abuse and Mental Health Services Administration) evidence-based practice implementation resource kits and other literature. The section on families incorporates information on a specific program, Family Psychoeducation. Other sections of the report include information about working with families and support systems as well.

The section on somatic interventions primarily focuses on medication and electroconvulsive therapy. The reader will find information of interest on polypharmacy and ethnopsychopharmacological issues along with a discussion of antipsychotic neurological side effects.

The next section offers an overview of crisis and acute care services, including mobile crisis teams, alternatives to hospitalization for acute and crisis care, and hospitalization. A discussion of outpatient commitment is also included.

The foundation of evidence-based practices is consumer outcomes. The section on outcomes measurement is an overview of salient outcomes that should be measured in the provision of evidence-based practices. Examples of standardized screening tools are also noted because their

use is recommended in order to objectively ascertain the consumer's level of functioning and progress.

The last section of the report is devoted to a recap of key findings and a list of recommendations based on these findings that the Saginaw County Community Mental Health Authority might consider in its endeavor to implement and/or enhance its use of evidence-based practices.

The appendices include quick reference guides, examples of fidelity scales, and the tenets of cultural competence.

It should be noted that a vast amount of information is available on the various topics covered in the report. This document is an attempt to give an overview of evidence-based practices and approaches and offers resources for additional reading and reference. It is hoped that reader will come away with a general understanding of evidence-based practices and an interest in promoting their applications.

INTRODUCTION

The Surgeon General's 1999 report on mental health (titled *Mental Health: A Report of the Surgeon General*), the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* in 2003*,* the National Institute of Mental Health's *Bridging Science and Service,* as well as other publications, have stimulated a national movement to disseminate and implement various evidence-based practices in routine mental health settings.

A significant number of evidence-based practices, approaches, treatments, and programs have been developed over the past several decades. However, it is clear that most consumers do not have the opportunity to benefit from them because they are not used in everyday practice in mental health settings. This access disparity is even greater for consumers from ethnic and racial minority groups. Moreover, even when they are available, they frequently deviate from the original model that demonstrated success. This can lead to lack of positive benefits. When results do not match anticipated benefits, practices are often abandoned.

To rectify the gap between research knowledge and practice, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Robert Wood Johnson Foundation have teamed up to provide funding to develop and test evidence-based practice implementation resource kits for mental health providers to implement six evidence-based practices for adults with mental illness. They are:

- Family psychoeducation
- Integrated treatment for co-occurring mental and substance use disorders
- Illness management and recovery
- Supported employment
- Assertive community treatment
- Medication management for schizophrenia

Each implementation resource kit contains information for administrators, clinicians, funders, consumers, and families. The implementation resource kits are comprised of manuals/workbooks, information pamphlets, videotapes, outcome measures, and fidelity scales. In addition, consultation is available from the various authors of the implementation resource sits.
The Michigan Department of Community Health is currently working on disseminating and implementing integrated treatment for individuals with mental illness and co-occurring substance use disorders and Family Psychoeducation. However, there are a number of other evidence-based practices for adults with mental illness. These include cognitive-behavioral therapy and Interpersonal therapy for anxiety, depression and other conditions, medication algorithms, and the collaborative care model for adults with mental illness who are seen in primary care settings. Consumer-operated services, jail diversion programs, supported housing, trauma services, and treatments for people with borderline personality disorder all show great promise. Outcomes research on their effects and best practice models are part of the federal agenda. The current evidence base is strong enough to recommend them.

There are a number of compelling arguments for the implementation of evidence-based practices and shifting resources away from ineffective or less effective services and supports including:

- Judicious use of evidence-based services and supports can lead to optimal functioning for consumers and their families, which in turn can promote independence and satisfactory participation as full citizens in community life.
- Consumers and their families have a right to be educated about optimal treatments and supports and to make informed decisions regarding receipt of them.
- In an era of shrinking resources and increasing demand, investing in practices that have been proven effective, and moving away from those that have not, makes sound fiscal sense.

Mental health services and supports should be consumer and family focused, with the goal of helping consumers assume fully functional roles in society, not just achieving stability of symptoms and community tenure. The ability and right of consumers to make decisions on the road to recovery resides fully with the consumer, not the practitioner. The practices and approaches discussed in this report are those with demonstrated capacity to promote optimal recovery.

AN OVERVIEW OF EVIDENCE-BASED CONCEPTS

This section is devoted to an overview of the scientific foundation of evidence-based practices. It is designed to familiarize the reader with definitions as well as information needed for assessing the literature on various approaches, practices, and interventions.

The quest for evidence of the effectiveness of interventions in the health sciences has a long history dating as far back as the middle ages. The use of group randomization in research dates back to 1662 in the field of agriculture. But, evaluation of medical treatments according to the rules of the scientific method only dates back about fifty years when Sir Austin Bradford Hill used the randomized control method in his work. Psychiatry adopted the methodology in 1955 in a comparison study of reserpine to placebo for individuals suffering from symptoms of anxiety and depression at the Maudsley Hospital in London. The phrase "evidence based medicine" was actually first used in 1990.

The term "evidence-based" practice refers to a clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting consumers achieve their desired goals or outcomes. An evidence-based practice is comprised of three components:

1. The highest level of scientific evidence
2. The clinical expertise of the practitioner
3. The choices, values and goals of the consumer

The strength of evidence for any given practice is referred to as the level of evidence. The highest level of evidence is based on a research methodology that is known as the randomized clinical or controlled trial (RCT). RCTs use sufficiently large number of participants (usually a minimum of thirty), or "subjects", who are randomly assigned to a specific intervention (the experimental group), or to a group that receives a routine or another intervention (the control group). In some studies, the control group does not receive any intervention (e.g., they are put on waiting list). Randomization reduces the potential for bias in the results. Outcomes from RCTs that are then replicated in typical clinical settings are assigned the highest level in the hierarchy of evidence.

In the most robust RCT the investigators and participants are " doubled blinded" as to which subjects are in the experimental group and which are in the control group. In most studies examining interventions of a psychosocial nature (e.g., assertive community treatment), it is impossible to keep practitioners and consumers unaware of the intervention. However, it may be possible to keep interviewers and/or individuals who are conducting the data analysis blind until data are collected and analyzed.

The next level of scientific evidence comes from RCTs that have not been replicated outside the controlled experimental situation. Less rigorous research designs are correlational research designs which entail observation of relationships to discern whether factors are associated or correlated, quasi-experimental studies which do not assign subjects to control and experimental groups on a random basis, and pilot studies. Pilot studies are evaluations or demonstrations that allow a comparison of the "before and after" the introduction of the intervention. They typically include findings from uncontrolled studies that can used to refine the interventions and investigational methodologies in subsequent controlled studies.

Promising practices are those which show potential for positive results and or have significant evidence or expert consensus for their use. Emerging practices are innovative practices that deal

with specific needs, but are not supported by the strongest scientific evidence. Expert consensus is another level of evidence that represents the incorporation of the opinions of practitioners who are deemed subject matter experts in their fields. Case reports or case studies constitute anecdotal evidence.

Meta-analyses use statistical techniques to combine the results of multiple research studies in order to determine the magnitude and consistency of the effect of a specific intervention detected across studies. In other words, the goal of a meta-analysis is to determine the magnitude and consistency of the outcome (i.e., the size or clinical significance) of a particular intervention detected across studies. It is important for a reviewer of a meta-analysis to ascertain whether the report includes studies with negative or insignificant results, and whether all of the studies are randomized or not. Omitting studies with negative or insignificant results and/or mixing differing levels of quality research can skew the results of a meta-analysis.

The following information is comprised of examples of levels of evidence that are used to base recommendations.

The Texas Medication Algorithm Project (TMAP) uses three levels of evidence to recommend treatment options:

Level A consists of controlled clinical trials
Level B consists of open trials and retrospective data analyses
Level C consists of case reports and clinical consensus

The Scottish Intercollegiate Guidelines Network uses the following levels of evidence to guide recommendations:

Levels of Evidence

1^{++}	High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1^{+}	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
1^{-}	Meta-analyses, systematic reviews, or RCTs with a high risk of bias
2^{++}	High quality systematic reviews of case control or cohort studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2^{+}	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g., case reports, case studies
4	Expert opinion

Levels of evidence are used to issue grades of recommendation.
The Scottish Intercollegiate Guidelines Network uses the following grades of recommendation:

A	At least one meta-analysis, systematic review of RCTs, or RCTs rated as 1^{++} and directly applicable to the target population, or
Or	A body of evidence consisting principally of studies rated as 1^{+}, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2^{++}, directly applicable to the target population, and demonstrating overall consistency of results

Or
Extrapolated evidence from studies rated as 1^{++} or 1^{+}

C A body of evidence including studies rated as 2^{+}, directly applicable to the target population and demonstrating overall consistency of results

Or
Extrapolated evidence from studies rated as 2^{++}

D Evidence level 3 or 4, or
Extrapolated evidence from studies rated as 2^{+}

The American Psychiatric Association uses the following levels of clinical confidence for making treatment recommendations:

Level I - recommended with substantial clinical confidence
Level II – recommended with moderate clinical confidence
Level III – may be recommended on the basis of individual circumstances

A guideline consists of a set of intervention strategies designed to assist practitioners in the process of clinical decision-making by synthesizing research and expert consensus into a practical form. Guidelines have been written for a number of illnesses including major depression, bipolar disorder, acute stress disorder, posttraumatic stress disorder, postnatal depression, and others are available from a variety sources including professional associations, such as the American Psychiatric Association, as well as the Agency for Healthcare Research and Quality, among others. An example is the Patient Outcomes Research Team (PORT) guideline for the treatment of schizophrenia.

An algorithm is a series of sequential steps that are to be precisely followed without deviation in the administration of an intervention. It is usually constructed as a flow chart that functions as a decision guide with recommendations regarding what changes are to occur based upon the consumer's response to the intervention. Thus, the results of each step determine the next step. The Texas Medication Algorithm Project (TMAP) for the treatment of schizophrenia, bipolar disorder, and major depression represents the most extensive application of algorithms thus far.

The use of guidelines and algorithms for medication has been shown to improve the quality of care and outcomes for consumers. They are designed to reduce practice variation, reduce polypharmacy, increase predictability of costs, as well as provide a benchmark for monitoring care and evaluating interventions. It is also thought that their use reduces liability exposure as well. In sum, they are tools designed to help practitioners in making clinical decisions to optimize outcomes; they are not a substitute for clinical judgment.

Texas Medication Algorithm Project (TMAP)	
Goal	To ensure quality care for people with serious mental illness by developing, applying, and evaluating medication algorithms. An algorithm is a step-by-step, systematic procedure in the form of a flow chart to help clinicians deliver quality care through the best choice of medications and brief assessment of their effectiveness. The target population is people with serious mental illnesses served by public programs.
Features	Development of algorithms as well as development of consumer education materials and other tools for treating serious mental illnesses. Public sector-university collaboration with support of stakeholders, education and technical assistance, and administrative supports to serve consumers who have the greatest medical complexity. Early phases of the project developed the algorithms and tested the benefits of their use; the program's latest phases focus on implementing TMAP in mental health treatment settings throughout the state.
Outcomes	The algorithm package implemented by Texas was more effective than treatment-as-usual for depression, bipolar disorder, and schizophrenia. It reduced symptoms, side effects and improved functioning. The package's benefit for reducing incarceration is being studied. TMAP algorithms have been adapted to treat consumers who have co-occurring mental and substance disorders.
Sites	Texas, Nevada; Ohio; Pennsylvania; South Carolina; New Mexico; Atlanta and Athens, GA; Louisville, Kentucky; Washington, DC; San Diego County, CA; private sector in Denver, Colorado.

Efficacy refers to whether an intervention works in the highly controlled research setting, whereas effectiveness refers to whether an intervention works in typical clinical settings. One of the biggest challenges is moving an efficacious intervention into routine settings to generate effective results. Most efficacy studies only include participants who are in good physical health, do not have any comorbid conditions such as a substance use disorder, and/or are adherent to treatment regimens. Moreover, highly trained and supervised specialists adhering to strict protocols that require frequent monitoring of the participants often conduct them. Thus, many interventions work better in clinical research then in everyday practice settings. This so-called efficacy-effective gap is now a matter of national concern with the drive to make evidence-based practices widely available.[1] This report contains information about practices with demonstrated effectiveness – that is, they have been consistently applied in everyday practice settings with success.

Fidelity refers to the level of adherence to the original model as specified in written materials, typically a manual, or by researchers. The degree of fidelity to the model affects outcomes. Research has demonstrated that the level adherence to the model strongly affects the ability to achieve the desired outcomes. However, it is sometimes necessary to adapt a practice to fit actual practice settings so that complete adherence to the original model is not maintained. This is referred to as adoption. This occurs because, as previously noted, controlled trials typically use individuals who are not representative of populations in typical settings. In order to be most effective, interventions need to be tailored to individuals with respect to gender, age, ethnicity, and culture.

The extent to which a practice can be explained in a manual, appraised for fidelity to the model and adopted in everyday service settings is the gold standard of evidence-based practices. A manual needs to clearly articulate the goals and standardized techniques of the intervention, to allow for

[1] There is a body of literature on the implementation of evidence-based practices in typical clinical settings. Many of the concepts from this body of literature are discussed in the SAMHSA implementation resource kits.

comparison of practice with the original model. When used with a fidelity scale, a manual can reduce drift from the original model.

A reader should review empirical literature with critical appraisal. The methodological features of a study need to be scrutinized when evaluating its significance. The design of the study, whether it is experimental or quasi-experimental, is of critical importance. The choice of outcome measures should reflect independent living outcomes, as well as reduction or remission of symptoms. The criteria for inclusion and exclusion should also be analyzed since many studies do not take into consideration differential effects on ethnocultural groups. The length of follow-up is important to assess, as it can be an indicator of enduring effects of an intervention. Finally, a fidelity instrument allows for comparison with the original model in subsequent studies.

CONSUMER EMPOWERMENT

Studies indicate that individuals who actively participate in their own treatment and who develop effective coping skills have the most favorable outcomes and enjoy a better quality of life. People who experience mental illness are experts in their experience of symptoms, the manner in which other people respond to them, and they know what is helpful to them and what is not.

Self-help has been demonstrated to reduce feelings of isolation, improve practice knowledge, and support coping efforts. Studies show that consumers who participate in self-help programs have more hopefulness about the future, enhanced self-esteem, more satisfying interpersonal relationships, fewer symptoms and fewer hospitalizations.

The recovery paradigm regards consumers as individuals who require accommodations to perform tasks to accomplish life's activities, rather than as individuals who cannot function due to a disability.

This section offers information about supporting the rights of individuals with a mental illness to make their own decisions regarding treatments, even when those decisions differ from the recommendations of professionals. In addition, it addresses the concepts of recovery, peer support, consumer-delivered services, empowerment and self-determination and person-centeredness. Psychiatric advance directives are discussed as they exemplify consumer empowerment. Illness Management and Recovery is an evidence-based practice that involves professionals. Other approaches that have been developed and promulgated by consumers are also reviewed.

THE RECOVERY CONTEXT

Ruth Ralph (2000) defines recovery as " a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society. The process is supported by those who believe in us and give us hope".

Much of what is known about the journey of recovery comes from first-person descriptions in the writings of consumers/survivors. The many first person accounts of consumers' journeys through the process of recovery have raised awareness of the need to incorporate recovery into systems of services and supports. "Nothing about us without us" is the mantra of the recovery movement. "Safety, voice and choice" typify the values of recovery promulgated by consumers/survivors.

The following section offers a review of recovery as a person-centered experience, resilience, self-help and illness management programs.

Driven by a burgeoning consumer/survivor movement and documented in many personal accounts, along with the Surgeon General's report on mental health as well as the report of the President's New Freedom Commission, there has been increasing emphasis on recovery in mental health care systems. Described in various ways, recovery is generally seen as a process of consumer empowerment wherein consumers learn to overcome daily challenges wrought by illness and symptoms, live independently, and have the opportunity to make decisions regarding their lives in a self-determined manner. Recovery does not denote cure, but is rather a process of acquiring the skills needed to learn to live with an illness so that the illness and its symptoms are not the dominant, prevailing force in the person's life. Recovery is thus the means by which consumers live, work, learn, and participate fully in community life. It is a person-centered experience. It requires a commitment

on the part of the service delivery system to help consumers move ahead with their lives and pursue their individual goals instead of just achieving clinical stability.

The recovery framework is characterized by shared decision-making in which consumers and providers are full partners in the treatment process. Providers are a source of hope, affirmation, and education and collaborate with consumers and their support systems (e.g., family) in a manner that fosters opportunity for choice and building resilience. In an evidence-based organizational culture, practitioners are professionals with expertise who convey information to consumers about the various options available to them to work on their goals and objectives. Consumers determine what will work for themselves based on their own perspectives.

The critical components of recovery include:

- Choices among good clinical care options
- Peer support and relationships
- Support of family and friends
- Work or other meaningful daily activity
- A feeling of power and control over one's life
- Overcoming stigma individually and collectively
- Productive involvement in the community
- Access to needed resources
- Education about the illness and about helpful behaviors to manage symptoms and triggering stressors

Resilience is an important concept in understanding the recovery paradigm. It is the ability to weather stresses, both large and small, bounce back from trauma and get on with life, learn from negative experiences and translate them into positive ones, gather the strength and confidence to change directions when a chosen path becomes blocked or nonproductive. It encompasses strengths that function as protective factors to enable one to withstand adversity and maintain well being. Supporting protective factors helps prevent the negative impact of stress and adversity and promotes health.

There is a growing movement to restore full citizenship to individuals with disabilities. Central to this movement is the concept of self-determination, which encompasses the right of individuals to exercise full power over their own lives irrespective of the presence of illness or disability. Michigan became the first state to formally put forward self-determination for individuals with mental illness when the Michigan Department of Community Health issued its policy and practice guideline on this subject on July 18, 2003.

Self-determination offers individuals the right to direct their own services using a personal budget to select and fund supports and services, make decisions regarding their health and welfare, and have freedom from involuntary treatment. It also promotes consumers playing vital roles in the design, delivery, and evaluation of services and supports. The development of a personal recovery plan and an individualized budget to procure services and supports are the hallmarks of self-determination.

At present, no evidence-based recovery practice per se exists due to the lack of randomized clinical trials with established results. However, the wealth of information from the recovery literature does provide ample evidence that recovery takes place, that the processes can be described in manuals, and taught to consumers. In fact, long-term follow-up studies indicate that two-thirds of people with a serious mental illness are able to leave the mental health system and attain independent living.

SELF-CARE AND CONSUMER-DELIVERED SERVICES

As consumers have become more active as participants in planning and directing service delivery, there has been a growing emphasis on self-care approaches and peer-delivered supports. Additionally, consumers are increasingly being employed as members of formal mental health treatment teams in traditional provider roles. The latter category includes consumers with professional training (who are sometimes referred to as "prosumers") as well as those who are "survivors".

Consumer-delivered and consumer-operated services, which are planned, managed, and operated by consumers, are increasingly integrated into traditional mental health systems. Consumer partnership services where consumers deliver services, but program control is shared with non-consumers, are also becoming more prevalent. Drop-in centers, clubhouses[2], housing programs (including outreach to individuals who are homeless), vocational programs, advocacy programs, housing programs, benefits acquisition services, and anti-stigma programs (including repertory companies, speakers bureaus, video productions, and others) are salient examples of both consumer-delivered and consumer partnership programs.

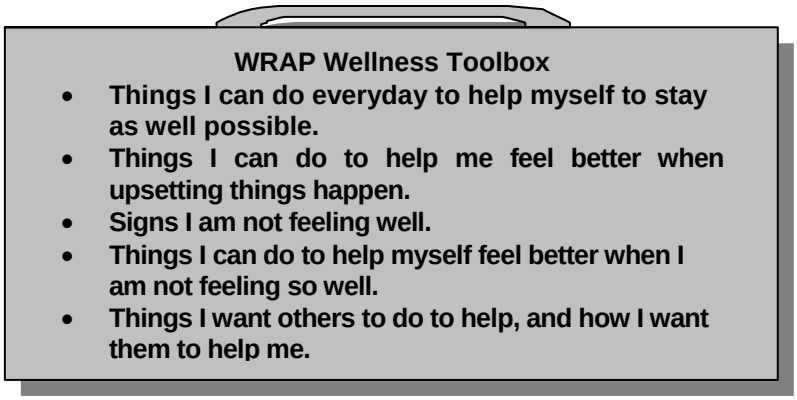
Consumers are being hired as employees in increasing numbers in positions such as case manager, peer counselor, peer specialist. Consumers have also been added to crisis and respite service programs, telephone hotlines, crisis residential services, in vocational programs as job coaches, psychoeducational programs, residential services, and supported education programs, etc.

Research has demonstrated consistently positive outcomes for the various consumer- delivered and operated services. In fact, consumer run case management programs have been shown to be as effective as professionally delivered case management services. Crisis teams that include consumers are as effective as those with professionals. Vocational services provided by consumers are associated with higher rates of employment.

Self-help has taken many forms including self-help groups, peer counseling, illness self-management, advocacy, and others. These include Recovery, Inc., GROW, the Depression and Bipolar Support Alliance (DBSA), Schizophrenics Anonymous, Double Trouble in Recovery, and Emotions Anonymous, to name a few.

Consumers have developed a number of noteworthy self-help programs. The Wellness Action Recovery Plan (WRAP) developed by Mary Ellen Copeland is a recovery-oriented practice in which individuals develop their own system for monitoring and responding to symptoms to attain wellness. In this program consumers and providers train and are trained together to encourage empowerment. The program helps professionals understand mental illness from the consumer's perspective. Copeland uses case vignettes to exemplify the approach using the development of a wellness toolbox, changing the title of the case manager to recovery specialist, and having the consumer complete a recovery plan instead of a treatment plan.

[2] Clubhouses were originally consumer-operated, but have moved from consumer-operated programs to a consumer as employee model.



The Personal Assistance in Community Existence (PACE) developed by Dan Fisher (a psychiatrist in recovery from a serious mental illness) and Laurie Ahern of the National Empowerment Center is another example. In PACE the focus is on entering into close, trusting relationships to (re)gain a valued social role and (re)capture one's dreams. It promotes the core belief that severe emotional distress is a temporary disruption in an individual's life and rejects coercive interventions.

Wilma Townsend's Recovery Management Plan process is based on what she terms the core principles of recovery:

- The consumer directs the recovery process; therefore, consumer input is essential throughout the process.
- Consumers are able to recover more quickly when their hope is encouraged, enhanced, and/or maintained; life roles with respect to work and meaningful activities are defined; spirituality is considered; culture is understood; educational needs as well as those of their family/significant others are identified, and socialization needs are identified.
- The clinician's initial emphasis on "hope" and the ability to develop trusting relationships influences the consumer's recovery.
- Clinicians operate from a strengths/assets model.
- Clinicians and consumers collaboratively develop a recovery management plan. This plan focuses on the interventions that will facilitate recovery and the resources that will support the recovery process.
- Family involvement may enhance the recovery process. The consumer defines his/her family unit.
- Mental health services are most effective when delivery is within the context of the consumer's community.

The Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) program is a recovery education model. Classes are held weekly for fifteen weeks in two-hour blocks. Class leaders are always consumers and work in groups of three with a leader/facilitator, a site coordinator, and an assistant. After finishing the course, leaders assist class members in starting peer support groups for participants to facilitate. BRIDGES is part of the SAMHSA Consumer Operated Services Program.

Researchers have documented a number beneficial effects for consumers who participate in self-help programs including enhanced self-esteem and well being, reduced hospitalizations, better community adjustment, decreased substance abuse, the opportunity to serve as positive role

models, and avoidance of stigma and discrimination. Participants experience the "helper's principle" wherein individuals who assist others derive enhanced self-esteem and feeling of self-worth. The SAMHSA Consumer Operated Services Programs found that efforts to develop and sustain consumer-operated services require effective technical assistance, strategic planning, and adequate funding. Self-care is an evidence-based practice based on research that confirms its significance. It is used both as an adjunct to traditional services and as an alternative to traditional services.

There are also family self-help and advocacy programs designed to assist families in coping with a loved one's illness. The most noteworthy of these is the National Alliance for the Mentally Ill's (NAMI) Family-to-Family Education Program (FFEP). It is a free twelve week, peer-based structured program for family members of individuals with severe mental illness, including schizophrenia, major depression, bipolar disorder, borderline personality disorder, anxiety disorder, obsessive-compulsive disorder, and co-occurring substance use disorders. The program is being run by trained NAMI members in forty-four states. It was developed by Joyce Burland, Ph.D. in the early 1990s and uses a structured, scripted manual that offers families information about mental illness, treatment options, medications, and rehabilitation programs. Families also learn self-care and communication skills along with problem-solving and advocacy approaches.

Two studies have been conducted on results of participation in the Family-to-Family Education Program. Both showed that participants had an increased sense of empowerment regarding the mental health system, felt better able to cope with their family member and experienced diminished subjective burden.

The above-noted programs are examples of illness self-management programs, which are peer operated, and focus on helping people cope more effectively with their illness. Illness management programs, on the other hand, are professionally-based approaches designed to help consumers cope more effectively with their symptoms, gain skills to enhance their effective collaboration with professionals, and reduce their vulnerability to relapses. SAMHSA's Illness Management and Recovery Program is an evidence-based intervention that exemplifies the latter approach.

ILLNESS MANAGEMENT AND RECOVERY (IMR)

Illness Management and Recovery consists of psychoeducation which includes the provision of information to consumers about their illnesses, including symptoms, stress management strategies, side effects of medications, and warning signs of impending relapse. The information provided in this section is from the SAMHSA implementation resource kit on this topic.

Illness Management and Recovery uses both individual and group formats, as well as combinations of both formats, depending upon need. The individual format is easier to tailor to the specific needs of the individual, allowing for more time on specific elements, whereas the group format has the advantage of providing more sources for feedback, role modeling, and social support. The program consists of a series of weekly sessions designed to help consumers develop and implement strategies for the management their illness and moving forward with their lives. It generally lasts for three to six months and can be provided in the community, the person's home, or can be office-based.

The goals of Illness Management and Recovery are to:

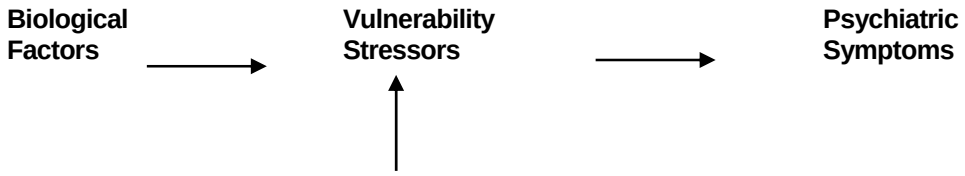
- Instill hope that change is possible
- Develop a collaborative relationship with a treatment team
- Help people establish personally meaningful goals to strive towards
- Teach information about mental illness and treatment options

- Develop skills for reducing relapses, dealing with stress, and coping with symptoms
- Provide information about where to obtain needed resources
- Help people develop or enhance their natural supports for managing their illness and pursuing goals

The following topics are covered in nine educational handouts:

1. Recovery Strategies
2. Practical Facts about Schizophrenia/Bipolar Disorder/ Depression
3. The Stress-Vulnerability Model and Strategies for Treatment
4. Building Social Support
5. Using Medication Effectively
6. Reducing Relapses
7. Coping with Stress
8. Coping with Problems and Symptoms
9. Getting Your Needs Met in the Mental Health System

The stress-vulnerability model is used to teach relapse prevention by disputing beliefs that relapses occur randomly and cannot be prevented. It suggests that vulnerability to relapses may be reduced by biological factors (such as by taking medications as prescribed and avoiding drugs and alcohol), environmental factors (such as enhanced social supports and reduced stress), as well as personal factors (such as meaningful structure and improved coping skills).



According to this model, a person has a biological vulnerability for a particular mental illness. The person with a biological vulnerability to the illness may develop that illness spontaneously or when experiencing stress. When the illness develops under the latter condition, it may recur intermittently. Vulnerability appears to increase with repeated recurrences for some individuals.

Illness Management and Recovery practitioners incorporate a number of cognitive-behavioral techniques designed to help the consumer learn to cope with symptoms and develop skills to deal with stress and relapses. Behavioral tailoring for using medications as prescribed encompasses teaching consumers strategies to incorporate medication use into their daily lives. This entails the use of cues as reminders to minimize forgetting to take medications. Examples include placing medication next to a toothbrush or deodorant, on the kitchen counter (to pair them with meal preparation), and wearing a watch with an alarm. Coping skills training is comprised of cognitive-behavioral interventions to cope with symptoms. For example, distraction techniques (e.g., listening music) are used to cope with auditory hallucinations. Relaxation training teaches muscles relaxation and breathing techniques paired with relaxing thoughts, which can be used when the person is in situations that evoke anxiety. Relapse prevention is also a significant element of the program. A discussion of this intervention is included in the section on prevention. Cognitive restructuring is also part of the program and used on a formal as well as informal basis. Information on cognitive restructuring can be found in the section on psychotherapeutic interventions. The practitioner uses a number of behavioral interventions to help people master skills including reinforcement, shaping, modeling, role-playing, and practice. Skills are practiced during sessions and homework assignments

are given so that the person can practice techniques in vivo. Family members are encouraged to become involved and assist the consumer.

The more than twenty-five studies conducted on Illness Management and Recovery indicate that psychoeducation is effective in improving consumers' knowledge about their illness, but does not affect other outcomes. On the other hand, cognitive-behavioral interventions are effective in helping those consumers who elect to take medication incorporate it in their daily lives. Consumers are able to learn to recognize and respond to early warning signs of relapse and thus prevent relapse and hospitalization. Cognitive-behavioral interventions are successful in assisting consumers to develop more effective coping strategies for dealing symptoms which leads to reduced symptom severity and distress.

PSYCHIATRIC ADVANCE DIRECTIVES (PADS)

Psychiatric advance-directives (PADs) are an emerging method of treatment planning that is self-directed. Advance directives are designed to establish an individual's preferences for intervention should the individual become unable to communicate those preferences as result of a crisis or incapacity. There are two forms of advance directives. The instructional directive informs providers what to do about treatment in the event that the individual becomes incapacitated. The proxy directive designates an individual the consumer wants to make treatment decisions in the event that he or she becomes unable to do so.

On January 3, 2005, the Michigan Mental Health Code was amended to allow individuals to create Psychiatric Advance Directives. Under the law, providers must comply with consumer advocate directives unless treatment is not consistent with generally accepted mental health best practices. The consumer is allowed to waive the right to revoke a consumer advocate designation for 30 days and allow the advocate to make mental health treatment decisions only if both a physician and a mental health practitioner have examined the consumer and certify, in writing, that the consumer is incapable of making decisions on their own behalf.

Online psychiatric advance directives are available form the Bazelon Center for Mental Health Law at http://www.bazelon.org.advir.html/. There are also a number of self-directed PAD programs that create a dialogue with the user who is then guided through a series of questions about key areas such as medication, emergency responses, specific interventions, and treatments. The answers to the queries drive the branching logic and enable a concise presentation of the material. AD MAKER is an example. The National Mental Health Association (http://www.nmha.org/), in conjunction with SAMHSA has developed an implementation resource kit for creating and implementing PADs that is available on line.

While there have been no empirical investigations of the effects of PADs, they are a promising practice to increase consumer empowerment and autonomy and improve crisis intervention planning. It is thought that they also have the potential to reduce hospitalizations, court proceedings, and costs. Studies indicate that compliance with advance directives can only be assured when they are disseminated to providers. The literature also provides the caveat that proxy decisions are effective only when consistent with the person's wishes.

THE CULTURAL CONTEXT

The gap between research and actual or usual practice is more pronounced for racial and ethnic minorities in the United States. There is a paucity of research involving significant numbers of members of racial and ethnic groups, as clinical trials do not always include data specific to minority populations. Many studies consist of small numbers of members of minority groups and are quasi-experimental, making it difficult to generalize findings.

It is incumbent on mental health providers to promote services and supports that demonstrate respect for the cultures of minority groups. This includes language, rituals, histories and traditions, beliefs and values.

This section provides an overview of salient issues for consumers from ethnic and racial minorities including, manifestations of mental illnesses, idioms for communicating distress, and patterns of help-seeking behaviors.

ETHNOCULTURAL ISSUES

The importance of culture on whether individuals seek help, what types of help they seek, their coping styles and social supports, as well as how much stigma they attach to mental illness all need to be considered in the design of services with cultural relevance. A system of services and supports that is culturally relevant addresses cultural orientation by understanding and valuing the unique attitudes, values, and points of reference that influence help seeking.

Saginaw County Census, 2000 (total population: 209,327)

White persons	75.3%
Black or African American persons	18.6%
American Indian and Alaska Native persons	0.4%
Asian persons	0.8%
Native Hawaiian and Other Pacific Islanders	Z
Persons of Hispanic or Latino origin	6.7%
White persons, not of Hispanic/Latino origin	72.4%
Persons reporting some other race	2.9%
Persons reporting two or more races	2.0%
Foreign born persons	2.0%
Language other than English spoken at home, pct age 5+	6.4%

Race, ethnicity, and culture significantly influence an individual's interface with the mental health system, from expression of illness, to response to medication and other interventions. It influences both whether and where a person seeks help. Numerous studies show that ethnic minorities are under represented in mental health programs nationally.

Research has documented serious racial and ethnic health disparities in the United States. These disparities are manifest in the dearth of information regarding their mental health needs and access to culturally relevant services. People from minority groups as less likely to seek mental health care, and they are more likely to delay seeking treatment until symptoms are more severe. They are also more likely to seek treatment from medical care providers than mental health practitioners.

Numerous studies note that African Americans are not typically prescribed newer antipsychotic medications, receiver higher doses of antipsychotic medication, and are likelier to receive depot

medications. Inpatient admissions for this population have been disproportionately high, especially those of an involuntary nature. African Americans also tend to drop out of treatment early and not utilize as many treatment service units despite often receiving more severe diagnoses. They are more often diagnosed with schizophrenia and under-diagnosed with affective disorders, and are less likely to be prescribed antidepressants. Latinos often view traditional mental health services as unnecessary and unwelcoming. They use less outpatient mental health treatment, use more crisis services, and have lower rates of voluntary hospital admissions than other population groups.

One of the ways culture affects mental illness is through the way it is described by consumers and how it is expressed. Many ethnic groups (e.g., some Asian cultures) do not make distinction between the mind and the body; somatization is an idiom of distress in some cultures. Somatic symptoms have been found to be more prevalent in Asian Americans (particularly Chinese Americans), African Americans and in Mexican American women, particularly those over the age of 40. There are also culture-bound syndromes (i.e., sets of symptoms that are more common in some cultures) such as *susto* (fright), *nervios* (nerves), *mal de ojo* (evil eye) found in Latino cultures, neurasthenia, and *hwa-byung* in Asian cultures. It is unclear whether some of these are manifestations of other disorders, but it is important to note their presence as symptoms of distress and provide appropriate intervention.

Stigma is a culturally determined factor in seeking mental health care. Mental illness still has a significant stigma attached to it. Research indicates that members of some minority groups have more stigmatizing attitudes about mental illness. For example, in Asian cultures mental illness is highly stigmatized and reflects poorly on one's lineage and potential suitability for marriage.

Attitudes toward mainstream providers can also vary with culture and ethnicity. For example, numerous studies point to African Americans' distrust of professionals (particularly those associated with governmental programs), Latinos' greater deference to them, and Asian Americans' reluctance to obtain services from them.

Many members of ethnic minority groups have had significant exposure to trauma. These include combat veterans, inner-city residents and immigrants from countries that are experiencing civil wars and genocide. Interventions that incorporate the identification and processing of traumatic experience may be contraindicated for individuals from nonwestern cultures (e.g., Asians) where open displays of affect are supposed to be suppressed.

Several studies point to the use of traditional healers and alternative therapies by members of certain cultural groups. Usually these are used in complement to traditional, so-called mainstream services. These include traditional healers in American Indian and Alaskan Native cultures and the reliance of African Americans on ministers. Other forms of indigenous healing include the herbalist and acupuncturist. Native American healing rituals include the sweat lodge and shamanic healing ceremonies. Use of folk remedies has been found to be more common than consultation with a folk healer. A culturally relevant system of care thus includes partnership with complementary practice providers.

Many ethnic minority cultures are more collectivistic and sociocentric while the Western European cultures tend to stress individualism more. Individuals from sociocentric cultures usually have very strong networks and are family-centered. For example, Latino and African American families have been characterized by their warmth and supportiveness. This kind of environment can serve as a protective factor as high expressed emotion (EE) is associated with relapse and more severe symptomatology. (A more detailed discussion of EE can be found in the section on working with families.) Appling Western European cultural values of individualism, autonomy, self-reliance and competitiveness to individuals from cultures that value allocentric personally attributes can conflict

with cultural norms and be counter therapeutic. A culturally relevant approach includes the family's perception, beliefs, and use of alternative healing practices. Interventions that incorporate family networks and utilize group modalities are congruent for consumers from sociocentric cultures.

Research has demonstrated that providing an ethnic match between the provider and consumer improves outcomes by reducing premature termination from treatment, contact with emergency and crisis services, and the number of days spent in the hospital. Thus, where possible, the ethnic and linguistic background of the provider and the consumer/family should be matched. Culture brokers can be used to bridge language and culture to facilitate transactions between formal and informal networks. Faith-based organizations can also facilitate culturally relevant approaches. Elders, traditional healers, and leaders of faith-based organizations may be more credible sources of information and support who can be called upon for assistance.

Although all systems of service and support are encouraged to function in a culturally competent manner, there is little research from which to draw a set of standards. The SAMHSA implementation resource kits include the following actions to promote cultural competence:

- Understand the racial, ethnic, and cultural demographics of the population served
- Become most familiar with one or two of the groups most commonly encountered
- Create a cultural competence advisory committee consisting of consumers, family and community organizations
- Translate forms and brochures
- Offer to match a consumer with a practitioner of a similar background
- Have access to trained mental health interpreters
- Ask each consumer about their cultural background and identity
- Incorporate cultural awareness into the assessment and treatment of each consumer
- Tap into natural networks of support, such as the extended family and community groups representing the culture of a consumer
- Reach out to religious and spiritual organizations to encourage referrals or as another network of support
- Offer training to staff in culturally responsive communication or interviewing skills.
- Understand that some behaviors considered in one culture to be signs of psychopathology are acceptable in a different culture
- Be aware that a consumer from another culture may hold different beliefs about causes and treatment of illness

Appendix C contains the framework for cultural competence that has been developed by the National Center for Cultural Competence at Georgetown University.

PREVENTION

Preventative measures are aimed at reducing risk factors and enhancing protective factors. While preventive measures may reduce the burden of mental illness, they cannot totally prevent it.

Screening for mental illnesses can lead to early detection that may be managed less expensively before progressing to a more severe stage. However, most screening programs lack adequate follow-up. For example, screening programs at health fairs and using self-directed approaches over the Internet are now quite common, but often ineffective due to lack of follow-up. Follow-up is essential to ensure the person follows through with treatment recommendations. Telephonic follow-up has been found to be an inexpensive, yet effective, means of increasing follow-up.

Emerging research suggests that intervening early can disrupt the negative course of some mental illnesses and may reduce long term disability. This means that early detection through screening and assessment can go along way to ameliorating long-term disability and negative course of illness. The SAMHSA implementation resource kit on family psychoeducation stresses early intervention, as do a number of other guidelines.

In primary care settings, routine screening for depression is recommended. Research supports screening (or rescreening) for all adults at every visit to a primary care provider because of the lack of recognition and treatment of depression in such settings. It is estimated that five to nine percent of adults seen by primary care providers have depression and that fifty percent or more go undetected. A simple two-question screen is usually sufficient to detect the need for further evaluation and intervention. The two questions are: "Over the past two weeks, have you felt down, depressed, or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?"

New York City has recently begun a depression screening initiative in primary care settings to screen for depression in adults using a simple questionnaire developed by the RAND Corporation based on their research:

Over the past two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Circle the number under your answer:				
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching TV	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead, or hurting yourself in some way.	**0**	**1**	**2**	**3**

1 – 4 Minimal Depression
5 – 9 Mild Depression
10 – 14 Moderate Depression
15 –19 Moderately Severe Depression
20 – 27 Severe Depression

Add columns ☐ + ☐ + ☐

Total Score = ☐

Psychoeducational interventions aimed at health education provide the individual with information to address emotional, perceptual and psychological issues to reduce barriers to adherence with prescribed treatment regimens. Relapse prevention is a good example of such an intervention.

RELAPSE PREVENTION

Relapse prevention strategies are woven into the SAMHSA evidence-based implementation resource kits and other guidelines (e.g., American Psychiatric Association). Such strategies focus on teaching individuals to identify early warning signs and situational triggers and then take actions to prevent or short-circuit exacerbations of symptoms or distress. These include relatives, friends, or other support system members to assist in this process. Some programs use a graphic display or timeline to help with the identification of early prodromal signs and symptoms of relapse. These charts show the sequences, frequencies, responses to treatment, environmental stressors, sleep patterns, etc. This can help the person understand and predict occurrences with the potential to exacerbate symptoms. Research clearly demonstrates that education for consumers and their families is related to the early warning signs of relapse is related to improved outcomes, including fewer relapses, hospitalizations, and lower costs.

SYSTEMS COLLABORATION

This section discusses other systems that have been found to be of significance for adults with mental illnesses and co-occurring substance use disorders. It covers working with faith-based organizations, primary providers, and the criminal justice system.

Many families from ethnic groups are known to draw upon their spirituality to cope with a relative's mental illness. Many members of ethnic groups prefer to receive service in general medical settings.

FAITH-BASED COLLABORATION

There is a growing evidence base of the value of services and supports that faith-based community organizations offer to individuals with mental illnesses. Researchers have discovered that faith-based community organizations provide valuable service and supports to persons with mental illness, not only through the comfort and solace of religious observation, but also through a complementary safety net of caring for some of the most vulnerable and underserved citizens. Faith-based initiatives are part of the national and state agendas.

The limited research available indicates that use of spirituality in coping with mental illness is an important and common method. It also suggests that various aspects of religious practices, affiliations, and beliefs are beneficial for mental health, thus functioning as protective factors. This has been found to be significant for Latinos and African Americans.

Partnering with faith-based organizations can confer a number of benefits to the mental health system including extending limited resources of safety net supports by enhancing the capacity to provide resources and services such as transportation, meeting space, respite care, etc. Additionally, those that serve specific racial, ethnic or cultural communities can become culture brokers in helping providers become more familiar with and connect with diverse communities. They can often offer interpreter services as well as assist with mental health community education and prevention programs, anti-stigma efforts, and other health promotion efforts. In some cultural groups, as previously noted, leaders in the faith/spiritual community, elders, and traditional healers are trustworthy sources of information and guidance.

A growing body of literature validates the positive responses of various ethnic and racial groups to educational and preventive efforts instituted by faith-based organizations. These efforts can improve self-care through developing culturally relevant services and incorporating spirituality into the provision of supports, expanding their reach and impact.

Rulings of the United States Supreme Court indicate that there are safe harbors for partnerships with faith-based organizations. Such safe harbors include three tests. The first is that the partnership's activities must be secular in nature. The second is that the activity must neither promote nor obstruct religion. The third is that the joint activity cannot promote excessive governmental involvement with religion. In other words, a governmental sponsor must remain neutral and there can be no proselytizing. The ultimate beneficiary of the joint services and supports must be the recipient, not the religious organization.

PARTNERING WITH PRIMARY CARE PROVIDERS

There is compelling evidence to support mental health and primary care collaboration. On the one hand, the medical needs of many consumers with mental illness go unmet. On the other hand, a significant numbers of individuals with mental illness are seen in primary care settings and their illnesses often go unrecognized and untreated. It should be noted that approximately half of the care for mental illnesses is delivered in medical settings. Primary care providers actually prescribe the majority of psychotropic medications (about sixty-five percent according to the literature).

Research indicates that many racial and ethnic minorities prefer to receive treatment in medical settings since such settings are not viewed as stigmatizing. The literature reports that Latinos are twice as likely to seek care for mental health issues in medical settings than in mental health settings.

Many individuals with severe and persistent mental illness have comorbid conditions such as diabetes, heart disease, respiratory ailments, hypertension, and infectious diseases such tuberculosis, HIV/AIDS, and Hepatitis B and C. The consequence of such conditions is an increased risk of non-suicide related mortality if they go untreated.

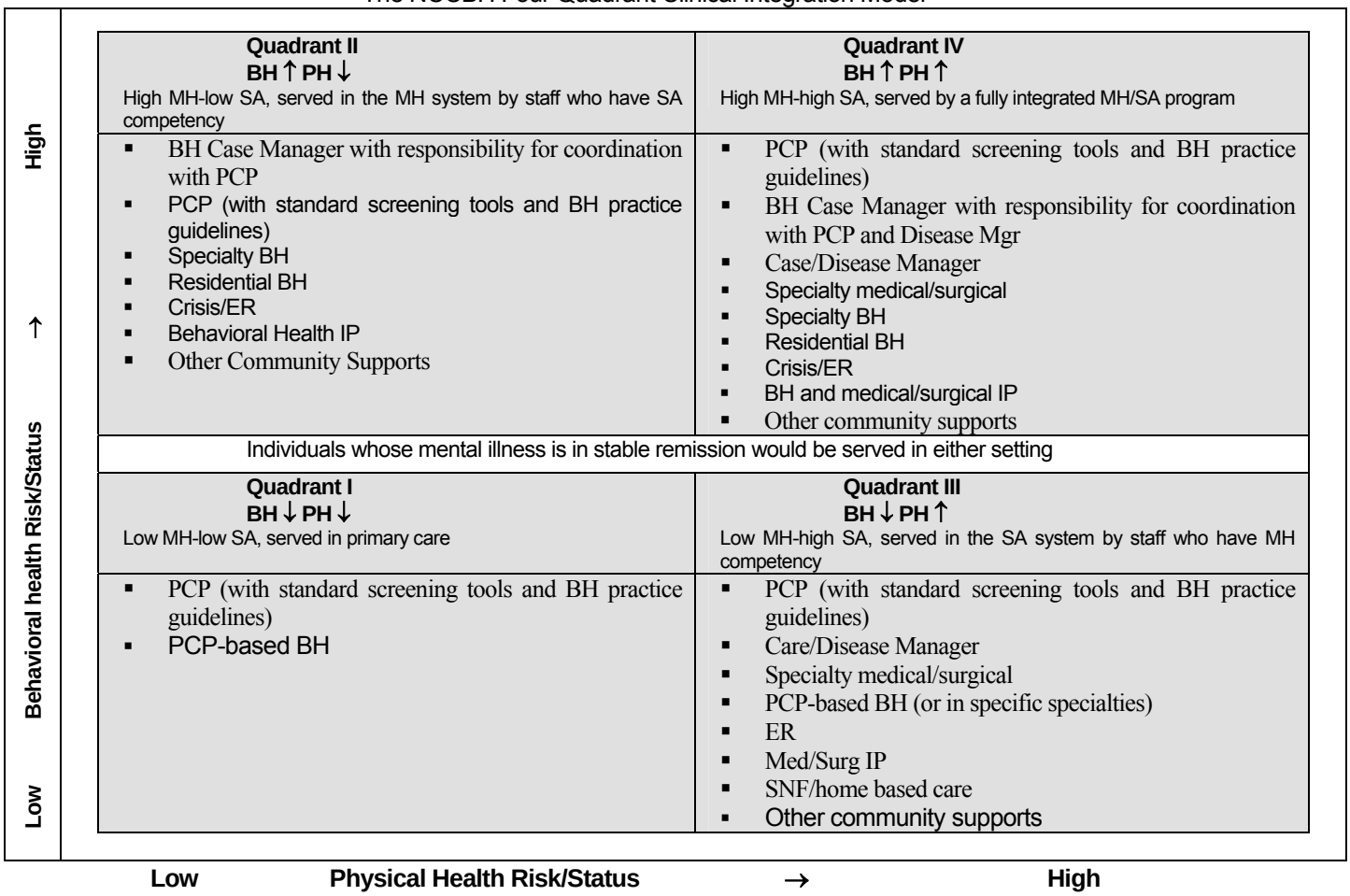
The literature strongly supports the development of a collaborative care model with a number of studies documenting its effectiveness. In fact, the Health Resources and Services Administration (HRSA), which is responsible for administering funding for the Consolidated Health Center Program, or Community Health Centers, has been in the process of implementing its Primary Care Integration Initiative across the country. This endeavor entails the addition of mental health services to Community Health Centers, thus offering a prime opportunity to establish collaborative relationships between community health and mental health safety net providers.

Collaboration can be implemented in a number of ways including co-location of services, consultation and referral programs. The result should be seamless, integrated care for the consumer. Core services should include mental health and substance use disorder screening, behavioral health consultation and follow-up. Mental health providers in primary care settings typically deliver brief, symptom focused therapy, psychoeducational groups, relapse prevention, and telephone consultation. (The latter has been shown to be a cost effective approach for follow-up especially with respect to helping people adhere to a depression medication regimen. As is indicated in the section on medication adherence, studies indicate that many people stop taking their medications prior to the minimum time needed to effectively treat an episode of depression.)

The National Council for Community Behavioral Healthcare has promoted a four-quadrant model for depicting collaborative service delivery. It is a useful schema adapted from Dr. Kenneth Minkoff's collaborative model for mental health and substance abuse service collaboration.[3]

[3] The model for mental health and substance abuse treatment service integration is essentially the same as this one except that it uses substance abuse providers in place of primary care providers.

Behavioral Health/Primary Care Integration
The NCCBH Four Quadrant Clinical Integration Model



Quadrant I: Low behavioral / health-low physical health complexity/risk, served in primary care with behavioral health staff on site; very low/low individuals served by the primary care provider, with the behavioral health staff serving those with slightly elevated health or behavioral health risk.

Quadrant II: High behavioral / health-low physical health complexity/risk, served in a specialty behavioral health system that coordinates with the primary care provider.

Quadrant III: Low behavioral / health-high physical health complexity/risk, served in the primary care/medical specialty system with behavioral health staff on site in primary or medical specialty care, coordinating with all medical care providers including disease managers.

Quadrant IV: High behavioral / health-high physical health complexity/risk, served in both the specialty behavioral health and primary care/medical specialty systems; in addition to the behavioral health case manager, there may be a disease manager, in which case the two managers work at a high level of coordination with one another and other members of the team.

Research supports integrative models of care with the combination of mental health and general medical care delivered by a team comprised of both mental and physical health providers to meet the overall health needs of consumers. Such a collaborative model should include screening and triage

for mental health care, a comprehensive mental health assessment for individuals for whom screening is inadequate to make recommendations for intervention, on-site mental health treatment which can include brief individual, family, group psychotherapies, and pharmacotherapy. Referral to other providers and agencies is made when appropriate, including specialty mental health providers, community agencies for services and supports (e.g., housing, entitlements, etc.).

COLLABORATION WITH THE CRIMINAL JUSTICE SYSTEM

Collaboration with the criminal justice system has become a priority due to the significant numbers of persons with mental illness in prisons and jails. The numbers of individuals with co-occurring substance use disorders and mental illnesses is even greater. This section reviews practices designed to prevent incarceration (diversionary services), and services and supports for individuals with a mental illness and/or co-occurring substance use disorder who are incarcerated.

There is currently no ideal single model for a collaborative mental health and criminal justice program. Several models currently exist in various jurisdictions around the county. Research indicates that the most effective ones have integrated services for co-occurring disorders, strong linkages through boundary spanners and regular meetings of the leadership of both systems. In addition, early identification and intervention for individuals with mental health issues is recommended.

JAIL DIVERSION

In general, jail diversion is comprised of programs designed to screen individuals with mental illnesses who encounter the criminal justice system in order to provide treatment alternatives to incarceration. Diversion can be categorized as prebooking, postbooking, or coterminous and is based on the principle of therapeutic jurisprudence, which recognizes the need to balance to public safety with the treatment of individuals with mental illnesses. This means the focus is on avoiding incarceration rather than on avoiding criminal charges. The goal of a diversion program is to avoid or reduce the amount of time a person is incarcerated, reduce recidivism and create linkages between criminal justice system and the mental health system to ensure the provision of appropriate community-based services and supports.

Booking is defined as the processing of an individual into jail custody. It can be separate from an arrest or part of an arrest procedure. There are a number of models of prebooking programs. They include mental health training for law enforcement and mobile crisis teams that accompany the police. In police-based diversion programs, individuals are usually transported to a central screening location (e.g., emergency room, crisis center) for evaluation. The person is then directed to the mental health system rather than being charged with a crime. Essential elements include: cross training of police and mental health staff; a single point of convenient entry; a no-refusal policy; a streamlined intake process including both substance abuse and mental health (allowing police officers to quickly return to their duties and not have to discern whether the person suffers from a mental illness, substance use disorder, or both).

In coterminous jail diversion, an offender is taken into custody by police, who then transport the person to a mental health setting and file charges. This can result in an assortment of dispositions from dropping the charges to compelling the offender to respond to them. Formal training of police officers in crisis intervention and recognition of mental health symptoms and pairing them with mental health professionals enhances the success of this type of community-based diversion.

Postbooking jail diversion occurs subsequent to arrest and booking (often for a misdemeanor offense). There are three common components in postbooking programs: screening, assessment and negotiation between diversion-based staff members and criminal justice-based staff to construct a treatment alternative and waive or reduce charges or time spent in jail.

Postbooking diversion (where booking is separate from arrest) may be jail-based or court-based. Jail-based diversion programs identify, screen, assess, and divert the person from incarceration. Court-based diversion programs may be centralized or decentralized. In the latter model, also known as court-liaison programs, diversion staff work in multiple courts and work with multiple judges, prosecutors and defense attorneys at any stage of the criminal process. Such programs provide case management and monitoring.

Specialized mental health courts (i.e., centralized models), also called collaborate justice courts, or problem-solving courts, are based on drug courts, usually have their own calendars and dockets, and typically restrict cases to nonviolent misdemeanants. (Two exceptions include San Bernadino County, which hears felony cases, and Broward County, which, with the victim's consent, hears assault cases.) [4]

Court-based diversion consists of preplea, postplea, and probation-based models. In the preplea model, prosecution is deferred and charges are dismissed after successful completion of treatment. In the postplea model, the person is adjudicated, but the sentence is deferred. The probation-based model typically consists of conviction with probation and a suspended or deferred sentence. Dismissal of charges following successful treatment is used as an incentive to participate in treatment.

Researchers have found the following crucial elements in common in successful diversion programs:

- Strong cross-system linkages based on mental health and criminal justice system collaboration in program development from the onset with regular and ongoing meetings.
- The presence of "boundary spanners" who facilitate communication across corrections, judicial and mental health staff, and agencies to coordinate services.
- Aggressive linkage to an array of community-based supports and services, especially for individuals with co-occurring disorders.
- Strong program leadership.

The research indicates that there is no single model of diversion that will work in all jurisdictions.

INMATE SERVICES

Jails are legally mandated to screen, identify, evaluate, and provide adequate treatment for inmates with mental illnesses and co-occurring substance use disorders. Effective inmate services include screening all incoming detainees for mental health and substance use disorders, and providing treatment including crisis intervention, medication, counseling and case management services. Most programs also include training corrections personnel to identify and work with inmates who have a mental illness and/or co-occurring substance use disorder.

[4] On November 13, 2000, President Clinton signed Senate Bill 865 into law. P.L. 106-515, America's Law Enforcement and Mental Health Project, which directed the attorney general to issues grants to states and state and local courts to establish up to one hundred demonstration mental health courts to provide supervision of offenders with mental illness, mental retardation, or co-occurring substance use disorders who are charged with a misdemeanor or nonviolent offense.

Maryland's Community Criminal Justice Treatment Program (MCCJTP) has been sited as an exemplary program for individuals with mental illness and co-occurring disorders who are in jail, on probation and parole. The Program provides screening, crisis intervention, counseling, discharge planning, community follow-up, case management services, and housing. It is depicted below.

The Maryland Community Criminal Justice Treatment Program	
Goals	To meet the comprehensive needs of offenders with mental illness, reduce recidivism to state psychiatric hospitals and the criminal justice system, and reduce homelessness.
Features	An advisory board that includes representatives of organizations that serve ex-offenders in the community, such as mental health, alcohol and drug abuse, public defender, judicial, parole and probation, law enforcement, social service, and consumer and advocacy agencies in each participating jurisdiction is developed. This board develops a memorandum of agreement that defines the specific services each agency will provide. On incarceration, offenders receive a comprehensive screening and assessment for mental illness and substance abuse, and crisis intervention services are provided as necessary. Medication may be prescribed following a medical evaluation. An individual treatment plan is developed, and the indicated therapies are begun as soon as possible. A program designed to help women offenders with substance-abuse problems and the effects of traumatic life experience is available. The services provided during prebooking and incarceration lay the foundation for discharge planning. In 1995, The Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration received a $5.5 million housing grant from the HUD to provide rental assistance to parolees and probationers who are homeless or in danger of being reincarcerated. Characteristics: Intensive case management; program flexibility; community partnerships; strong advocacy; blended funding; an individualized continuum of care; monthly monitoring of supportive services The recidivism rate of those in the program has been less than 4 percent.
Eligibility	Individuals who are incarcerated in local detention centers or are on probation and parole for misdemeanors and nonviolent felonies, are homeless, and have a mental illness.
Outcomes	In 2002, 92 percent of those participated in the Shelter Plus Care Housing Program maintained permanent housing and 87 percent maintained or increased their income. Only 6 percent were reincarcerated for criminal offense, 1.5 percent were hospitalized for psychiatric treatment, and 1 percent returned to homelessness.
Sites	24 jurisdictions in 21 counties

Suicide is a significant risk in correctional settings and inmates with a mental illness and co-occurring substance use disorder are at especially high risk. Suicide is the third leading cause of death in U.S. prisons, and inmates with a mental illness make almost all the suicide attempts among inmates during incarceration. One of the most consistent and robust findings from research is the correlation between segregation and successful suicide. Research strongly supports avoiding segregation. National standards for supervision of inmates who are suicidal includes close observation (every fifteen minutes) for inmates who have expressed suicidal ideation or have a recent history of self-destructive behaviors, while constant observation (continuous observation) is reserved for inmates who are threatening to or have engaged in an act of suicide.

In addition to screening for suicidal behavior, inmates with mental illnesses should be screened for PTSD (posttraumatic stress disorder). Thirty percent of male inmates with mental illness and seventy-eight percent of female inmates report a history of physical and/or sexual abuse and exhibit symptoms of depression and anxiety.

Since jail stays are often short, community re-entry or transition planning begins upon admission. Effective transitional services ensure continuity of services and supports by creating linkages with and referral to community-based care, including supported housing, supported employment, case management, relapse prevention intervention, entitlements, medication and other supports as needed. The goal is to help the person engage with the range of services needed to successfully reintegrate into the community. This is considered a cost-effective preventive measure that is designed to reduce recidivism and the adverse consequences of lack of ongoing treatment.

EDUCATION AND EMPLOYMENT

Returning to school and to work are the hallmarks of successful community integration for people with mental illnesses. Two noteworthy, evidence-based, psychosocial rehabilitation practices, supported education and supported employment, are discussed in this section.

SUPPORTED EDUCATION (SED)

Research indicates that almost fifty percent of individuals with a mental illness have had some college education and sixty two percent have a desire to start or finish an education program. Many individuals with a mental illness have had their education interrupted by the illness. It has been estimated that almost five percent of individuals who drop out of college have a mental illness.

Completion of secondary education has become more important in attaining upward occupational mobility. Studies have shown that participation in supported education is the most prominent and consistent predictor of successful employment. Individuals who do not obtain degrees can find themselves relegated to lower paying jobs and underemployment.

Supported education provides an array of services and supports to adults with mental illness to assist them in returning to school in order to complete their academic career and ultimately attain degrees and secure gainful employment. It is an evidence-based program with significant research showing that the vast majority of participants successfully complete their educations. It is recognized by SAMHSA as an exemplary practice.

The first supported education program began in 1983 at Boston University and there are now well over thirty supported education programs throughout the country, including the Michigan Supported Education Program at the University of Michigan (known as SECAG, or the Supported Education Community Action Group).

Core services include: pre-admission assessments, financial aid planning, school enrollment help, career planning, on-site campus support groups and mentorships, coordination with community mental health agencies and other community resources.

There are three basic models of supported education:

Mobile support:	Services and supports are delivered by community-based providers and are not tied to a specific educational institution.
Classroom support:	A pre-set curriculum that focuses on academic skill building, career goals, and support is used.
On-site support:	Services are housed in existing campus programs and provided by the school's staff.

To date no longitudinal studies have been conducted to ascertain outcomes in terms of attainment of degrees and economic upward mobility. However, the data available suggest supported education is successful in helping individuals integrate into the post secondary educational milieu. Students who participate in supported education programs are able to complete ninety percent of classes they enroll in. They maintain a grade point average of 3.14. In addition, they report increased self-esteem, levels of satisfaction with their living situation, finances, family and social relationships, and daily activities when compared to individuals who are not attending school.

SUPPORTED EMPLOYMENT (SE)

The high unemployment rate of persons with mental illnesses is sizeable, with many estimates as high as eighty-five percent in public mental health systems. Yet, studies also point to the great desire of people with mental illness to be gainfully employed. Most reports indicate that sixty to seventy percent of people with severe mental illness would like to work.

People with mental illnesses usually fail to complete traditional vocational rehabilitation programs twice as often as people with physical disabilities. Traditional vocational rehabilitation programs with their extensive screening and testing, skill training, work readiness activities, vocational counseling, and, in some cases, transitional or sheltered workshop employment, are considered ineffective for individuals with mental illnesses and are not recommended.

Supported employment programs, on the other hand, show success with sixty to eighty percent of participants successfully obtaining at least one competitive job (compared to nineteen percent for those involved in traditional vocational rehabilitation). The individual placement and support (IPS) approach to supported employment is an evidence-based practice that differs significantly from traditional vocational rehabilitation in that extensive pre-vocational training is supplanted by in vivo work experience.

As noted, studies show that sixty to seventy percent of adults with mental illness would like to work; yet, eighty-five percent of those served in public mental health systems are unemployed. In fact, only about one in three adults with mental illness are employed.

The philosophy of supported employment is that everyone with a mental illness is capable of attaining competitive employment if the right "fit" is found. It emphasizes jobs that pay competitive wages and are in integrated settings that include co-workers who do not have disabilities. Supported employment de-emphasizes prevocational assessment and training. The importance of rapid job searches and placements for anyone who expresses a desire to work are stressed. These programs have a zero exclusion policy; consumers are not excluded due to symptoms, substance abuse, prior work history or because they are "not ready" to work.

Supported Employment for People with Serious Mental Illnesses	
Goal	To secure employment quickly and efficiently for people with mental illness.
Features	An employment specialist on mental health treatment team. The employment specialist collaborates with clinicians to make sure that employment is part of the treatment plan. Then the specialist conducts assessments and rapid job searches and provides ongoing support while the consumer is on the job.
Outcomes	In general, about 60% to 80% of those served by the supported employment model obtain at least one competitive job, according to three randomized controlled trials in New Hampshire; Washington, DC; and Baltimore. Those trials found the supported employment model far superior to traditional programs that include prevocational training. The cost of the supported employment model is no greater than that for traditional programs, suggesting that supported employment is cost-effective.
Sites	30 states in the USA, Canada, Hong Kong, Australia, and 6 European countries.

In this model, employment specialists work with the consumer's treatment team. Employment specialists can accommodate caseloads of twenty to twenty-five people. They provide follow-along supports on an indefinite basis; individualized supports continue for as along a consumer wants assistance. Employment specialists need to work full time without the diversions of other roles (e.g., case manager). They also need to be fully integrated into the treatment team and participate in team

meetings. Their performance is the most productive when they are members of a vocational unit where staff can provide backup for each other.

While concern has been expressed that competitive work may increase stress for the consumer, studies indicate that supported employment does not lead to increased symptoms, distress, or other negative effects. Supported employment has been successfully implemented in many different types of communities, both urban and rural. There does not appear to be any specific consumer characteristic that affects outcome. In other words, supported employment has been successful irrespective of age, gender, diagnosis, symptomatology, prior hospitalization, education, and racial or ethnic group. However, a very depressed labor market may affect job availability.

The research on supported employment shows that consumers who participate in supported employment programs are more successful in obtaining competitive employment, work more hours, earn more wages from work than those in traditional vocational programs. While participation does not generalize to non-vocational outcomes, there is evidence that when consumers find competitive work, their self-esteem improves, as does their satisfaction with finances and symptoms. As noted, outcomes indicate that, on average, twenty-one percent of individuals with mental illnesses who participate in traditional vocational rehabilitation programs secure competitive employment, compared to fifty-eight percent of those who participated in the individual placement and support model of supported employment.

The estimated costs of supported employment range from $2000 to $4000 per participant on an annual basis, which is comparable to those of traditional vocational programs. Moreover, employer accommodations (e.g., adaptive work schedules, supervisory orientation, and on-site support services) for persons with a mental illness appear to be quite inexpensive.

Research indicates that a rapid job search, integration of employment and clinical services, a zero exclusion policy, and assisting consumers in finding work that is the best fit with their individual goals and preferences leads to the best outcomes. Services must also be provided in vivo (i.e., in the community) where job searches and employment take place. The two most important indicators of program fidelity to the model are the use of full time employment specialists (without other roles) and providing services in the community (in vivo) as opposed to office-based settings.

WORKING WITH FAMILIES

The involvement of family members and other supporters is important to recovery; they should be engaged in treatment, as appropriate. Families are an important component in all of the SAMHSA evidence-based resource implementation resource kit manuals. For example, in integrated treatment for individuals with dual disorders, practitioners help consumers reconnect with their families. In ACT, the team works with family members on issues related to reducing family burden and parenting. Illness Management and Recovery involves families in homework assignments and educational interventions. Other programs, such as NAMI's Family-to-Family Education program, offer support and information to help families cope with a loved one's illness. In some cultures, the family is considered vital to a person's recovery from mental illness and co-occurring substance use disorders.

Family Psychoeducation involves a partnership among consumers, families, supporters, and practitioners. It helps families and consumers learn about mental illness and master new ways of managing the mental illness. It reduces tension and stress within the family, helps families provide social support and encouragement to each other, and focus on the future. It helps find ways for families and supporters to help consumers in their recovery. Relationship building, education, collaboration, problem solving, and an atmosphere of hope and cooperation are key elements of the program.

FAMILY PSYCHOEDUCATION (FPE)

Statistics indicate that between twenty-five and sixty percent of individuals with a serious mental illness live with their families, and many others maintain contact with relatives. The relationship of the family and the person with a mental illness has been shown to have a significant impact on that person's capacity to cope with symptoms and illness as well as family members' capacity to sustain their own lives. Supporting a family member with a serious mental illness carries high costs for relatives and creates what is known as burden of illness. Burden of illness can be distinguished by objective stress which refers to such activities as paying medical care costs, obtaining services, providing help with activities of daily living, and subjective stress, which is the family's emotional response such as worry and displeasure. Extensive research demonstrates that a negative emotional climate in families directly correlates to a more severe course of illness.

Family Psychoeducation is an evidence-based practice that reduces relapse rates and facilitates recovery by partnering with families and providing education about the illness and teaching specific problem-solving strategies for dealing with difficulties arising from the illness. It is derived from theories of expressed emotion (EE), which are based on observations that individuals with schizophrenia discharged home from hospitalizations to families with high expressed emotion are more likely to suffer a relapse. Expressed emotion has two components: criticism (CR) and emotional overinvolvement (EOI). Expressed emotion is characterized unsupportive, critical, negative interactions. It has been shown to be a significant and strong predictor of relapse with studies demonstrating that individuals living in household with high levels of EE are much more likely to relapse than those living in households with low-EE.

The SAMHSA implementation resource kit strongly recommends offering Family Psychoeducation as early in the course of an illness as possible since it can help prevent relapse and disability, maintain and improve family relationships and social supports for the consumer's recovery. According to the

implementation resource kit, family Psychoeducation represents the approach with the greatest potential cost effective benefit on the early and perhaps entire course of a mental illness.

Family Psychoeducation is designed to replace individual meetings with consumers. It is an approach to working with families in a partnership to help them acquire coping skills for dealing with difficulties posed by mental illness in the family and supporting the recovery of a family member with a mental illness. The partnership is engendered by collaborating with families as consultants to help with the management of the illness. Family Psychoeducation is not family therapy; the focus of intervention is the illness, not the family.

Family Psychoeducation can be provided in the home, community settings, mental health offices, hospitals, or other settings. In the context of Family Psychoeducation, family is defined as anyone the consumer designates as such. It does not have to be a relative, and can be anyone committed to the support of the person including friends, relatives, landlords, neighbors, etc. The requirement is that at least one person in the consumer's life participates as a "sponsor" or "supporter".

The following are the core components of family Psychoeducation:

- Joining with consumers and their families.
- Education about the illness and useful coping skills. This includes an education curriculum comprised of the following modules:
    - The psychobiology of mental illness
    - Diagnosis and treatment
    - Family reaction and its stages
    - Psychosis as a family trauma, relapse prevention and family guidelines
- Problem-solving strategies for difficulties caused by illness. This includes the following problem solving techniques and process from the multifamily format:

    Techniques:
    1. Select a problem for one consumer / family
    2. Define the problem in behavioral terms
    3. Generate at least eight suggestions for solution to the problem
    4. Explore with the consumer and family pros and cons for each suggestion
    5. Have consumer and family select the best suggestion
    6. With consumer and family, develop a step-by-step plan

    Process:

    Step 1. Define the problem or goal (family, consumer, and practitioners)
    Step 2. List all possible solutions (all group members)
    Step 3. Discuss first advantages and then disadvantages of each in turn (family, consumer, and practitioners, group members)
    Step 4. Choose the solution that best fits the situation (consumer and family)
    Step 5. Plan how to carry out this solution by forming a detailed, written action plan (consumer, family, and practitioners)
    Step 6. Review implementation (practitioners in concert with consumer and family)

- Creating an optimal environment for recovery by establishing a strengths-based environment where all members are respectful of one another.
- Creating social and support groups wherein families establish connections with others who have similar experience and gain a broader social network.

Families meet every two weeks for the first months, then once a month for as long as they choose to meet. Programs last from nine months to five years. There are both single[5] and multi-family formats. The multifamily format consists of six to eight families and consumers. Both entail referrals and encouragement to participate family support groups such as NAMI's Family-to-Family Education Program to reduce social isolation and stigma. Both formats aim to reduce expressed emotion, with multifamily models addressing stigma and social isolation as well.

Principles of Working with Families of Persons who have Mental Illness

- Coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative, supportive relationship
- Pay attention to both the social and the clinical needs of the consumer
- Provide optimum medication management
- Listen to families' concerns and involve them as equal partners in the planning and delivery of treatment
- Explore family members' expectations of the treatment program and expectations for the consumer
- Assess the strengths and limitations of the family's ability to support the consumer
- Help resolve family conflict by responding sensitively to emotional distress
- Address feelings of loss
- Provide relevant information for the consumer and his or her family at appropriate times
- Provide an explicit crisis plan and professional response
- Help improve communication among family members
- Provide training for the family in structured problem-solving techniques
- Encourage family members to expand their social support networks – for example, to participate in family support organizations such as NAMI
- Be flexible in meeting the needs of the family
- Provide the family with easy access to another professional in the event that the current work with the family ceases

Family Psychoeducation has been demonstrated to be beneficial for persons with schizophrenia, schizoaffective disorder, bipolar disorder, major depression, borderline personality disorder, anorexia nervosa, and obsessive-compulsive disorder. Researchers have documented significantly greater reductions in relapse and rehospitalization rates among consumers whose families participate in Family Psychoeducation than among those who receive typical individual services. The differences have ranged from twenty to fifty percent over two years indicating enduring effects, especially when programs are more than three months duration. Additionally, families report reduced burden and enhanced well being when participation is ongoing for at least nine months. Consumer participation in vocational rehabilitation increases and costs of care decreases. Thus, the longer the participation, the greater the improvement; families who participate for up to two years show the most favorable outcomes. FPE has been shown to be extremely effective in reducing the cost of care with significant reductions in hospital admissions, hospital days, and crisis intervention contacts. Ratios of $1 spent for this service to $10 in saved hospital costs have been routinely reported.

The initial costs of providing Family Psychoeducation are estimated to be about $350 per year per consumer in staff time for an ongoing multi family group using a mater's prepared practitioner (based on East Coast salaries). The single-family format costs about twice that of the multifamily format. The initial implementation costs are approximately $250 per practitioner.

[5] Researchers have found African American families with low expressed emotion and consumers who have a good response to medication benefit more from the single-family format.

The SAMHSA implementation resource kit on FPE discusses multifamily group models of Family Psychoeducation for bipolar illness, major depressive disorder, borderline personality disorder, and obsessive-compulsive disorder, all which have demonstrated potential. The strongest evidence base is for FPE for schizophrenia.

HOUSING

There does not appear to be a single model of supported housing that meets the needs and preferences of all individuals with mental illness. Safe, affordable, permanent housing of one's choice with flexible, responsive community supports has been demonstrated to contribute to housing stability.

Supported housing denotes a movement away from models that "place" consumers in housing "slots" that vary in levels of services in accordance with the level of disability and use transitional settings and standardized supports. The supported housing paradigm centers on a permanent home, integrated into the community, is self-selected, and fosters the development of daily living skills with the provision of flexible supports provided in accordance with what the person needs and wants.

Research has demonstrated that success in supported housing requires two critical ingredients: consumer choice and subsidized funding.

AFFORDABILITY ISSUES

Any discussion of housing options for individuals with mental illness must include a review of affordability issues as they pose a significant challenge to implementing a model of supported housing.

The lack of access to affordable housing for individuals with mental illness is cited as a priority issue. Supplies of affordable housing have been decreasing because of federal initiatives, which place emphasis on housing funding programs for higher income groups. The situation is so dire that there is no housing market in the country an individual who receives SSI benefits can afford to pay rent in.

The federal definition of affordability for people with low incomes means that they pay no more than thirty percent of their monthly income for monthly rent and utilities. HUD considers low income households that pay between thirty-one and fifty percent of their income toward housing costs to be "rent burdened", while those that pay more than fifty percent are deemed "worst case" in terms of need for housing assistance. Fair market rent is defined as costing less than the typical unit of that bedroom size in the area; it is modest, not luxurious.

In 2002 (the latest year for which figures are available), the SSI benefit was $559.00 per month in the Saginaw - Bay City - Midland area, an amount equivalent to 17.4% of the one-person median household income. The average rent for a modest one-bedroom rental unit in this area was 73% of this SSI benefit amount. It was 66.4% for an efficiency unit in the area.

The National Low Income Housing Coalition's housing wage is the amount of income per hour that full time workers must earn for their housing costs to be affordable. The housing wage as a percentage of hourly SSI benefits in Michigan was 326% in 2002; SSI as an hourly wage was $3.23, while the housing wage was $10.53. In the Saginaw, area the housing wage was $7.25.

Because of the dearth of affordable housing and the limited income of many consumers, it is essential to have access to financial resources for subsidized housing. Federal programs include:

- Shelter Plus Care (S+C) provided through the McKinney/Vento Homeless Assistance Act[6]
- Supportive Housing Program (SHP) provided through the McKinney/Vento Homeless Assistance Act
- Section 8 Moderate Rehabilitation SRO (S8SRO) provided through the McKinney/Vento Homeless Assistance Act
- Home Investments Partnership Program (HOME)
- Community Development Block Grant (CDBG)
- Low Income Housing Tax Credits (LIHTC)
- Section 811 Supportive Housing for Persons with Disabilities
- Section 8 Choice Voucher Program
- Housing Opportunities for Persons with AIDS (HOPWA)

The literature on supported housing recommends creating deeply subsidized housing with government funding to build, purchase, or renovate properties, as well the provision of funds for rental assistance. Bridge subsidies can be used to assist with rent until a Section 8 voucher can be secured. Additional assistance can be provided for rental deposit assistance and rent payment gaps. The threat of becoming homeless can be mitigated with funds set aside for rent and/or utility payments in the event of due to loss of a benefit check or a job, family crisis, exacerbation of symptoms, or other exigent situation. Deposit assistance funds are used to compensate a property owner for property damages and rent payment gap funding is used to help when individuals do not pay their rent (e.g., due to financial difficulties, refusal to pay) to prevent eviction. It is also recommended that organizations partner with public housing authorities to create a Section 8 waiting list preference for individuals with disabilities.

The National Alliance for the Mentally Ill (NAMI) has produced an excellent housing implementation resource kit as part of the Targeted Technical Assistance project of the National Association of State Mental Health Program Directors (NASMHPD) and the Division of State and Community Systems Development (Mental Health Block Grant) for the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. It is posted on the NAMI web site (http://www.nami.org/). The Technical Assistance Collaborative (TAC) also has a number of informative housing resources on its web site (http://www.tacinc.org/).

THE SUPPORTED HOUSING PARADIGM

Research consistently demonstrates that consumers with serious mental illnesses can live successfully in their own homes in the community. However, as is evident from the above-noted data, without sufficient financial support, affordable housing is not an attainable goal for many consumers.

Research also indicates that consumer choice in housing is vital to success in maintaining community tenure. Consumer surveys have found living in integrated settings is preferable to single use housing. The supportive housing model places emphasis on a permanent home integrated into the community. Services and supports are delivered on an individualized basis. They are flexible and tailored to the needs and choices of consumers. In other words, this is an in vivo service model.

[6] The McKinney/Vento Homeless Assistance Act provides assistance through a national competition. These funds are awarded through what is known as a Continuum of Care process for funding permanent housing. The Continuum of Care is a strategic plan to address homelessness in a community. It addresses homelessness through ongoing planning and includes outreach, assessment, emergency shelter, transitional housing, supportive services, homelessness prevention activities, and others.

The supported housing model is an outgrowth of the independent living and consumer empowerment movements and consists of a variety of models that include permanent housing with ongoing supports and services as needed or desired by the resident. The key is individual choice in terms of type of housing and services as well as rights of tenancy. Control of service provision does not control housing "placement". Instead of "placing" individuals into "slots", consumers select their own housing where they receive support services. The intensity of services may fluctuate over time in accordance with the person's needs. Treatment-oriented group homes, residential facilities, and other congregate models are not part of this paradigm.

Supported housing is a direct contrast to traditional linear or continuum housing placement approaches for individuals with mental illness where housing is congregate and supports and services are tied to the bricks and mortar. The continuum model offers individuals with the most significant difficulties the most restrictive settings, while those who are less disabled live in less restrictive settings. In this model, an individual moves through the continuum in accordance with their functional status, which means they move between residences and settings to access services, a disruptive and choice-limiting model.

The modified therapeutic community (MTC) and safe haven are two examples of the linear or continuum model of housing for persons with mental illness. The MTC is an offshoot of the therapeutic community, which is used for residential treatment for individuals with substance use disorders. MTCs can be used for people with a mental illness as well as those with a co-occurring substance use disorder. They are highly structured residential, community-based settings that stress mutual self-help, involvement in community activities, counseling, medication, and skills training. MTCs vary in their level of treatment intensity. The Safe Haven program was created by HUD as a low-demand setting for individuals who are homeless and have a serious mental illness. They usually provide services for people who have refused assistance, or have been excluded from other programs that serve individuals who are homeless.

To summarize, affordability, accessibility, safety, and independence are key to the supportive housing paradigm. Its core principles are:

- Government funded housing assistance due to extreme poverty.
- Control and choice over one's environment is essential.
- Housing is permanent.
- Housing is unbundled from supports and services and is not made contingent on the receipt of services; services and supports are available if needed and desired.
- Supports and services are flexible and tailored to the individual rather than defined by a program.

CASE MANAGEMENT

Even though case management is widely applied in mental health service delivery systems, it takes many different forms. There is no consensus regarding how to specify models of case management. In fact, the literature is replete with different labels including, but not limited to, strengths-based, broker, advocacy, social network, rehabilitation, intensive, and generalist models. ACT is also frequently mistakenly categorized as an intensive case management model. Case management models are typically depicted along a continuum of intensity with more intense models providing outreach to individuals who are reluctant to engage in services. Models that are more intensive also typically provide more consumer contacts per month.

Since case management is not a well-defined program model, it may be more instructive to review the commonalities with an evidence base across the various "types" of case management.

- Assertive community outreach for individuals who are reluctant to engage in services (usually a prominent feature in working with individuals who are homeless and/or have co-occurring substance use disorders and serious mental illnesses).
- A psychosocial assessment to determine strengths, difficulties, and needs.
- Development of a comprehensive plan for services and supports based upon the individual's own established goals and documented in the assessment.
- Assistance with obtaining necessary resources either through direct service provision or through linkages with services, systems and resources.
- Ongoing evaluation of progress and needs through monitoring.
- Advocacy activities to ensure access to appropriate services, supports, and resources.
- Crisis intervention either through direct intervention or by mobilizing needed services and supports.
- Discharge planning to help with transitions between service settings and programs.
- Supportive counseling.

The following stages are common to more intensive models of case management are used in working with people who are homeless, and people who have co-occurring mental illnesses and substance use disorders:

- Engagement: developing a therapeutic/helping relationship and provision of basic services such as food, clothing, and shelter.
- Persuasion: recognizing accepting treatment.
- Active treatment: developing skills and supports and pursuing goals
- Relapse prevention: using strategies to maintain recovery.

Outcome studies on case management indicate that inclusion of consumers as peer specialists produce results that are more positive. In fact, teams totally comprised of consumers produce the same results as those comprised of professional staff. Those that are more intensive produce better outcomes in terms of community tenure, independence, and reduction of days spent in the hospital.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Through it is often characterized as intensive case management, Assertive Community Treatment is a service delivery model; it is not a case management program. The core of ACT is a transdisciplinary team that is comprised of ten to twelve practitioners including psychiatrists nurses, master's and doctoral level professionals, consumers, employment specialists, substance abuse specialists, and a program assistant, who serve approximately one hundred consumers. The ratio of staff to consumers is recommended to be one to ten. ACT teams work together in a highly integrated fashion across professional boundaries to the maximum extent possible to support a consumer's life in the community. They are available twenty-four hours a day, seven days a week. Services are provided in vivo rather than office-based settings, allowing for the delivery of supports in natural contexts where problems arise and skills are needed. The team provides care coordination on a continuous basis, including when the consumer is in the hospital.

ACT team members do not have individual caseloads. ACT teams are organized around specific tasks: keeping consumers out of the hospital and supporting their recovery. This means that there is no predetermined configuration of resources and services. Resources and services are organized around the tasks to be accomplished.

ACT is designed for a relatively small group of consumers who experience the most serious and intractable symptoms, have the greatest difficulties in activities of daily living, and have not responded well to services that are more traditional. Typically, such consumers have been extensive users of inpatient hospitalization services, have a co-occurring substance use disorder, involvement in the criminal justice system, as well as experiences of homelessness, and unemployment.

Consumers are not excluded from ACT services due to severity of illness, disruptive behaviors, refusal to participate in other services, or take medication. There is no specific time limit on services; they can be provided indefinitely.

Areas in which assertive community treatment teams provide assistance	
Daily Activities/Community Living Skills • Grocery shopping and cooking • Purchasing and caring for clothing • Using transportation • Hygiene • Nutrition • Housekeeping	**Health Promotion** • Education to prevent health problems • Medical screening • Scheduling routine visits • Linking with medical providers for acute care • Sex education and counseling on reproductive health
Family Life • Crisis management • Counseling and psychoeducation for family members • Coordination with child welfare and family service agencies • Supporting people in carrying out their roles as parents	**Medication Support** • Ordering medications from pharmacies • Deliver medications, if needed • Education about medications • Reminding individuals to take medications • Monitor adherence and side effects
Housing Assistance • Finding suitable housing • Helping negotiate leases and pay rent • Purchasing and repairing household items • Developing relationships with landlords • Improving housekeeping skills	**Work Opportunities** • Educating employers about serious mental illness • Help preparing for employment • Help finding and keeping employment Employment support (Job Coaching)

Financial Management • Planning a budget • Troubleshooting financial problems e.g., disability payments • Assisting with bills • Increasing independence in money management	**Entitlements** • Assisting with applications • Accompanying consumers to entitlement offices • Managing food stamps if needed • Assisting with redetermination of benefits
Counseling • Use problem solving approach • Built into all activities • Goals addressed by all team members • Includes development of illness management skills	**Substance Abuse Treatment** • Substance abuse treatment provided directly by team members • Individual and group interventions are available

The team develops a comprehensive assessment and a psycho/social timeline with information that allows for the identification of previous events (e.g., hospitalizations), an evaluation of what has been effective and what has not, and pinpoints possible antecedents of stress-inducing events. Such information leads to the development of a treatment plan that covers the services and supports the consumer will receive.

The team meets on a daily basis, with meetings structured around a daily communication log. The team develops a daily team schedule for planned activities. Team members work in shared space allowing for ease of communication and maintain a weekly consumer schedule.

Ten Principles of Assertive Community Treatment

- Services are targeted to a specified group of individuals with severe mental illness.
- Rather then brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team.
- Team members share responsibility for the individuals served by the team.
- The staff-to-consumer ratio is small (approximately 1 to 10).
- The range of treatment and services is comprehensive and flexible.
- Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
- There is no arbitrary time limit on receiving services.
- Treatment and support services are individualized.
- Services are available on a 24-hour basis.
- The team is assertive in engaging individuals in treatment and monitoring progress.

ACT teams also engage consumer's family members in a collaborative relationship designed to alleviate stress and burden on the family as caregivers. They assist consumers with a range of activities related to fulfilling responsibilities as parents by helping them with obtaining services such as parent training, child care and respite services as well as in relating to schools and other systems.

The SAMHSA ACT manual lists the following activities related to parenting and pregnancy:

- Arranging prenatal, physical, and practical care
- Soliciting and using appropriate social services agencies
- Facilitating admission to the hospital and effective communication with hospital staff during the birth process and immediate neonatal period
- Supporting neonatal, infant, and childhood parenting at home
- Changing psychiatric treatment, particularly psychotropic medications, to match the needs of pregnancy, and delivery
- Educating the consumer about birth control

The ACT team works to involve partners and other members of the consumer's support system. The team also offers support to consumers in carrying out their parental responsibilities and in coordinating services for the children of consumers. This includes dealing with other systems such as schools, and securing needed services, such as parent training, respite services, childcare. The mother-child relationship can be a specific focus. This is important because of the significant number of mothers with a mental illness who face the loss of custody, either voluntarily (to other family members, foster and adoptive parents), or involuntarily.

An extensive research base for ACT exists. Studies show that it is very effective in reducing hospitalization and improving housing stability. Its effects on quality of life, social functioning, and symptoms are similar to those of other interventions such as case management. Reduced levels of substance abuse are found when a substance specialist is part of the team. Higher rates of competitive employment are achieved when employment specialists are part of the team. Most studies have also shown that consumers and their families are more satisfied with ACT than other types of services.

It is estimated that the per-consumer annual cost of ACT is about $9,000 to $12,000 per annum. It is cost effective for individuals with extensive hospital utilization. This is why it is generally reserved for a specific subset of consumers, as indicated above.

The Dartmouth Assertive Community Treatment Fidelity Scale (DACTS) is used to monitor adherence to the ACT model. A copy can be found in Appendix B.

PSYCHOTHERAPY

This section addresses evidence-based practices for specific illnesses, including mental illness and co-occurring substance use disorders, depression, anxiety, and others.

INTEGRATED DUAL DISORDERS TREATMENT (IDDT)

Substance abuse is the most common and clinically significant comorbid disorder among adults who have a serious mental illness. Estimates are that at least fifty percent of consumers who have schizophrenia are affected by substance use. About thirty percent of individuals with anxiety and depression experience a substance use disorder at some point. Moreover, these co-occurring disorders are associated a number of negative outcomes including increased rates of relapse, hospitalization, violence, legal problems, incarceration, suicide attempts, homelessness, and serious infections such as HIV and hepatitis. Consumers with co-occurring disorders challenge traditional service delivery systems, frequently are high utilizers of costly services, and rarely fit into the parallel substance abuse and mental health systems where they are often extruded or drop out. Studies show that these separate systems do not deliver appropriate services for this population and are ineffective.

There are three approaches to the treatment of co-occurring disorders. The sequential approach is where the individual receives treatment for one disorder from one provider, then the other disorder from another provider. The parallel approach consists of two providers, one for substance abuse, and another for mental health, providing treatment at the same time. The integrated service approach consists of concurrent treatment for both disorders provided by the same practitioner or treatment team. Integrated treatment produces superior results in terms of reductions in substance use and severity of symptoms of the mental illness.

Principles of Treating Co-occurring Mental Health & Substance Use Disorders

- Comorbidity should be expected, not considered an exception
- Psychiatric and substance use disorders should be regarded as primary disorders when they coexist, each requiring specific and appropriately intensive assessment, diagnosis and treatment, in accordance with established practice guidelines
- Serious psychiatric and substance use disorders are chronic, relapsing illnesses that can be conceptualized by using a disease and recovery model, with parallel phases of treatment or recovery
- Within each subtype of the treatment population, consumers are in different stages of change with regard to their illness. Thus a comprehensive array of intervention that are phase and stage specific is required
- Whenever possible, treatment of persons with complex comorbid disorders should be provided by individuals, teams, or programs with expertise in mental health and substance use disorders
- The system should promote a longitudinal perspective on the treatment of consumers with dial diagnoses, emphasizing the value of continuous relationships with integrated treatment providers, independent of participation in specific programs
- Admission criteria should not be designed to prevent consumers from receiving services, but rather to promote acceptance of consumers at all levels of motivation and readiness and with any combination of comorbid disorders
- The service system should not begin or end at the boundaries of formal treatment programs; rather, it should include interventions to engage the most detached individuals (e.g., those who are homeless)
- The fiscal and administrative operation of the system should support the accomplishment of the system's mission and the implementation of these principles
- Assessment for either disorder should begin as early as possible, without the imposition of arbitrary waiting periods of sobriety, and without a requirement of psychiatric stabilization, on the basis of data collection for an integrated, longitudinal history
- For each disorder, assessment should include a definition of the stage of change or level of motivation
- When mental illness and a substance use disorder coexist, each disorder should be considered primary, and integrated dual primary treatment should be provided; the treatment for each disorder should be matched to the diagnosis and the stage of change
- Medication for known serious mental illness should never be discontinued on the grounds that the consumer is using substances
- Benzodiazepines are not recommended in the ongoing treatment of consumers with known substance dependence with or without a comorbid psychiatric disorder. If a prescriber believes that an exception is warranted, this belief should be considered an indication for peer review, expert consultation, or a second opinion

The core components of the integrated approach are as follows:

- Interventions are staged:
  - *Engagement* is the first stage when the consumer is in a *precontemplation* stage and the practitioner endeavors to form a trusting relationship with the consumer.
  - The next stage is *persuasion*, which entails helping the consumer develop the motivation to become involved in recovery–oriented interventions.
  - The third stage is *active treatment* wherein the consumer acquires the skills and supports for controlling both illnesses and pursuing their goals.
  - The last stage is *relapse prevention*, which is aimed at helping the consumer develop and use strategies to maintain recovery.

    Relapse prevention includes designing a relapse prevention plan, supporting and using previously acquired skills for sobriety, foster social skills to enhance friendships with persons who are sober, fostering social and leisure pursuits, exploring opportunities for employment, and encouraging and facilitating

participation in self-help groups (e.g., Alcoholics Anonymous, Rational Recovery, Narcotics Anonymous, Double Trouble and Dual Recovery Anonymous).

It should be noted that consumers do not necessarily move through these stages in a linear progression and they may be in different stages with respect to substance abuse and mental illness.

- Since many individuals with dual disorders have had trouble engaging with the service system, providers use assertive outreach and meet with consumers and their support systems in the community to offer services.
- Motivational interventions are used to help consumers during the engagement and persuasion stages when they are not yet exhibiting readiness to reduce substance use or become abstinent to achieve their goals. They are matched to the individual's stage of recovery.

  The five key principles of motivational enhancement are:
  - Expressing empathy
  - Noting discrepancies between the consumer's current behavior and their stated desired behavior
  - Avoiding arguments
  - Refraining from directly confronting resistance
  - Encouraging the consumer's belief in their ability to change.

  Motivational interviewing differs from traditional substance abuse treatment in that confrontation is avoided. If a consumer does not want to move on a certain path (or exhibits what has typically been termed "resistance" or is in "denial"), the practitioner does not challenge it. Instead, the practitioner "rolls with it" allowing the consumer to express their opinions and views. The practitioner focuses on magnifying the discrepancy between what the consumer's goals are and their behavior. The consumer is helped to identify their goals, break them down into realistic steps, and ascertain that, in order to attain one's goals, one must manage the illnesses.

- Social support enhancement. Working with families and other supporters is extremely important for an individual with a dual disorder. Interventions include providing education and information about the illnesses, family therapy, helping them get involved family support groups and involvement in treatment planning.
- Since recovery tends to occur over months or even years and it often takes many attempts to achieve stable remission or abstinence, effective programs take a long-term perspective. Recovery in the context of co-occurring disorders means that the individual becomes skilled at gaining mastery over both illnesses in order to pursue meaningful goals.
- The service system incorporates integrated intervention into all aspects of service delivery from medication management, laboratory screening, hospitalization, assessment, crisis intervention, and all other services.

A number of behavioral interventions are used to reduce or stop substance use. These include conversational skill development, assertive training, relaxation skills development, and enjoyable leisure activities development.

Since the majority of individuals who have a substance use disorder have experienced traumatic events, and many have posttraumatic stress disorder, all individuals with co-occurring disorders need to be screened for PTSD. Support groups and trauma education groups are used along with cognitive-behavioral therapy as interventions.

It is important to work with the families of individuals with co-occurring disorders since many have very limited social networks. They are often cut off from family and lack social supports. Interventions for families include involvement in treatment planning, education about the illnesses, family therapy, and support groups.

INTERPERSONAL THERAPY (IPT)

Interpersonal therapy is based on research that has demonstrated the protective function of interpersonal support as well as the associations between interpersonal adversity and depression. It is derived from theories that view depression as the result of interpersonal conflicts and/or deficits. It is a time-limited, manualized psychotherapy. IPT is usually provided in one-hour weekly sessions for up to twenty sessions.

Interpersonal Therapy focuses on the following areas:

- Interpersonal disputes (non-reciprocal role expectations with a significant other)
- Role transitions (life changes leading to a change in one's interpersonal role and sense of self in a new context)
- Grief (prolonged, complicated bereavement)
- Interpersonal/social deficits (lack of supports; absence of life events; interpersonal sensitivity)

Studies have demonstrated that IPT is equally as effective in the short-term treatment of depression as antidepressant medication therapy; IPT is also provided as part of multimodal approach in conjunction with medications. IPT has also been found to be an effective treatment for depression from adolescence to late life, for women with postpartum depression and for individuals with comorbid medical problems. For recurrent depression in the continuation and maintenance phases of treatment, "low-dose", once-monthly maintenance IPT can reduce relapse rates and prolong periods between depressive episodes. IPT has been found moderately beneficial for dysthymia. (The model has also been adapted for eating disorders, social anxiety, and bipolar disorder.)

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

Solution-focused therapy is a form of brief therapy that builds upon individuals' strengths by helping them evoke and construct solutions to their problems. It has been refined over the years since its development and applied in a number of settings (e.g., hospitals, residential treatment settings, outpatient office settings), and for a variety of problems (e.g., substance abuse, panic attacks, phobias, eating disorders, family relationship problems). The therapy focuses the future rather than the past or present, and on hope and achievement, rather than problems and their causes. It entails developing a solution to a problem and discerning the resources to accomplish the solution. A central aspect of solution-focused therapy is the active exploration of the person's strengths and resources, and acknowledgement of them. It is not driven by diagnostic formulations or problem exploration.

The first session entails four therapeutic tasks as depicted below:

Task of therapist	*Examples of opening questions*
Find out what the person is hoping to achieve from the meeting or the work together	What are your best hopes of our work together? How will you know if this is useful?
Find out what the small, mundane and everyday details of the person's life would be like if these hopes were realized	If tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow?
Find out what the person is already doing or has done in the past that might contribute to these hopes being realized	Tell me about the times the problem does not happen When are the times that bits of the miracle already occur?
Find out what might be different if the person made one very small step towards realizing these hopes	What would your partner/doctor/friend notice if you moved another 5% towards the life you would like to be leading?

(Iveson 2002)

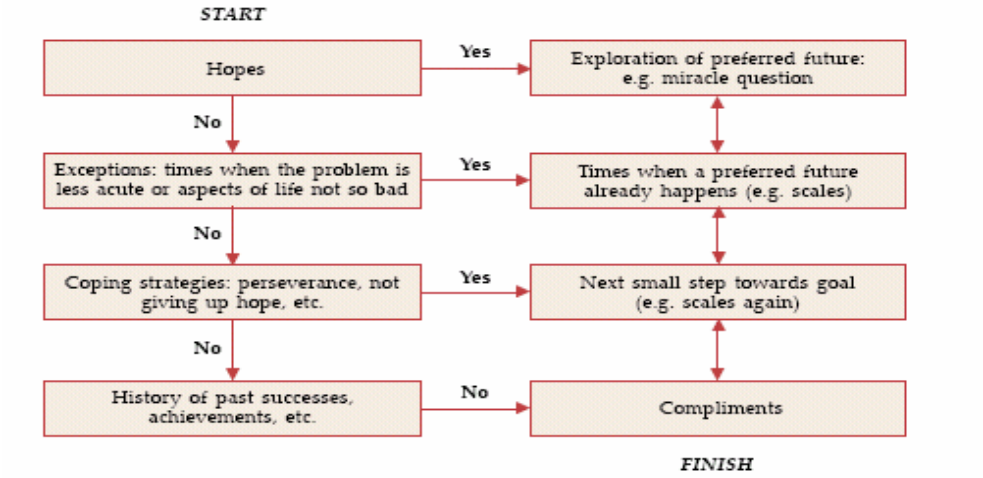
A zero to ten scale is used to assist the person to rate their achievements. It is used to distinguish different characteristics of the problem, as well as the solution. A ten indicates that all of the identified goals have been achieved. A zero signifies that none of the person's goals have been achieved. Scaling is used to determine progress during each session in response to the therapist's opening question: "What is better?" The therapist verbally commends the person's reports of progress.

	Points to mark	*What to explore*
10	The perfect solution	The miracle question as a means to encourage creative thinking
7	A good but realistic outcome	A realistic description of the consumer getting on with his/her life without the problem interfering too much. The more concrete and realistic the better, since it is the small, mundane aspects of living that go together to make a acceptable life
3	Where the consumer is now	Everything the consumer is doing that has helped him/her reach this point on the scale and/or everything he-she is doing to prevent matters getting worse
0	The worst scenario	Best not to delve into

(Iveson 2002)

The average duration of solution-focused therapy is five (to eight) forty-five minute sessions. If there is not demonstrable improvement after three sessions, it is unlikely that this therapy will prove effective for the person. The time between sessions is typically extended as the person makes progress so that a five-session course of treatment takes place over several months. It should also be noted that there are reports in the literature of effective single-session successes, but these typically involve individuals who are "stuck" in a problem and can be assisted to see a clear way out through the explication of a desired future, or have already solved their problem, but do not realize it.

Most sessions start with the top left of the flow chart, then move down through the right column. Subsequent sessions are more likely to focus on the second and third boxes in each column, more to the left if progress is minimal and more to the right if progressing well.



(Iveson 2002)

There are more than thirty published research studies on solution-focused brief therapy demonstrating successful outcomes in sixty-five to eighty-three percent of cases. However, due to the lack of diagnostic specificity, and the fact that most of these outcome studies rely on subjective reports from consumers or referral sources, they have limited objective validity. A large multi-site research project using more rigorous scientific methodologies is currently being conducted in Europe. The European Brief Therapy Association (EBTA) has developed a training manual. It is available on the web at http://www.ebta.nu/.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) has a strong evidence base for a number of mental illnesses including anxiety disorders, depressive disorders, eating disorders, and personality disorders. Cognitive behavioral therapies are also used to ameliorate the neurocognitive deficits of some serious mental illness and various CBTs are employed as part of many of the SAMHSA evidence-based practice protocols (e.g., behavioral tailoring, motivational interviewing, relapse prevention, psychosocial skill enhancement, relaxation training, and so forth). A multimodal approach that involves the combination of CBT and medication has been shown to enhance outcomes. CBT can be provided in either individual or group therapy sessions.

Cognitive–behavioral therapy for panic attacks, phobias and PTSD, addresses the individual's threat appraisal process through repeated exposure. It is combined with stress inoculation training using breathing exercises, relaxation training, thought stopping, role playing and cognitive restructuring to desensitize the person to trauma related triggers. Homework exercises are given so that the techniques can be practiced and used in vivo where triggers are encountered. It is usually a brief intervention typically lasting for twelve to twenty weeks. According to the research, cognitive-behavior therapy has more long-lasting effects than medication. In other words, individuals who have been treated with CBT are less likely to become symptomatic following treatment cessation than those previously treated with medication. Studies have also shown that stress inoculation appears to be more effective in the short run, while prolonged exposure therapy appears to be more effective on a long-term basis.

EXPOSURE THERAPY FOR PTSD

Prolonged Exposure Therapy (PE) is a cognitive behavioral therapy for individuals suffering from PTSD with a significant research base to support its effectiveness in reducing symptoms of PTSD, anger, depression, and general anxiety. It is a SAMHSA model program.

The standard treatment protocol consists of nine to twelve ninety-minute individual therapy sessions conducted in accordance with a manual that specifies the agenda and content for each session. It includes three components:

- Psychoeducation about common reactions to trauma and the cause of chronic post trauma difficulties
- Imaginal exposure: repeated recounting of the traumatic memory (emotional reliving)
- In vivo exposure gradually approaching trauma reminders (e.g., situations, objects) that, despite being safe, are feared and avoided.

Research shows that PE reduces intrusive thoughts, nightmares and flashbacks, irritability, avoidance, emotional numbing, excessive avoidance, sleep disturbances, attention and concentration difficulties, sleep disturbances, and hypervigilance which are the hallmarks of PTSD.

A number of studies have also demonstrated that PE is very effective in reducing symptoms of PTSD in female victims of rape, aggravated assault, and childhood sexual abuse. It has been shown to be very beneficial for both men and women whose PTSD symptoms are related to combat exposure, traffic and industrial accidents, and violent crime. Finally, PE is effective for individuals with mental illness and co-occurring substance use disorders when it is combined with substance abuse intervention.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a cognitive-behavioral therapy that is used for the treatment of posttraumatic disorders. It combines CBT with exposure therapy. In EMDR an image of a traumatic event is evoked while visually tracking an external image (usually the therapist's finger as it moves back and forth across the consumer's visual field, or a moving light, or tones alternating from one ear to another.) The eye movements are used to engage attention to an external stimulus while focusing on distressing material. It is thought that after repeated exercises, the consumer's thinking about the traumatic event is altered so that new, more adaptive associations are made.

EMDR uses a staged approach with eight phases that include compiling a complete history, preparing the consumer, identifying target and their components, actively processing past, present and future aspects, and on-going evaluation.

There is a significant divergence in the protocols used by practitioners of EMDR with sessions ranging from one ninety-minute session to models of eight to ten sessions. In addition, dismantling studies have failed to establish any enhanced effect from the use of eye movements in outcomes. The beneficial effects of EMDR have been deemed likely to be due to the exposure-based elements of CBT. EMDR has been shown to be effective in reducing the symptoms of PTSD, but it appears to be no more effective exposure therapies.

DIALECTICAL BEHAVIOR THERAPY (DBT)

Dialectical Behavior Therapy (DBT) is a cognitive behavior therapy for the treatment of borderline personality disorder and self-harm behaviors. It is conducted by therapists working together in a team approach.

The theoretical basis for DBT is that individuals with borderline personality disorder have a pervasive deficit in their capacity to regulate emotions. This deficit is thought to originate in and be maintained by negative social interactions that are invalidating to the individual. In DBT, the practitioner takes a nonjudgmental approach in relation to the individual which eliminates the typical tendency of others to blame the person for their own maladaptive behaviors.

Treatment begins with establishing a collaborative relationship between the consumer and practitioner who then jointly construct a list of prioritized targeted behaviors to change. This list guides the rest of sessions which are divided into four stages. Stage one focuses on mastery skill development and behavioral control. Stage two focuses on resolving posttraumatic stress. Stage three is comprised of addressing issues of self-regard and individual goals. Stage four is aimed at enhancing the person's capacity to experience pleasure. The consumer monitors his or her own progress with a diary card that is reviewed with the therapist.

DBT uses a number of modalities and requires a treatment team that is trained in the approach. There are five treatment components. The first consists of a two-hour and a half weekly skills training group using a DBT skills training manual. The second consists of individual psychotherapy on a weekly (or twice weekly in some instances) basis aimed at enhancing motivation for treatment and behavior change. The third component consists of consumer telephone calls to their therapists between sessions for coaching and skill generalization in vivo. The fourth component is comprised of weekly consultative meetings of individual therapists and group skills trainers aimed at improving their skills and maintaining their motivation. The fifth consists of the structure of the treatment environment provided by DBT program directors and case managers' provision of assistance to consumers to help them structure their environments.

Research findings across studies indicate that DBT reduces target severe maladaptive behaviors and increases treatment retention. It has also been found to reduce hospitalization. Outcome data suggests that improvements are maintained for a year following termination of treatment. However, no fidelity scale has been developed for DBT; practitioners need to consult with DBT experts to measure their adherence to the model.

COGNITIVE BEHAVIORAL THERAPY FOR MALE SEX OFFENDERS

Cognitive-behavioral therapy has shown to be helpful in the treatment of sex offenders with data indicating a thirty percent reduction in recidivism over seven years for CBT (as well as antiandrogen therapy). However, while treatment has been shown to decrease sex offenses, it does not totally eliminate sex offender behavior.

The cognitive-behavioral techniques that have been found to be most effective in treating sex offenders are aimed at eliminating deviant arousal by altering belief systems, eliminating inappropriate behaviors, and altering reinforcement contingencies. Cognitive restructuring, victim empathy training, social skills training, covert sensitization, imaginal desensitization, and aversion treatment are some of the specific interventions with an evidence base that are used to eliminate

deviant sexual arousal and promote prosocial behaviors. (Masturbatory reconditioning is also used but does not have a strong an evidence base to recommend it.)

Cognitive restructuring involves modifying distorted beliefs that are used to justify aberrant sexual behavior through the use of confrontational and role playing techniques. Social skills training focuses on development of skills that help the individual express him or herself more effectively in social situations. Victim awareness and empathy training involves assisting the individual to understand the impact of their deviant behavior on victims. Aversion therapy consists of paring deviant fantasies with a punishment such as a noxious odor or self-administered electrical shock. Covert sensitization pairs deviant sexual fantasies with mental images of negative (or aversive) consequences such as being arrested and jailed. Imaginal desensitization entails training in deep muscle relaxation and pairing relaxed states with the chain of events leading to the deviant behavior, thus increasing tolerance of urges without acting upon them. Relapse prevention involves identification of situations that have a high risk for relapse, the decisions that lead to relapse, and coping techniques to avoid relapse.

The literature suggests that cognitive-behavioral intervention is a promising treatment for paraphilias and should include the following elements: cognitive restructuring, social skills training, victim empathy/awareness training, and relapse prevention. For individuals who are at high risk for recidivism, the research indicates that a multimodal approach is more effective – e.g., CBT and antiandrogen medication, which has been shown to reduce sexual behavior in general, or CBT and buspirone, which as been shown to reduce paraphilic fantasies and obsessions.

COGNITIVE RESTRUCTURING

Cognitive restructuring is an effective intervention for reducing the severity of psychotic symptoms as well as distress. Such techniques involve assisting the person in evaluating the evidence supporting their delusional beliefs, testing out their beliefs and generating alternative, more realistic explanations when confronted with facts that are not consistent with their beliefs. Cognitive therapy helps consumers evaluate the evidence supporting their delusional beliefs, test out those convictions, and formulate alternative, more feasible explanations when confronted with evidence that is contrary to their beliefs.

Cognitive restructuring involves teaching people about common cognitive distortions that are used to interpret events. These include overgeneralization, jumping to conclusions, black and white thinking, catastrophizing, and selective attention. Cognitive restructuring teaches that negative feelings associated with cognitive distortions are the result of thoughts, and that such thoughts are not accurate. The person's thinking can be changed based on assessment of the evidence.

Cognitive therapy has been found to be effective in reducing the severity of symptoms of psychosis and distress with some studies suggesting reductions in psychiatric service use in numerous studies. All of the studies indicate it is far superior to supportive counseling in decreasing the severity of psychotic symptoms and that it reduces negative symptoms such as social withdrawal and anhedonia. It is a component of the SAMHSA Illness Management and Recovery program.

Cognitive restructuring has also been found to be effective for individuals with PTSD. It focuses on helping the person recognize self-defeating thoughts and distortions related to traumatic experiences. As with this technique for psychosis, common cognitive distortions (e.g., "no one can be trusted") are evaluated in conjunction with manifest evidence. New ways of evaluating that evidence are taught.

MEDICATION

The use of medications within specific parameters is an evidence-based practice for people with serious mental illness.

This section is comprised of a discussion of the highlights of findings from the Texas Medication Algorithm Project (TMAP), the Patient Outcomes Research Project (PORT) study, the American Psychiatric Association's various practice guidelines, Medication Management Approaches in Psychiatry (MedMAP)[7] and other expert consensus guidelines and algorithms.

The evidence base that supports the effectiveness of medication for severe mental illness greatly exceeds all other interventions. However, the rapid development of new medications creates challenges for prescribers attempting keep up to date with those developments and incorporates them into clinical practice. This has been addressed by the development of practice guidelines and algorithms based upon research and expert consensus. Despite the availability of these guidelines and algorithms, evidence indicates that medications are often used inconsistently. In particular, antipsychotic medication prescribing patterns have been shown not adhere to expert recommendations. Moreover, it has also been shown that medication is often poorly documented in the clinical record and often does not adequately address residual side effects and symptoms.

TMAP, PORT and MedMAP provide specific direction for dosing, managing side effects, cross tapering strategies for medication changes, augmentation strategies, documentation, educational materials for consumers and their families, and strategies for managing suboptimal response.

Theoretically, the selection of medications for the treatment of schizophrenia is associated to the phase of illness (acute, resolving/stabilizing, maintenance/stable) as well as to the targeted symptoms, taking into account the person's previous responses to medications and concomitant symptoms (e.g., depression, anxiety. obsessions and compulsions, agitation, labile affect, aggression and hostility).

The following table depicts medications that are used for the treatment of schizophrenia.

[7] The SAMHSA implementation resource kit, *Medication Management Approaches in Psychiatry (MedMAP),* contains a lot of useful information on pharmacotherapy for schizophrenia, but does not contain up-to-date information; it omits some of the newer medications. MedMAP is currently being field tested to ascertain whether SAMHSA will continue to work to update and revise the document on an ongoing basis, or discontinue it.

Commonly Used Antipsychotic Medications*

Antipsychotic Medication		Recommended Dose Range (mg/day)	Chlorpromazine Equivalents (mg/day)	Half-Life (hours)
FGAs				
Phenothiazines				
	Chlorpromazine	300-1000	100	6
	Fluphenazine	5-20	2	33
	Mesoridazine	150-400	50	36
	Perphenazine	16-64	10	10
	Thioridazine	300-800	100	24
	Trifluoperazine	15-30	5	24
Butyrophenone				
	Haloperidol	5-20	2	21
Others				
	Loxapine	30-100	10	4
	Molindone	30-100	10	24
	Thiothixene	15-50	5	34
SGAs				
	Aripiprazole	10-30		75
	Clozapine	150-600		12
	Olanzapine	10-30		33
	Quetiapine	300-800		6
	Risperidone	2-8		24
	Ziprasidone	120-200		7

Dosage range recommendations are adapted from the 2003 Schizophrenia Patient Outcome Research Team (PORT) recommendations.

Chlorpromazine equivalents represent the approximate dose equivalent to 100 mg of chlorpromazine (relative potency). Chlorpromazine equivalents are not relevant to the SGA.

The half-life of a drug is the amount of time required for the plasma drug concentration to decrease by one-half; half-life can be used to determine the appropriate dosing interval. The half-life of a drug does not include the half-life of its active metabolites.

*APA Practice Guideline for the Treatment of Schizophrenia

The first-line treatment for schizophrenia is any of the second-generation antipsychotic medications (SGAs) with the exception of Clozapine. SGAs are those medications including clozapine and those introduced after Clozapine. The older medications, known as first generation antipsychotics (FGAs), are those that preceded the introduction of Clozapine. FGAs are not recommended as a first-line treatment due to their side effects. TMAP indicates that FGAs are to be used only after adequate trials of SGAs have proven unsuccessful, a fourth line position.

The optimal dose is considered the range of medication that produces maximal therapeutic response and minimal side effects. Very low and intermittent dosing strategies are not recommended due to increased risk of relapse. Rapid and high dose loading are also not recommended due to harmful side effects. A trial of Clozapine is recommended for a person who has not responded to trials of other SGAs. There are no treatments with proven efficacy for the treatment of the negative symptoms of schizophrenia; early, short-term studies indicating clozapine's effectiveness have since been called into question.

Clozapine has been shown to alleviate hostility and aggression (although valproate is more commonly used for this). Clozapine also appears to be effective in treating psychosis-induced polydipsia (along with water restriction and sodium replacement to prevent seizures).

Suicide is the leading cause of premature death among persons with schizophrenia with statistics indicating that twenty to forty percent of individuals attempt suicide with death rates of four to ten percent. Clozapine has been demonstrated to reduce the suicide rate by as much as seventy-five to eighty-five percent.

Researchers find increasing use of combinations of antipsychotic medications since the introduction of the SGAs. There is very little evidence to support this practice and significant evidence against it due to drug-drug interactions, increased side effects, potential nonadherence to more complex regimens, and costs. The only support in the literature is for adding another antipsychotic to Clozapine because Clozapine is the best medication currently on the market for refractory illness and approximately half of consumers who receive treatment with Clozapine have a suboptimal response. (More discussion on the topic of polypharmacy follows.)

In brief, the TMAP guideline for the bipolar illness indicates that the treatment of hypomanic and manic episodes starts with a single mood stabilizer, lithium, or divalproex (*not* valproate[8]). If monotherapy has not been effective, or only partially effective, TMAP recommends a trial of an anticonvulsant and lithium. Adequate trials must be of sufficient duration (with ranges from two to four or more weeks depending on the phase, and blood level of the medication). Continued suboptimal response indicates a trial of two anticonvulsants and then a trial of an SGA with a mood stabilizer. For depressive episodes, TMAP starts with a trial of a single antidepressant from the SSRI class or bupropion SR. Inadequate response indicates a trial of an alternate antidepressant with a mood stabilizer, a trial of two antidepressants with a mood stabilizer, and then a trial of an MAOI with a mood stabilizer. Psychotic symptoms are treated with a concurrent SGA.

There are four major classes of antidepressant medication: tricyclics and heterocyclics (TCAs and HCAs), monoamine oxidase inhibitors (MAOIs), and selective serotonin reuptake inhibitors (SSRIs).

Type of Medication	Generic Name	Brand Name
	Citalopram	Celexa
SSRI Antidepressants	Fluoxetine♦	Prozac
	Fluvoxamine	Luvox
	Paroxetine	Paxil
	Sertraline	Zoloft
MAOIs♦♦	Phenelzine	Nardil
	Tranylcypromine	Parnate
Tricyclic Antidepressants♦♦♦	Amitriptyline	Elavil
	Imipramine	Tofranil
Other Antidepressants	Nefazodone	Serzone
	Venlafaxine	Effexor

♦ Fluoxetine is the only medication approved by the FDA for the treatment bulimia nervosa.

♦♦MAOIs are generally restricted for people who do not respond other medications because they may cause a potentially lethal hypertensive reaction when taken with certain foods contain tyramine (some aged cheeses and red wines). MAOIs are potentially dangerous in patients with chaotic eating and purging.

The toxicity of tricyclic antidepressants in overdose, up to and including death, also dictates caution in patients who are at risk for suicide.

♦♦♦ Tricyclic antidepressants are toxic in overdose (and can cause death); they are not recommended as a first-line medication for individuals who are at risk for suicide.

[8] This is contrary to the American Psychiatric Association's Guideline for the treatment of bipolar disorder, which recommends valproate as a first-line option.

TMAP recommends the use of selective serotonin reuptake inhibitors (e.g., fluoxetine, paroxetine, sertraline, citalopram), bupropion, nefazodone, and venlafaxine as the first-line treatment options for the acute phase of major depressive disorder without psychosis. For major depression with psychosis, TMAP recommends a tricyclic antidepressant (TCA) such as amitriptyline, clomipramine, desipramine, imipramine, or nortriptyline plus an antipsychotic or a selective serotonin reuptake inhibitor and an antipsychotic or venlafaxine XR plus an antipsychotic, or amoxapine. Adequate dosing within recommended ranges and trials of four to eight weeks enhances responses to medications. TMAP recommends lithium augmentation (the addition of lithium to the current treatment) for treatment refractory major depression before augmentation with other medications or combinations of medications.

Postpartum depression is treated the same way as depression at any other time but with consideration regarding effects of antidepressant medications on breast-feeding. (The same holds true for puerperal psychosis.) Highlights from the literature on cautions related to taking medication while breast feeding indicate medication for mothers who breast feed should be taken in a single dose prior to the infant's longest period of sleep. It is best to breast feed immediately before taking medication. Women who take TCAs (other than doxepin) are usually advised to avoid breast-feeding. Paroxetine (because of its low plasma ratio) is considered preferable to other SSRIs. Lithium toxicity has been reported in breast fed infants, so breast feeding should be avoided when taking lithium. . Benzodiazepines should be avoided during breast-feeding.

Exposure to trauma and violence is a significant factor in the development of posttraumatic stress disorder. Research indicates that there is a high prevalence of trauma exposure and posttraumatic stress disorder among consumers of mental health services, with rates of PTSD occurring in the range of twenty to forty-three percent. However, research also indicates that PTSD is often not detected or treated. This can contribute to more severe symptoms of psychosis, depression, suicidality, anxiety, dissociative states, and hostility.

While a number of medications have proven effective for PTSD, the SSRIs are recommended as the first-line treatment of PTSD because they are effective in alleviating the primary symptoms clusters of PTSD (re-experiencing, avoidance/numbing, and hyperarousal). They are also effective for other mental illnesses that often co-occur with PTSD including depression, panic disorder, social phobia, and obsessive-compulsive disorder. In addition, the SSRIs may reduce symptoms of impulsivity, suicidality, and aggressive behaviors that often complicate the course of PTSD.

Mood stabilizers such as divalproex are used for partial response to antidepressant therapy. For concurrent symptoms of irritability or anger, the adjunctive use of a mood stabilizer is recommended. Anti-anxiety medications (e.g., alprazolam, clonazepam, lorazepam) are helpful on short-term basis. However, they must be used with caution because of their potential for dependence. It is recommended that medication be continued for six to twelve months when the symptoms are present for less than three months. When symptoms persist beyond three months, it is recommended that medication be continued for one to two years.

ETHNOPSYCHOPHARMACOLOGY

Ethnopsychopharmacology is the examination of ethnocultural variation that affects the effectiveness of psychotropic medications. For example, there is evidence that suggests that one third of African Americans have genetic polymorphisms of some enzymes that metabolize psychotropic medications which results in altered metabolism and side effect risk. Also, individuals of Jewish descent have been noted to be at a greater risk for clozapine-induced agranulocytosis than other individuals with schizophrenia. The majority of the research in this area has focused on gene polymorphisms

(variations of DNA) in the liver that affect enzymes that metabolize psychotropic drugs. After a medication is ingested, it enters the blood and is circulated to the liver where it is metabolized by enzymes (proteins encoded by genes). Certain genetic variations affecting the functions of these enzymes are more common in certain racial or ethnic groups. Such variations affect the speed of metabolism of drugs.

While there is considerable overlap in the distribution of metabolic rates across racial and ethnic groups, and there is usually more diversity within a population than between populations, lifestyle factors (e.g., diet, use of alternative or complementary treatments, smoking[9], alcohol consumption, etc.) are thought to outweigh genetic factors. Nonetheless, genetic polymorphisms need to be considered in prescribing practices. Two common substrates and implications regarding medication dosages are reviewed below.

Genetic polymorphisms in hepatic Cytochrome P450 (CYP) enzymes occur in variable numbers in certain ethnic groups and, since most psychotropic medications are metabolized through the CYP 450 system, isomorphic variation can affect response to dosages of the medications. Genetic polymorphisms for the Cytochrome P450 isoenzymes 2C19 and 2D6 are two examples discussed below.

2D6 and 2C19 metabolize several psychotropic medications. There are three phenotypes for the CYP 2D6: poor metabolizers (PMs), extensive metabolizers (EMs), and ultra rapid metabolizers (URMs). Poor metabolizers are unable to synthesize the active form of the CYP 2D6 enzyme so that when given standard doses of medications that are metabolized predominantly by CYP 2D6, higher blood levels are reached or toxicity occurs. Sub-therapeutic levels occur in people given standard doses who have ultra rapid metabolism. This may be mistakenly ascribed to nonadherence. The most common phenotype is extensive metabolism, which lies between these two. Haloperidol, perphenazine, fluphenazine, risperidone, chlorpromazine, nortriptyline, amitriptyline, clomipramine, desipramine, imipramine, fluoxetine, and paroxetine are CYP 2D6 substrates. (Fluoxetine and paroxetine have a wide therapeutic index so genetic polymorphism is not of critical concern in their metabolism.)

The activity of the enzyme encoded by the CYP 2D6 gene is very low or absent in about five to eight percent of Caucasians and in about two to five percent of African Americans and Asians. One percent of Asians (Chinese, Korean, Japanese) are poor metabolizers. One to three percent of Middle Europeans and twenty nine percent of Ethiopians have very rapid metabolism by means of the CYP 2D6 enzymes. .

The only known phenotypes for 2C19 are poor metabolizers and extensive metabolizers, the latter dependent upon the genotype of the person. About twelve to twenty-two percent of Asians are poor metabolizers of 2C19. Researchers have discovered that about three to six percent of Caucasians are poor metabolizers of CYP 2C19 substrates. However, although Asians have a low incidence of poor metabolizers, they have been found to require lower doses of tricyclic antidepressants and haloperidol than Caucasians. Studies have also demonstrated that Asians require lower does of

[9] Cigarette smoking is a strong inducer of Cytochrome P450 1A2, an isoenzyme involved in the metabolism of a number of medications including clozapine, haloperidol, and olanzapine, which may increase the metabolism of such medications and reduce their serum levels. It has been estimated that between seventy and eighty percent of individuals with schizophrenia smoke cigarettes. The serum concentrations of individuals who take Clozapine and smoke are thirty-two percent lower than those of nonsmokers. Studies indicate that Clozapine is associated with reductions in cigarette smoking; serum levels of clozapine can increase when such individuals quit smoking. Reductions in enzymatic activity occur following smoking cessation. This can lead to seizures and other harmful events.

diazepam, a CYP 2C19 substrate, than Caucasians. (Imipramine, diazepam, and phenytoin are also substrates of CYP 2C19.)[10]

In addition to the genetic polymorphisms mentioned above, there is also significant evidence of differential diagnosis and prescribing patterns for individuals from ethnic and minority groups, and that consumers from racial and ethnic minorities are less likely than Caucasians to receive second generation antipsychotics and are more likely to receive long-acting depot medications. The PORT study showed that consumers from racial and ethnic minority groups, especially African Americans, receive doses higher than the recommended ranges. Higher dosing, along with genetic polymorphisms that alter metabolism of psychotropic medications, increases the risk for side effects. This can lead to increased rates of nonadherence, hospitalizations, and other adverse outcomes.

POLYPHARMACY ISSUES

Polypharmacy is the prescription of multiple medications to the same person. Same-class Polypharmacy is the use of more than one medication from the same medication class (e.g., two SSRIs, two SGAs, etc.). Multi-class Polypharmacy refers to the use of more than one medication from different medication classes for the same symptoms (e.g., prescription of one of the SGAs with lithium for the treatment of bipolar illness). Adjunctive polypharmacy entails the use of medication to treat the side effects of another medication from a different medication class (e.g., use of an antiparkinsonian drug with a first generation antipsychotic medication). Augmentation is the use of one medication at a lower than standard dose with a medication from a different class at its full dose for the same symptoms or the addition of a medication that would not be used alone for the same symptoms.

There are a number of concerns regarding polypharmacy noted in the literature:

- The risks for drug-drug interactions are increased.[11]
- Multiples medications can create a regimen that becomes complex and can lead to nonadherence because of that complexity.
- Polypharmacy can contribute to adverse medication effects.
- Polypharmacy can increase costs.

There are situations where polypharmacy is justified. For example, research supports the use of tricyclic antidepressants (TCAs) in combination with monoamine oxidase inhibitors (MAOIs) for the treatment of major depression, the use of tricyclic antidepressants with SSRIs, and combinations of antipsychotic agents with mood stabilizers for the treatment of mania. The TMAP algorithm for schizophrenia includes the use of more than one antipsychotic agent at the sixth step of the algorithm, after the consumer has not responded to as many as five steps of monotherapy. Both the TMAP and the APA guidelines for major depressive disorder recommend using different classes of

[10] It is estimated that between twenty-five and sixty percent of the general population metabolize drugs ineffectively. A genetic test, called the AmpliChip CYP450, allows prescribers to tailor medication doses to a person's genetic composition, was approved for use by the United States Food and Drug Administration in December 2004. It is about the size of a matchbox and contains millions of DNA molecules in a DNA chip. It uses the chip to analyze the genetic material from a person's blood to identify fast metabolizers (who end up with too little medicine in their bodies) and slow metabolizers (who can building up dangerous levels of a drug). This will allow more accurate pinpointing of doses. The devise should be on the market in June 2005 from Hoffmann-La Roche.

[11] Most drug-drug interactions are due to the Cytochrome P450 system. Medications that activate hepatic enzymes (e.g., carbamazapine, which is metabolized through Cytochrome P450 isoenzyme 3A3/4) cause a reduction in serum tricyclic antidepressant levels, can reduce the level of valproate, and reduce the activity of clonidine. Carbamazapine levels can be increased by medications that inhibit Cytochrome P450 isoenzyme 3A3/4 such as fluoxetine and fluvoxamine. The use of tricyclic antidepressants with monoamine oxidase inhibitors, norepinephrine, and epinephrine can result in hypertensive crises. There can be a lethal interaction between SSRIs and MAOIs.

antidepressants after several trials of different single antidepressants. The TMAP guideline recommends using augmentation polypharmacy with non-antidepressant medication as early as the second step after using a single antidepressant and before using multiple antidepressants. The APA guideline presents either antidepressant polypharmacy or augmentation polypharmacy as being appropriate following multiple trials of a single antidepressant. For bipolar disorder, the use of more than one mood stabilizer is considered appropriate early in the course of treatment. The TMAP algorithm for bipolar disorder recommends adding a second mood stabilizer in the second step of the treatment process. Finally, there is justification for polypharmacy during cross tapering of medications where one is being used to replace another and both are used together for a limited period.

In general, same class (same mechanism) medications should not be used concurrently. It has shown that more than one medication from the FGAs, SGAs, TCAs, MAOIs, benzodiazepines, or stimulants should not be prescribed concurrently.

ANTIPSYCHOTIC NEUROLOGICAL SIDE EFFECTS

Side effects of medications are critical and are a primary cause for nonadherence. While this section focuses on neurological side effects of antipsychotic medication, it should be noted that the SSRIs have also been associated with extrapyramidal symptoms such as akathisia, dystonia, parkinsonism, and tardive dyskenesia, as well as serotonin syndrome.

Common side effects of antipsychotic medications include neurological (i.e., acute and chronic extrapyramidal effects, neuroleptic malignant syndrome), sedation, cardiovascular (i.e., hypotension, tachycardia, and conduction abnormalities), anticholingeric and antiadrenergic effects, weight gain, glucose (although the evaluation of the risk of antipsychotic related diabetes is complicated by the increased risk for diabetes associated with schizophrenia) and lipid abnormalities, and sexual dysfunction..

Selected Side Effects of Commonly Used Antipsychotic Medications*

Medication	EPS/TS	Prolactin Elevation	Weight Gain	Glucose Abnormalities	Lipid Abnormalities	QTc Prolongation	Sedation	Hypotension	Anticholinergic Side Effects
Thioridazine	+	++	+	+?	+++	+++	++	++	++
Perphenazine	++	++	+	+?	+?	0	+	+	0
Haloperidol	+++	+++	+	0	0	0	++	0	0
Clozapine[a]	0[d]	0	+++	+++	+++	0	+++	+++	+++
Risperidone	+	+++	++	++	++	+	+	+	0
Olanzapine	0[d]	0	+++	+++	+++	0	+	+	++
Quetiapine[b]	0[d]	0	++	++	++	0	++	++	0
Ziprasidone	0[d]	+	0	0	0	++	0	0	0
Aripiprazole[c]	0[d]	0	0	0	0	0	+	0	0

0 No risk or rarely causes side effects at therapeutic dose
+ Mild or occasionally causes die effects at therapeutic dose
++ Sometimes causes side effects at therapeutic dose
+++ Frequently causes side effects at therapeutic does.
? Data too limited to rate with confidence
[a] Also causes agranulocytosis, seizures, and myocarditis
[b] Also carries warning about potential development of cataracts
[c] Also causes nausea and headache
[d] Possible exception of akathisia

*APA Practice Guideline for the Treatment of Patients With Schizophrenia

The FGAs are noted for their extrapyramidal side effects (e.g., acute dystonia, akathisia, parkinsonianism, and tardive dyskenesia). Intermittent treatment seems to increase the risk tardive dyskenesia. Lowering the medication dose and adding adjunctive anticholinergic, antiparkinson

medications are the strategies used to treat these side effects. As is evident from the table above, the SGAs can also cause extrapyramidal side effects. Risperidone carries the greatest potential risk.

The following table presents medications used in the treatment of extrapyramidal side effects:

Selected Medications for Treating Extrapyramidal Side Effects*

Generic Name	Dose (mg/day)	Elimination Half-Life (hours)	Target EPS
Benztropine mesylate	0.5-6.0	24	Akathisia, dystonia, parkinsonianism
Trihexyphenidyl Hydrochloride	1-15	4	Akathisia, dystonia, parkinsonianism
Amantadine	100-300	10-14	Akathisia, parkinsonianism
Propranolol	30-90	3-4	Akathisia
Lorazepam	1-6	12	Akathisia
Diphenhydramine	25-50	4-8	Akathisia, dystonia, parkinsonism

*APA Practice Guideline for the Treatment of Patients With Schizophrenia

Neurological side effects can be serious and include neuroleptic malignant syndrome (NMS) which is potentially life threatening. NMS is rare, with estimates ranging from .02 to 3.23 percent of persons treated with antipsychotic medications, particularly the FGAs. It is even rarer with the SGAs. Its symptoms include severe muscle rigidity, tremor, fever, hyperthermia, and autonomic dysfunction. It appears that there is increased risk for NMS during a rapid switch from to SGAs to FGAs, but there is no way to predict a first or subsequent occurrence, no test to definitively rule it out, and no proven treatment exists. Its pathophysiology is not completely understood.

Treatment of NMS starts with immediate discontinuation of antipsychotic medication. Supportive treatment is provided to maintain hydration and treating fever and other symptoms are recommended. Treatment with dopamine agonists (e.g., bromocriptine, amantadine) to reduce skeletal muscle rigidity or with dantrolene for hyperthermia is thought to improve symptoms, as is treatment with benzodiazepines (lorazepam). Hospitalization may be required in severe cases. Severe and treatment-resistant NMS often responds to electroconvulsive therapy. Clozapine is recommended for re-treatment with antipsychotic medication.

NONADHERENCE

Nonadherence is defined not taking medication as prescribed. The term nonadherence is used instead of compliance as the latter implies the lack of a partnership with the consumer and connotes paternalism and authority; compliance indicates that the consumer is subordinate to the prescriber who issues medical orders, whereas a partnership allows for consumer choice regarding treatment.

While there is overwhelming evidence of the effectiveness of medications for treatment of the symptoms of serious mental illness, nonadherence remains a concern and is strongly associated with relapse. Studies indicate that as many as fifty percent of individuals with schizophrenia do not follow their medication regimens, and that many people with depressive disorders stop taking medication before the minimal time required to effectively treat an episode of depression. This especially true in primary care settings where studies show the rate of nonadherence to antidepressant medication surpasses fifty percent within six months of the initial prescription.

Psychoeducation about medications (e.g., medication education groups) has been shown to improve participants' knowledge about medication but is ineffective in improving adherence to medication regimens. Motivational interviewing, behavioral tailoring, and simplifying medication regimens, on the

other hand, have all been shown to be highly effective. Motivational interviewing entails linking medication adherence to personal goals. Behavioral tailoring entails the use of self-monitoring cues and fitting medication into one's daily routine.

The use of a liquid suspension (e.g., risperidone, haloperidol), a fast dissolving tablet (e.g., olanzapine, risperidone), or a short-acting intramuscular form of medication (e.g., ziprasidone, haloperidol), are options for concealed nonadherence (e.g., cheeking). Both depot and SGAs should be used before an FGA is considered.

Electroconvulsive Therapy (ECT)

While years of research clearly demonstrate the effectiveness and general safety of ECT for selected mental illnesses, it remains controversial and its use varies. It is estimated that less than eight percent of psychiatrists in this country provide ECT.

ECT has been found to be beneficial for major depression, bipolar depression, and mania. The average response rate of between sixty and seventy percent for depression or mania accompanied by psychosis or catatonia is comparable to that of results from pharmacotherapy, but evidence indicates its effects occur more rapidly than with medication. There is also sufficient evidence for its use for the treatment of schizophrenia. The three TMAP algorithms use it as a fifth or sixth level approach for individuals who have not responded to medications alone or in combination. It is most well established for treatment refractory mood disorders and catatonia (that has not responded to lorazepam). Its safety for mother and fetus make it a choice for use during pregnancy. It has also been shown to have good results in the treatment of neuroleptic malignant syndrome.

A typical course of ECT consists of six to twelve treatments, three times a week on either an inpatient outpatient basis. The production of an adequate, generalized seizure is required for therapeutic effect. Research indicates that bilateral electrode placement produces results if an adequate seizure is produced, whereas with unilateral electrode placement, a therapeutic response cannot be obtained without increasing the electrical dose above the seizure threshold.

Some medications interact negatively with ECT and it is recommended that they be avoided during ECT. For instance, clozapine can raise the seizure threshold which makes it more difficult to obtain a therapeutic effect from ECT. Lithium adds to confusion and cognitive impairment when taken during a course of ECT.

CRISIS INTERVENTION AND ACUTE CARE

OUTPATIENT COMMITMENT

The Michigan Mental Health Code was recently amended to incorporate criteria for Assisted Outpatient Treatment (AOT) under court order. The definition of "a person requiring treatment" in Michigan now includes individuals who have a mental illness but are nonadherent with recommended mental health treatment and such nonadherence previously resulted in hospitalization, incarceration, threats, or actions of a violent nature. AOT includes coordination of care through intensive case management or assertive community treatment.

The literature supports mandatory outpatient commitment for a small subgroup of individuals who experience repeated relapses and rehospitalizations that are associated with nonadherence to medication regimens. Studies show that mandated outpatient treatment for a select group of persons with mental illness is associated with reductions in substance use, reductions in violence (both as victim and perpetrator), adherence to medication regimens, reduced hospitalization, and improved quality of life. It also promotes enhanced adherence to medication regimens. Some reports indicate reductions from fifty percent to eighty percent in relapse and rehospitalization rates. However, it is only maximally effective when combined with services that are more intensive; seven contacts per month is the minimal recommendation.

CRISIS INTERVENTION PROGRAMS

Crisis intervention can be provided by mobile teams or in crisis centers, emergency rooms of hospitals, and crisis residential facilities. Alternatives also include home-based care, family-centered crisis intervention, and crisis care. ACT teams also provide crisis intervention.

Research shows that such programs are as effective, and at times more effective, than hospitalization in terms of increasing consumer and family satisfaction, promoting continuity of services, alleviating family stress and cost. Studies have demonstrated that crisis intervention is associated with reduced hospital readmission rates, reduced symptoms, and preservation of role functioning. Additional support comes from the benefits of early response and intervention since delays in treatment can increase the duration of psychotic episodes. It is recommended that relapse prevention interventions should be part of crisis intervention programs.

MOBILE RESPONSE PROGRAMS

Mobile teams provide assessment, pre-hospital screening, and case management in addition to crisis intervention. They consist of multidisciplinary teams of mental health and substance abuse practitioners (master's prepared professionals, nurses and psychiatrists), as well as consumers, who provide services on twenty-four hour basis. An ACT team is an example. However, ACT teams only provide such services to the consumers for whom they have responsibility. Other teams partner with police, may provide services on behalf of emergency departments, or may work with individuals who may or may not be current consumers of services. Mobile response programs have been used effectively in jail diversion. Access to psychiatric services for medication prescription is critical to reducing hospitalization. Members of the team who are able to provide both mental health and substance abuse interventions are also an essential element.

Crisis Residential Services

Models of crisis residential facilities include apartments, group homes, foster homes and the consumer's own residence. The concept behind them is creating a normal, community-based environment that provides a high level of support for individuals who voluntarily accept treatment and are medically stable. A multidisciplinary team provides twenty-four hour staffing. Psychotherapy (individual and group), case management, medication, and linkage to community-based services as well as other supports are provided.

Crisis residential services can be used as a hospital diversion alternative or as means to shorten a hospital stay through a step-down approach for individuals who accept treatment voluntarily. Studies of crisis residential programs indicate they provide acute crisis care at considerably less cost than hospital care with outcomes that are comparable to those of hospital care.

Hospital-Based Extended Observation Services

Extended observation beds may be provided on a 23-hour or 72-hour basis, depending upon need. Either model is essentially a crisis hospitalization approach for an individual who requires observation during an acute crisis when exhibiting suicidality, homicidality, and intoxication. Unlike crisis residential, individuals who do not voluntarily accept intervention can use this service. Extended observation has been shown to be an effective hospital diversion program for individuals whose crises are of transient nature, particularly when they occur in the context of a substance abuse episode and for self-harm behaviors exhibited by individuals with personality disorders.

Partial Hospitalization

Partial hospitalization services can be used as a diversion from inpatient hospitalization or as a step-down from inpatient to shorten length of stay and assist in transition back to community living. Partial hospital programs provide the same types of services and supports as those found in the inpatient milieu. The advantage is that services are provided in a less restrictive, more integrated environment and are less disruptive than an inpatient stay. Partial hospitalization also does not appear to have the stigma that inpatient hospitalization carries.

Some studies of partial hospitalization indicate that it is as effective acute inpatient care; others show it is more effective in reducing symptoms, hospitalization, and maintaining the person's role functioning in the community. Partial hospitalization is less costly than inpatient hospitalization, typically half of the daily inpatient rate.

Inpatient Hospitalization

The research on hospital care indicates that intensive behavioral treatment combined, with appropriate pharmacotherapy (provided in accordance with established algorithms), produces the best outcomes. A functional assessment of behavior and individualized interventions to provide feedback for appropriate and inappropriate behaviors along with milieu management, group skills training, and cognitive remediation are all evidence-based inpatient interventions. Illness Management and Recovery, Family Psychoeducation, and Integrated Dual Disorders Treatment are all applicable to the inpatient setting.

Standardized screening instruments with established validity and behavioral anchors should be used to assess the consumer's status upon admission and subsequent to the initiation of intervention to

ascertain progress. (The next section covers instruments that are used for this purpose.) Screening and assessment for co-occurring mental illness and substance use disorders should be conducted. Individual and group interventions should address recovery from both disorders. Consumers should also be screened for trauma exposure. The use of seclusion and restraint should be avoided for consumers who have experienced trauma as these have been found to have deleterious effects on such consumers.

Inpatient treatment should include the provision of information about the consumer's illness, including symptoms and treatment options. Opportunities for helping consumers learn skills to manage their illness and teaching strategies for reducing relapses and coping with symptoms should be the focus of group and individual interventions. Techniques include motivational, educational, and cognitive-behavioral strategies. Education regarding the benefits and risks of medication should be included. The goal is to place the consumer in charge of his or her illness and set personal goals for recovery.

Token economies are used to create a social learning milieu in which points are earned for meeting specific target behaviors. Points can be redeemed for various privileges (e.g., recreational activities found enjoyable by the consumer) or tangibles (e.g., special foods). Inpatient behavior therapy includes feedback given for appropriate and inappropriate behaviors through prompting the consumer in a manner that stresses the consequences of behavior. The consumer is assisted in selecting appropriate behavior when necessary. Behaviors such as hygiene and grooming, attending and participating in groups can be enhanced with such methods. As the consumer's behavior becomes more appropriate, external reinforcers (tokens) are used less frequently and replaced more and more by social reinforcers. Studies show that cognitive-behavioral interventions, combined with medication, reduce the frequency of incidents, use of seclusion and restraints, and rehospitalizations.

Working with families and/or other supporters of consumers who are hospitalized is important and incorporates the following:

Information/Education Provided for Families
• Provide information on evidence-based treatments from medications to rehabilitation to self-help. • Provide relevant supportive information and coping strategies for the recipient and his or her family and support network at appropriate times. • Provide information about navigating the mental health system: community resources and services available, advocating for services. • Provide education on the nature of mental illness: biological causes, identifying symptoms, course of illness, what helps improve outcomes, what hurts. • Provide education on optimum medication management: the side effects of medications, the importance of medication adherence, and strategies to improve adherence, alternatives to medication, how to effectively stop using medication without side-effects. • Provide education on relapse prevention: identifying early warning signs, triggers of relapse, early intervention planning, self-help and peer support, coping strategies • Provide an explicit crisis plan and an appropriate response, or use of Advance Directives and the family's awareness of where the Advance Directive is filed and what the wishes of the recipient are. • Provide training for the family in structured problem-solving techniques.

Discharge planning for community re-entry begins upon admission to the hospital. It is designed to ensure that the consumer is connected to community-based services and supports for follow-up and maintenance of progress. This includes medication, benefits, housing, case management or outpatient therapy, vocational and educational services, etc. Effective discharge planning is intended to reduce recidivism and is considered preventive in nature in that successfully engaging the

individual with the range of services and supports needed to maintain community tenure can lead to reductions in unnecessary readmissions.

Research consistently demonstrates that length of stay is unrelated to outcome. Brief stays produce the same outcomes as longer term stays including improved community adjustment, symptom reduction, and readmission rates. However, while short stays are typical, there is still a small subset of individuals for whom longer-term hospitalization may be necessary.

MEASUREMENT TOOLS

The underpinning of evidence-based practices is consumer outcomes. This section reviews measurement issues, as well as consumer and system-level outcomes.

The use of various standardized instruments for screening, assessment, monitoring, and outcomes measurement is recommended in the literature. Some examples are provided below.

EXAMPLES OF CONSUMER SCREENING AND MONITORING INSTRUMENTS

The Dartmouth Assessment of Lifestyle (DALI) is an eighteen-item questionnaire with two scales that is used to screen for substance use disorders. It is a screening instrument that can be used to determine the need for integrated dual disorders treatment for co-occurring mental illness and a substance use disorder. It is on the web at http://www.dartmouth.edu/~psychrc/alcohol.html.

The Brief Psychiatric Rating Scale (BPRS) is a twenty-four-item scale that has been shown to be valid and reliable tool to assess the level of impairment in mood, affect, thought content and processes, and behavior. It is used to monitor symptoms. It can be found in the TMAP modules located on the web at http://www.mhmr.state.tx.us/meds/map.htm.

The SAMHSA MedMAP uses a four item Positive Symptom Rating Scale (PSRS) and the Brief Negative Symptom Assessment (BNSA) to assess symptomatic response to medications. Other assessment instruments are used to evaluate the presence of adverse effects of medications, such as the Abnormal Involuntary Movement Scale (AIMS), the Barnes Akathisia Rating Scale (BARS), the Simpson-Angus Extrapyramidal SE Scale (SAS), and the Patient Global Ratings of Side Effects (PGRSE). MedMAP can be found on the web at http://www.mentalhealthpractices.org/.

The Global Assessment Scale (GAS), Global Assessment of Functioning (GAF) can be used to ascertain overall mental health status and functioning.

The Mini-Mental Status Exam (MMSE) is used to monitor cognitive impairment, while the Brief Cognitive Rating Scale (BCRS) can be used to assess cognitive capacity for interventions.

The SAMHSA implementation resource Kits use the Kansas Consumer Satisfaction Survey to measures levels of satisfaction and the Quality of Life Assessment to obtain consumer self-reports to measure functioning.

PROGRAM MONITORING INSTRUMENTS

Implementation of evidence-based practices requires outcome monitoring. This entails measuring fidelity to the practice by comparing how well it is being implemented in relation to the original model. Adherence to the core components of a practice has been shown to increase positive results. Use of a fidelity scale allows for such monitoring and provides performance benchmarks.

The General Organization Index can be found in all the SAMHSA implementation resource kits. It is used as a companion to fidelity scales and measures an organization's overall capacity to implement and sustain evidence-based practices. A copy can be found in Appendix B along with examples of fidelity scales.

OUTCOMES

Productivity measures, such as the number of consumers served or the number of contacts per month, indicate very little, if anything, about the effects of services and supports on consumers. The emphasis should be on the ends, not the units of service or paperwork completed. Furthermore, the focus on the typical outcomes of symptom control, prevention of relapse or rehospitalization and adherence to treatment are inconsistent with a consumer-driven, recovery-oriented perspective. The latter include independence, employment, satisfying relationships, and other measures of quality of life. In a recovery-oriented, consumer-driven system of services and supports, consumers define outcomes, and interventions are geared to support attainment of their personally meaningful goals. Consumer satisfaction should be measured for the above variables including health and mental health status, substance use, housing, level of social support, work, etc.

The SAMHSA implementation resource kits include the following outcomes:

- Psychiatric or substance abuse hospitalization
- Incarceration
- Homelessness
- Independent living
- Competitive employment
- Educational involvement
- Stage of substance abuse treatment

System level outcomes include:

- Access to services and supports
- Systems integration/collaboration
- Continuity of services and supports
- Cost effectiveness
- Degree of consumer involvement
- Prevention activities
- Availability of comprehensive services

SUMMARY AND CONCLUSIONS

More importance is being placed on a recovery orientation in the delivery of mental health services. This shift was advocated in the 1999 report on mental health produced by the Surgeon General and the 2003 President's New Freedom Commission report. Both also place increasing importance on access to evidence-based practices, particularly for individuals from ethnic and racial minority groups. A recovery-oriented, culturally relevant, consumer-driven system of care supports consumer and family partnerships in the delivery of services, promotes self-care and self-help, incorporates culturally driven practices and offers evidence-based approaches designed to help consumers achieve their goals. Choice is an essential ingredient in a system that values self-determination and consumer empowerment. A focus on functional outcomes promotes consumers' full participation in community life. The identification and collaboration with natural supports including family members, religious and spiritual resources, traditional healers, churches, civic and community organizations are emphasized. Cross-system linkages foster partnerships to coordinate services among sectors of potential interface: primary medical care, faith-based, complementary care providers and criminal justice. Collaboration extends limited resources and enhances access by allowing entry through any "door". Collaboration with faith-based organizations, complementary care providers, and primary care providers can increase help seeking behaviors and reduce stigma. Well designed collaborative models require strong leadership and effective boundary spanners, and the ability to provide integrated services for individuals with co-occurring disorders.

Safe and affordable housing along with the potential to obtain gainful employment will strengthen opportunities for an individual's recovery. Supported housing, supported education, and supported employment models are the evidence-based practices that offer the greatest potential in these domains. Linear or continuum models for education, employment and housing services and supports have been replaced by in vivo services and supports.

Evidence-based practices do not identify one specific intervention as the most effective, but offer options and alternatives to consider. Moreover, incorporating various evidence-based practice "modules" in accordance with the needs of the individual can produce superior outcomes. For example, the combination of assertive community treatment, family psychoeducation, and supported employment has been associated with improved competitive employment than traditional vocational rehabilitations programs.

Judicious use of medications (antipsychotics, mood stabilizers, and antidepressants), prescribed and monitored in accordance with well-researched algorithms, combined with social skills training, family psychoeducation and supported employment produce better outcomes for consumers and their families.

Decisions regarding the use of various practices require a collaborative relationship with the consumer wherein the practitioner educates the consumer (and their family) about the alternatives available. A shared decision making process allows for consideration of various options with the consumer determining which options will result in attainment of the consumer's goals.

Effective interventions are staged in terms of phase of illness (acute, continuation, maintenance) and the individual's readiness for change (precontemplation, contemplation, action and maintenance).

Psychoeducation alone is insufficient for behavior change. It must be paired with cognitive and behavioral interventions (e.g., motivation techniques, behavioral tailoring, etc). Illness management

and recovery practices incorporate such interventions for consumers and their families in an empowering manner.

RECOMMENDATIONS

It takes time and considerable effort to inculcate evidence-based thinking and practices into an organization's culture. The delivery of evidence-based practices requires competency development and, while is initially a resource intensive endeavor, the outcomes have the potential to yield a significant return on the investment. Because the implementation of evidence-based practices in everyday use requires considerable focus of resources, the organization should prioritize its needs in accordance with the consumers it serves. State and federal initiatives will drive part of this decision making since efforts are already under way to promulgate specific approaches.

The Saginaw County Community Mental Health Authority has already implemented many evidence-based practices reviewed in this report. Any additions to the current armamentarium should be subject to its stakeholders' views of need and availability of resources. The following is a list of recommendations for consideration:

1. Promote recovery-oriented practices and incorporate the values of recovery in the organization's mission and values. Create shared decision making relationships with consumers and their supporters. Offer education and choice in options (housing, treatment interventions, etc.) so consumers can make informed decisions regarding the attainment of personally valued goals using a range of viable options.

2. Continue to support consumer-directed services ensuring that adequate levels of technical assistance and funding are available. Enhance opportunities to employ consumers in active roles in various programs and expand existing supported self-employment practices. The Michigan Department of Community Health has indicated it will be focusing on consumer-directed services in the near term.

3. Continue to enhance cross-system alliances and promote a "no wrong door" policy for access. The Michigan Department of Community Health has indicated its intention to focus on physical and mental health integration.

4. Provide interventions for individuals with co-occurring mental illness and substance use disorders. Incorporate substance abuse treatment skills into the mental health system. Consider structural or functional integration with the local substance abuse coordinating agency to create a seamless service system for individuals with co-occurring disorders. Since the Michigan Department of Community Health intends to implement integrated treatment for co-occurring disorders across the state, the organization needs to address how it will integrate the skills and talents of both types of providers into a unified system for this evidence-based practice. Effective cross-system collaboration (e.g., primary care, criminal justice) also requires capacity for treating dual disorders in an integrated fashion.

5. Ensure that screening for co-occurring substance use disorders and trauma are conducted as part of a standardized intake process.

6. Use standardized measurement tools with established validity to monitor progress and assess outcomes. Incorporate outcomes into the QA system.

7. The assertive community treatment program should have a well-defined substance abuse treatment component. ACT should consider using the DACTS to monitor its fidelity to the model.

8. Create a distinct vocational unit with employment specialists and direct resources to only the individual placement and support model of supportive employment. Such a unit can liaise with the various units and treatment teams, including ACT, clubhouse, and the outpatient provider network to provide a well-supported evidence-based intervention. It should include consumers as service providers.

9. Consider adopting supported education in conjunction with local colleges and universities. The University of Michigan's program is a good place to start. It has national recognition and is well supported.

10. The Michigan Department of Community Health has stated its intention to implement Family Psychoeducation statewide. Since Family Psychoeducation is a cost effective intervention that reduces family burden and improves outcomes, it is worthy of consideration as a program element.

11. Continue to work with cultural and religious organizations to promote community education and awareness, enhance the dissemination of culturally relevant information, and provide outreach and extension of resources.

12. Interpersonal and cognitive behavioral therapy approaches require staff training, but tend to be more time-limited and, because of their strong evidence base, should be considered part of the armamentarium of practitioners within the system. These, along with illness management and recovery programs are worthy investments. Using them in groups in an economical alternative to individual sessions. Illness management and recovery practices can be used throughout the adult mental health services and support system. This includes inpatient hospitals, ACT, clubhouse, and crisis residential. Many of the components of IMR are cognitive-behavioral interventions with general applicability to a number of diagnoses.

13. The use of medication algorithms can produce better outcomes than the considerable prescribing practice variation typically found in community practice. It is recommended that the adoption of the TMAP algorithms be given due consideration due to their proven effectiveness. They are easy to follow and offer very specific guidance on dosage, timeframes, serum levels, and alternatives for individuals who do not respond to specific protocols, polypharmacy issues, management of side effects, educational materials, etc.

14. Develop a policy statement on the adoption of evidence-based practices for the service delivery system and use it in purchase of service contracts for office-based, community-based, residential, and inpatient service providers.

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SELECTED RESOURCES

Federal Health Information Centers and Clearinghouses:

The National Guideline Clearinghouse (NGC), sponsored by the Agency for Healthcare Research and Quality (AHRQ), contains over 1000 diseases, condition guidelines that can be accessed through their website
Agency for Healthcare Research and Quality
Center for Outcomes and Evidence
540 Gaither Road, 6th Floor
Gaithersburg, MD 20850
(301) 427-1600
http://www.guideline.gov/

National Information Center on Health Services Research and Health Care Technology
National Library of Medicine
Building 38A, Room 45-410, Mail Stop 20
8600 Rockville Pike
Bethesda, MD 20894
http://www.nlm.nih.gov/nichsr/nichsr/html

National Resource Center on Homelessness And Mental Illness
345 Delaware Avenue
Delmar, NY 12054
http://www.nrchmi.samhsa.gov/

SAMHSA's National Mental Health Information Center
P.O. Box 42557
Washington, DC 20015
http://www.mentalhealth.samhsa.gov/

National Quality Measures Clearinghouse
Center for Outcomes and Evidence
Agency for Healthcare Research and Quality
540 Gaither Road, 6th Floor
Rockville, MD 20850
http://www.qualitymeasures.ahrq.gov/

The Chronic Care Model (CCM) has been adopted by the National Program Office for Depression in Primary Care
http://www.wpic.pitt.edu/dppc

SAMHSA and RJW: Implementing Evidence Based Practices Project has resource kits for:
Illness Management and Recovery (IMR)
Medication Management Approaches In Psychiatry (MedMAP)
Assertive Community Treatment (ACT)
Family Psychoeducation (FPE)
Supported Education (SE)
Integrated Dual Disorders Treatment (IDDT)

http://www.mentalhealthpractices.org/

Other Resources:

New York State Office of Mental Health Initiatives
www.omh.state.ny.us/omhweb

The National Association of State Mental Health Program Directors' (NASMHPD) website has a wealth of information about evidence-based practices as well as links to other sites with resources at http://www.nasmhpd.org

The Human Services Research Institute (HSRI) website has information on evidence-based practices at http://www.hsri.org/

The American Association of Community Psychiatrists' diagnosis specific guidelines can be found on line at http://www.wpic.pitt.edu/aacp/default.htm

The American Psychiatric Association's practice guidelines can be found on line at http://www.psych.org/

A useful frequently updated website for information of drug interactions is maintained by Dr. David Flockhart at Indiana University
http://medicine.iupui.edu/flockhart

Texas Medication Algorithm Project/Texas Implementation of Medication Algorithms (TMAP/TIMA)
http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html
http://www.mhmr.state.tx.us/centraloffice/medicaldirector/IMAP.html

U.S. Department of Health and Human Services (HHS)
http://www.hhs.gov/

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/

Health Resources and Services Administration
http://www.hrsa.gov/

Centers for Medicaid and Medicare Services
http://www.cms.gov/

U.S. Department of Housing and Urban Development (HUD)
http://www.hud.gov/

U.S Department of Veteran's (VA)
http://www.va.gov/

U.S. Social Security Administration
http://www.ssa.gov/

Consumer-Delivered Services:

National Mental Health Consumers' Self-Help Clearinghouse
http://www.mhselfhelp.org/

Consumer-Operated Services Program
http://www.cstprogram.org/

Consumer Organization & Networking Technical Assistance Center
http://www.contact.org/

The National Alliance for the Mentally Ill (NAMI) web site offers a wealth of useful information including manuals, workbooks, and videotapes.
http://www.anmi.org/

Faith-Based and Community Initiatives:

U.S. Department of Health and Human Services Center for Faith-Based and Community Initiatives
http://www.hhs.gov/fbci

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/faithbased

SAMHSA's National Mental Health Information Center
http://www.mentalhealth.samhsa.gov/

Resource Center to Address Discrimination and Stigma
http://www.adscenter.org/resources/faith.shtml

Consumer-Delivered Services:

National Mental health Consumers' Self-Help Clearinghouse
http://www.mhselfhelp.org/

Consumer-Operated Services Program
http://www.cstprogram.org/

The National Empowerment Center
http://www.power2u.org/

Consumer Organization & Networking Technical Assistance Center
http://www.contact.org/

The Medical Library
http://www.medem.com/

United States Psychiatric Rehabilitation Association (formerly IASPRS)
http://www.uspra.org/

Advance Directives:

Bazelon Center for Mental Health Law
http://www.bazelon.org.advir.html/
Duke University Program on Psychiatric Advance Directives
Psychiatric advance directives (PADs) are new legal instruments that may be used to document a competent person's instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. This website provides implementation resource Kits and instructions for consumers, clinicians, and family members to complete psychiatric advance directives and health care power of attorney documents.

National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
Phone 703/684-7722
http://www.nmha.org/

Recovery:

Advocacy Unlimited
200 Russell Road
Wethersfield, CT 06109
Phone: (860) 667-0460
http://www.mindlink.org/

Awakenings Project
University of Chicago
Center for Psychiatric Rehabilitation
7239 Arbor Drive
Tinely Park, Il 60477
Phone: (708) 614-4780
http://www.ucpsychrehab.org/programs/awakenings/

Boston University's Center for Psychiatric Rehabilitation
Center for Psychiatric Rehabilitation
Boston University
940 Commonwealth Avenue West
Boston, MA 02215
Phone: (617) 353-3549
http://www.bu.edu/cpr/

Consumer Organization and Networking Technical Assistance Center (CONTACT)
CONTAC
P.O. Box 11000
Charleston, WV 25339
Phone: (888) 825-Tech
http://www.contact.org/

Mary Ellen Copeland (WRAP)
Mary Ellen Copeland, MS, MA
P.O. Box 301
West Dummerston, VT 05357
Phone: (802) 254-2092
http://www.mentalhealthrecovery.com/

Mental Health Client Action Network (MHCAN)
MHCAN
1051 Cayuga Street
Santa Cruz, CA 95062
Phone: (831) 469-0462
http://www.mhcan.org/

Mental Illness Education Project
The Mental Illness Education Project, Inc.
P.O. Box 470813
Brookline Village, MA 02447
Phone: (617) 562-1111
http://www.miepvideos.org/booklist.html

National Empowerment Center (PACE)
The National Empowerment Center
599 Canal Street
Lawrence, MA 01840
Phone: (800) POWER2U or (800) 769-3728
http://www.power2u.org/

Peoplewho
People Who
146 Chrystal Terrace 5
Santa Cruz, CA 95060-3654
http://www.peoplewho.net/

Recovery, Inc.
Recovery, Inc. National Headquarters
802 Dearborn Street
Chicago, IL 60610
Phone: (312) 337-5661
http://www.recovery-inc.com/

Posttraumatic Stress Disorder:

National Center for Post-Traumatic Stress Disorder (A program of the U.S. Department of Veterans Affairs)
http://www.ncptsd.org/

Evidence-Based Practices – Great Britain
The Centre for Evidence-Based Mental Health at Oxford
http://www.cebmh.com/

National Health Service (NHS) Centre for Reviews and Dissemination at York
http://www.york.ac.uk/inst/crd/ebhc.htm

Health Bulletin Wales
http://www.uwcm.ac.uk/mental/chapter5.htm

Homelessness:

Health Care for the Homeless Information Resource Center
Health Care for the Homeless (HCH) is the only Federal program with the sole responsibility of addressing the critical primary health care needs of homeless individuals.

National Health Care for the Homeless Council
The National Health Care for the Homeless Council is a membership organization comprised of Organizational Members and hundreds of individuals who are organized as the HCH Clinicians' Network. Members of the National Council work together for reforms of the health care system to best serve the needs of people who are homeless.

National Resource Center on Homelessness and Mental Illness (NRC), Policy Research Associates, Inc.
As one of CMHS's national technical assistance centers, NRC is the only national center specifically focused on the effective organization and delivery of services for people who are homeless and have serious mental illnesses.

Projects for Assistance in Transition from Homelessness (PATH), Policy Research Associates (PRA) and Advocates for Human Potential (AHP)
Congress created the Projects for Assistance in Transition from Homelessness (PATH) formula grant program in 1991 to help states and territories provide flexible, community-based services for people who are homeless and have serious mental illnesses. As one of CMHS' national technical assistance centers, AHP provides onsite technical assistance and other activities to help states/territories and the local organizations that receive PATH funds operate and monitor the program.

The Corporation for Supportive Housing
CSH brings together people, skills, and resources and provides high-quality advice and development expertise, by making loans and grants to supportive housing sponsors, by strengthening the supportive housing industry, and by reforming public policy to make it easier to create and operate supportive housing.

Housing:

Technical Assistance Collaborative: www.tacinc.org

Web sites:
HUD: www.hud.gov (summaries of ConPlans are available on line)
Center for Community Change: www.communitychange.org
HUD SHP Desk Guide:
http://www.hud.gov/offices/cpd/homeless/library/shp/shpdeskguide/dgintro.cfm
Enhancing Shelter Plus Care Operations
http://www.hud.gov/offices/cpd/homeless/library/spc/shelterplusguide.PDF
Understanding Shelter Plus Care
http://www.hud.gov/offices/cpd/homeless/library/spc/understandingspc/index.cfm

Understanding SRO
http://www.hud.gov/offices/cpd/homeless/library/sro/understandingsro/index.cfm
HUD's guide to PHAs
http://www.hud.gov/offices/pih/pha/policy/pha-plan-guide.pdf

Publications:
How to Be a "Player" in the Continuum of Care: Tools for the Mental Health Community. www.tacinc.org
Guide to Continuum of Care Planning and Implementation. U.S. Department of Housing and Urban Development. http://www.hud.gov/cpd/cont/gcoc.html
Continuums of Care for States.
http://www.hud.gov/offices/cpd/homeless/library/coc/cocstates.pdf
The Section 8 Guidebook (February 2002). www.tacinc.org.
Opening Doors: Affordable Housing in Your Community What You Need to Know! What You Need to Do! Issue 8, September 1999, TAC & CCD, www.tacinc.org
Public Housing Agency (PHA) Plan Desk Guide,
Piecing It All Together: Playing the Housing Game (1999), TAC, www.tacinc.org
Opening Doors: HUD's HOME Program: Can it Really Work for People with Disabilities?, Issue 16, December 2001, TAC & CCD, www.tacinc.org.
Opening Doors: Challenging Choices: Housing Development 101 Issue 9, December 1999, TAC & CCD, www.tacinc.org.

CMHS-Funded National Technical Assistance Centers:

Center for Psychiatric Rehabilitation (CPR), Boston University
The Center for Psychiatric Rehabilitation is a research, training, and service organization dedicated to improving the lives of persons who have psychiatric disabilities by improving the effectiveness of people, programs, and service systems.

Consumer Organization and Networking Technical Assistance Center (CONTAC)
The West Virginia Mental Health Consumer's Association, Inc. (WVMHCA) provides services as a national consumer-run technical assistance center, created to strengthen and support consumer networks, to identify technical assistance needs and implement related strategies for diverse consumer groups, and to encourage relationship building through its Consumer Organization and Networking Technical Assistance Center (CONTAC).

Depression and Bipolar Support Alliance (DBSA) Peer-to-Peer Resource Center
Our goal is to put in place a national system to train and certify peer specialists who work with other mental health consumers to promote outcomes of self-directed recovery, independence, and community integration.

National Alliance for the Mentally Ill (NAMI) Assertive Community Treatment (ACT) Technical Assistance Center
This national TA Center assists NAMI state organizations, local affiliates, other entities, and individuals in their efforts to make the ACT model available in more communities across the country.

National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR), University of Colorado Health Sciences Center
The NCAIANMHR is one of four minority mental health research Centers sponsored by the National Institute of Mental Health and is the only program of this type in the country focusing specifically on American Indian and Alaska Native populations.

National Consumer Supporter Technical Assistance Center (NCSTAC), National Mental Health Association (NMHA)
The purpose of NCSTAC is to strengthen those organizations supporting mental health consumers, survivors, and ex-patients by providing technical assistance in the forms of research, informational materials, and financial aid.

National Empowerment Center, Inc. (NEC)
The mission of the National Empowerment Center Inc. is to carry a message of recovery, empowerment, hope, and healing to people who have been diagnosed with mental illness.

National GAINS Center for People with Co-Occurring Disorders in Contact with the Justice System
The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system.

National Mental Health Consumers' Self-Help Clearinghouse
The National Mental Health Consumers' Self-Help Clearinghouse is a consumer-run national technical assistance center serving the mental health consumer movement that helps connect individuals to self-help and advocacy resources, and offers expertise to self-help groups and other peer-run services for mental health consumers.

National Research and Training Center on Psychiatric Disability (NRTC), University of Illinois at Chicago
The National Research and Training Center (NRTC) on Psychiatric Disability is a program of research, training, technical assistance and dissemination activities designed to promote self-determination among people with psychiatric disabilities.

National Technical Assistance Center for State Mental Health Planning (NTAC)
NTAC's mission includes assisting its core constituents to bring about long-lasting improvements in the design, delivery and evaluation of mental health services; foster consumer recovery and independence through consumer-centered services; and prepare for the future of public mental health care.

Training and Advocacy Support Center (TASC), National Association of Protection and Advocacy Systems (NAPAS)
The Training and Advocacy Support Center (TASC) is a centralized repository for training and technical assistance information and coordination for federally mandated Protection and Advocacy (P&A) Programs.

Consumer, Family & Advocacy Resources:

Consumer-Operated Services Program (COSP) Multisite Research Initiative
The Consumer-Operated Services Program (COSP) Multisite Research Initiative is a federally-funded national effort to discover to what extent consumer-operated programs as an adjunct to traditional mental health services are effective in improving the outcomes of people with serious mental illness.

National Association for Rights Protection and Advocacy (NARPA)
NARPA is an independent organization that exists to expose abuse, to shed light on coercive and dangerous practices, and to promote real alternatives to the traditional mental health system.

National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA)
The National Association of Consumer/Survivor Mental Health Administrators represents state mental health department senior managers who are current or former recipients of mental health services.

Federal Agencies & Resources:

Achieving the Promise: Transforming Mental Health Care in America, the final report of the President's New Freedom Commission on Mental Health
http://www.mentalhealthcommission.gov/reports/interim_toc.htm The subcommittee reports can be found at: http://www.mentalhealthcommission.gov/subcommittee/Sub_Chairs.htm
Agency for Healthcare Research and Quality (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) research provides evidence-based information on health care outcomes; quality; and cost, use, and access.
Center for Mental Health Services (CMHS)

The Center for Mental Health Services (CMHS) is charged with leading the national system that delivers mental health services. The goal of this system is to provide the treatment and support services needed by adults with mental disorders and children with serious emotional problems.
Center for Substance Abuse Prevention (CSAP)

The Center for Substance Abuse Prevention (CSAP) is the sole Federal organization with responsibility for improving accessibility and quality of substance abuse prevention services.
Center for Substance Abuse Treatment (CSAT)
CSAT's mission is to improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation.

FedWorld
This service assists agencies and the public in electronically locating Federal Government information, both information housed within the National Technical Information Service (NTIS) repository and outside of NTIS.

FirstGov
FirstGov.gov, the official U.S. gateway to all government information, is the catalyst for a growing electronic government.

Health Resources and Services Administration (HRSA)
Through its four Bureaus (key program areas), HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities.

Indian Health Service (IHS)
The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Their goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

National Institute of Mental Health (NIMH)
The mission of the National Institute of Mental Health (NIMH) is to diminish the burden of mental illness through research.

Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

US Census Bureau
The Census Bureau serves as the leading source of quality data about the nation's people and economy.

US Government Printing Office
GPO captures, stores, authenticates, produces, and disseminates information from Congress and other Federal publishers for the public to access directly and through the Federal Depository Library Program.

Managed Care:

Managed Care Information Center (MCIC)
The Managed Care Information Center (MCIC) gathers, collects, compiles, analyzes, studies, interprets and distributes business news and information on the managed care industry.

National Committee for Quality Assurance (NCQA)
NCQA is an independent, 501(c)(3) non-profit organization whose mission is to improve health care quality everywhere. NCQA evaluates health care in three different ways: through accreditation; through the Health Plan Employer Data and Information Set (HEDIS®); and through a comprehensive member satisfaction survey.

SAMHSA'S Office of Managed Care/Managed Care Initiative
SAMHSA's Office of Managed Care (OMC) was created to reflect the commitment of SAMHSA to address the many difficult issues that managed care presents to consumers, payers, and providers. The OMC is responsible for coordinating all managed care activities of the agency.

Multicultural Related Resources:

American Psychological Association (APA), Society for the Psychological Study of Lesbian, Gay and Bisexual Issues
The Society for the Psychological Study of Lesbian, Gay, and Bisexual issues was founded in 1985 as a Division of the American Psychological Association to represent sexual orientation issues within and beyond the Association.

American Psychological Association (APA), Society for the Psychology Study of Ethnic Minority Issues
The Society for the Psychology Study of Ethnic Minority Issues, a Division of the American Psychological Association, (APA), is the major representative body for psychologists who conduct research on ethnic minority concerns or who apply psychological knowledge and techniques to ethnic minority issues.

Asian & Pacific Islander American Health Forum (APIAHF)
The Health Forum is a national advocacy organization dedicated to promoting policy, program, and research efforts to improve the health and well being of Asian American and Pacific Islander (AAPI) communities.

Center for the Study of Issues in Public Mental Health, Multicultural Research Issues
The Center is dedicated to improving the outcomes of public mental health services through the effective integration of research, policy, and practice.

Diversity RX
This site is devoted to promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities.
Ethnomed
The EthnoMed site contains information about cultural beliefs, medical issues, and other related issues pertinent to the health care of recent immigrants.

Gay, Lesbian, Bisexual, Transgender (GLBT) Health Access Project
The mission of this organization is to strengthen the Massachusetts Department of Public Health's ability to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for GLBT people through a variety of venues including community awareness, policy development, advocacy, direct service and prevention strategies.

National Asian American and Pacific Islander Mental Health Association (NAAPIMHA)
NAAPIHMA's mandate, then, is to advocate on behalf of AAPI mental health issues, to serve as a forum for effective collaboration and to network among stake holders of community based organizations, consumers, family members, service providers, program developers, researchers, evaluators and policy makers. Moreover, NAAPIMHA will endeavor to work with direct service providers, such as nonprofit community-based organizations, to augment this effort.

National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
National Asian Pacific American Families Against Substance Abuse (NAPAFASA) is a private, non-profit, 501(c)(3) membership organization dedicated to addressing the alcohol, tobacco, and other drug issues of Asian and Pacific Islander (API) populations on the continental U.S., Hawaii, the six Pacific Island jurisdictions and elsewhere.

National Center for Cultural Competence (NCCC)
Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

National Institute of Mental Health/Women's Mental Health Consortium
The Women's Mental Health Consortium at the National Institute of Mental Health provides regularly updated information on how the occurrence, treatment, and outcomes of mental illnesses differ between men and women, how the Consortium promotes research that takes these differences into account, and how it seeks to encourage public policy that reflects the results of this research, to the benefit of both women and men.

National Latino Behavioral Health Association (NLBHA)
The mission of the National Latino Behavioral Health Association (NLBHA) is to provide national leadership for the advancement of Latino behavioral health services.

National Library of Medicine, American Indian Health Search
An information portal to issues affecting the health and well being of American Indians.

National Research Center on Asian American Mental Health (NRCAAMH)
NRCAAMH aims to contribute theoretical and applied research that will have a valuable impact on mental health policy and service delivery to Asian Pacific Americans.

Program for Research on Black Americans (PRBA)
PRBA seeks to collect, analyze, and interpret empirical data on African Americans as well as international data on people of African descent.

The Center for Cross Cultural Research
The Center for Cross-Cultural Research was started in response to the Euro American bias in psychological theory, research, and practical applications. We believed then, as now, that for the discipline of Psychology to become a universally valid science it must expand its horizons beyond the narrow cultural basis that continues to characterize much of Psychology in the Western world.

The Center for Research on Ethnicity, Culture and Health (CRECH)
The Center for Research on Ethnicity, Culture and Health provides a forum for basic and applied public health research on relationships among ethnicity, culture, socioeconomic status and health.

The Minority HIV/AIDS Initiative
The Minority HIV/AIDS Initiative provides funds to community-based organizations, faith communities, research institutions, minority-serving colleges and universities, health care organizations, state and local health departments, and correctional institutions to help them address the HIV/AIDS epidemic within the minority populations they serve.

The National Alliance for Hispanic Health
The National Alliance for Hispanic Health is the Nation's oldest and largest network of Hispanic health and human services providers.

The Office of Minority Health Resource Center (OMHRC)
The mission of OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health.

US Department of Health and Human Services/Office on Women's Health
The Office on Women's Health (OWH) in the Department of Health and Human Services (HHS) is the government's champion and focal point for women's health issues, and works to redress inequities in research, health care services, and education that have historically placed the health of women at risk.

Outcome Measurement:

Adult Mental Health Workgroup
The Adult Mental Health Workgroup was formed as an outgrowth of the Consensus Forum on Mental Health and Substance Abuse Performance Measures at the Carter Center in the spring of 2001. Leaders representing a wide range of concerned groups came together to assess the progress made to date on the development and implementation of performance measures in behavioral health care and related service systems.

Center for the Study of Issues in Public Mental Health, The Nathan Kline Institute
Dedicated to improving the outcomes of public mental health services through the effective integration of research, policy and practice.

Ohio Mental Health Consumer Outcomes Initiative
The mission of the Ohio Mental Health Outcomes Task Force is to identify an initial set of critical consumer outcomes and recommend to the Ohio Department of Mental Health a standard, statewide, ongoing approach to identifying and measuring consumer outcomes and performance of Ohio's mental health system.

Outcome Measurement Resource Network, United Way of America
The Resource Network offers information, downloadable documents, and links to resources related to the identification and measurement of program- and community-level outcomes.

PacifiCare Behavioral Health, ALERT Annual Report, Outcomes Management
Presents graphical information and explanatory text about results of various outcome and quality measures in PacifiCare Behavioral Health's ALERT system as of January 2002.

Research, Policy & Practice:

AcademyHealth
AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health research and policy.

Bazelon Center for Mental Health Law
The Bazelon Center for Mental Health Law is the leading national legal advocate for people with mental disabilities. Through precedent-setting litigation and in the public policy arena, the Bazelon Center works to advance and preserve the rights of people with mental illnesses and developmental disabilities. The web site also has forms for creating psychiatric advance directives.

Center for Mental Health Services Research, University of Massachusetts Medical School
The Center conducts research on the structure and outcomes of mental health services, mental health policy, factors affecting the involvement and functioning of persons with mental disorders, including both adults and children in various systems and settings, and the role of law, violence, substance abuse and other problematic behaviors on the' course and outcomes of mental illness.

Duke University Services Effectiveness Research Program
The multidisciplinary Duke University SERP program is concerned with etiology, course, prognosis, treatment and outcomes of psychiatric disorders and utilizes public-health approaches to examine the prevalence of mental illness and its treatment in communities.

Evidence-Based Practices Project
A national project with three major goals: 1) to help more consumers and families access services that are effective, 2) to help providers of mental health services develop the skills necessary to deliver effective services, and 3) to help administrators set up mechanisms to support and maintain these effective services.

Policy Information Exchange (PIE), Missouri Institute of Mental Health
The primary purpose of PIE Online is to provide a comprehensive, web-based source for information related to mental health, substance abuse, and disability policy, including a searchable database of over 4600 documents.

Rural Mental Health:

National Association for Rural Mental Health (NARMH)
The National Association for Rural Mental Health (NARMH) was founded in order to develop and enhance rural mental health and substance abuse services and to support mental health providers in rural areas.

National Rural Health Association (NRHA)
The National Rural Health Association is a national membership organization whose mission is to improve the health and healthcare of rural Americans and to provide leadership on rural issues through advocacy, communications, education and research.

Office of Rural Mental Health Research (ORMHR), National Institute of Mental Health
The ORMHR directs, plans, coordinates, and supports research activities and information dissemination on conditions unique to those living in rural areas, including research on the delivery of mental health services in such areas; and coordinates related Departmental research activities and related activities of public and nonprofit entities.

Rural Information Center (RIC)
The Rural Information Center (RIC) provides information and referral services to local, state, and federal government officials; community organizations; rural electric and telephone cooperatives; libraries; businesses; and, rural citizens working to maintain the vitality of America's rural areas.

Substance Abuse:

National Alcohol & Drug Addiction Recovery Month
Recovery Month is sponsored SAMHSA's Center for Substance Abuse Treatment (CSAT). An annual observance that takes place during September, Recovery Month highlights the societal benefits of substance abuse treatment, lauds the contributions of treatment providers and promotes the message that recovery from substance abuse in all its forms is possible.

National Clearinghouse for Alcohol and Drug Information (NCADI), SAMHSA
SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) is the Nation's one-stop resource for information about substance abuse prevention and addiction treatment.

The National Center on Addiction and Substance Abuse (CASA), Columbia University
A unique think/action tank that engages all disciplines to study every form of substance abuse as it affects our society.

APPENDIX A: QUICK REFERENCE GUIDES

MODEL	FEATURES	TARGET POPULATION	LEVEL OF EVIDENCE	POTENTIAL BARRIERS/CHALLENGES
ILLNESS MANAGEMENT AND RECOVERY (IMR)	Psychoeducation Social skills training Coping skills training Cognitive-behavioral therapies	Adults with mental illness and/or co-occurring disorders	+++	
ASSERTIVE COMMUNITY TREATMENT (ACT)	Transdisciplinary team provides 24/7 services and supports in community setting 1:10 staff: consumer ratio	Serious mental illness and/or co-occurring substance sue disorder and a recent history of frequent or long-term hospitalization, at risk for rehospitalization or extremely impaired psychosocial functioning requiring daily assistance to live in the community	+++	Fidelity to the model is critical to success
CASE MANAGEMENT	Several models based on intensity of service	Adults with mental illness and/or co-occurring disorders	Lack of standardization	
PSYCHOPHARMACOLOGY	PORT TMAP MedMAP Various Guidelines (APA, etc.)	Schizophrenia Schizophrenia, Bipolar, Major Depression Various diagnoses	+++ +++ +++ ++	
ELECTROCONVULSIVE THERAPY (ECT)	Bilateral (electrode placement) Unilateral (electrode placement)	Severe and refractory depression Mania Schizophrenia Schizoaffective disorder Schizophreniform disorder Catatonia	+++	
FAMILY PSYCHOEDUCATION (FPE)	Education of family members aimed at reducing stress and tension, promoting social support and empathy, establishing a collaborative relationship between the treatment team and family. NAMI's Family-to-Family Education Program SAMHSA	Schizophrenia, schizoaffective disorder, bipolar illness, major depression, borderline personality disorder, and obsessive compulsive disorder	+++	Ethnocultural adaptations
INTEGRATED DUAL DISORDERS TREATMENT (IDDT)	Individuals receive treatment from 1 clinician or treatment team through 1 program that combines appropriate treatments for both disorders.	Individuals with co-occurring mental illnesses and substance use disorders	+++	Separate funding streams, recipient rights, confidentiality, credentialing, billing, and coding. Skilled workforce with experience in providing dual diagnosis interventions.
SUPPORTED EMPLOYMENT (SE)	Individual Placement and Support (IPS)	Adults with serious mental illness and co-occurring disorders	+++	
COGNITIVE BEHAVIORAL THERAPY	Brief (12-20 week) psychotherapy for controlling	Depression		

MODEL	FEATURES	TARGET POPULATION	LEVEL OF EVIDENCE	POTENTIAL BARRIERS/CHALLENGES
(CBT)	mood, anxiety, and preventing relapse. Includes exposure therapy, behavioral tailoring, relapse prevention, relaxation training, cognitive restructuring, etc.	PTSD Anxiety disorders Panic attacks Phobias Problems with relationships, family, work, school, insomnia, self-esteem	+++	
DIALECTICAL BEHAVIOR THERAPY (DBT)	Time-limited psychotherapy that teaches behavioral skills for interpersonal relationships and managing stress	Suicidality Self-harm behaviors Borderline personality disorder	++	Lack of a fidelity scale
EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)	Combines CBT with exposure therapy.	PTSD	+	
INTERPERSONAL PSYCHOTHERAPY (IPT)	Time limited psychotherapy the focuses on: role disputes, role transitions, unresolved grief, and social deficits. Uses education as primary tool.	Depression	+++	
SOLUTION-FOCUSED BRIEF THERAPY (SFBT)	Short term, solution enhancing intervention. Elements of systemic and family therapies of CBT	Family relationship problems Eating Disorders Substance Use Disorders Anxiety, phobias, panic attacks	+	
CULTURAL COMPETENCE	Ethnic matching Culture brokers Traditional healing practices LEP	Individuals from ethnic and cultural minority groups		
FAITH BASED COLLABORATION	Partnerships for complementary support delivery	Individuals who belong or wish to belong to spiritual/religious groups		
SELF-HELP/EMPOWERMENT	Models developed by consumers based on their own experiences and coping techniques: WRAP PACE BRIDGES Various 12-Step models PADs Proxy Instructional	Adults with mental illness and /or co-occurring disorders	++	Technical assistance and funding The Michigan MHC allows for proxy PADs
CONSUMER-OPERATED SERVICES	Drop-in centers Supported businesses Respite care services Employment programs Housing programs Crisis services Outreach programs Case management programs Warm lines Hotlines Advocacy	Adults with mental illness and co-occurring disorders	++	Michigan Medicaid covers: Drop-in centers Vocational and housing programs Peer counseling Peer case management Crisis alternatives to hospitalization Advocacy training Peer support groups Peer education

MODEL	FEATURES	TARGET POPULATION	LEVEL OF EVIDENCE	POTENTIAL BARRIERS/CHALLENGES
	Peer support programs Hospitalization alternatives			Consumer-run businesses
JAIL DIVERSION PROGRAMS	Prebooking / Postbooking / Coterminous MH/police crisis team programs Jail based MH/CD/DD courts Preplea Postplea	Adults with mental illness and/or co-occurring disorders	++	
JAIL-BASED SERVICES	Screening / Assessment Counseling Crisis intervention Medication Community re-entry / transition planning	Individuals with mental illness and/or co-occurring disorders	++	
CRISIS INTERVENTION & ACUTE CARE	Outpatient Commitment Crisis Centers/ERs Mobile Crisis Teams Crisis Residential Hospital-Based Extended Observation 23-Hour 72-Hour Partial Hospitalization Inpatient Hospitalization Short-Term Long-Term	Adults with mental illness and/or co-occurring disorders who are in crisis	+++ +++ +++ +++ +++ +++ +++ +++ +++ +++ +++	Michigan Medicaid covers 23 hour extended observation beds
HOUSING	Supportive housing	Adults with mental illness and/or co-occurring disorders	++	
SUPPORTED EDUCATION (SED)	Mobile support Classroom support On-site support Individual and group help	Adults with mental illness and/or co-occurring disorders	+++	
COLLABORATIVE CARE (WITH PRIMARY HEALTH CARE PROVIDERS)	Co-location Referral Consultation	Adults with mental illness and/or co-occurring disorders	++	

DIAGNOSIS	INTERVENTIONS
Schizophrenia	Medications: MedMAP, PORT, TMAP ECT Family Psychoeducation (FPE) Family-To Family Education Program (NAMI) Supported Employment (SE) Illness Management & Recovery (IMR) ACT Supported Education Supported Housing
Bipolar Disorder	Medication: TMAP ECT Family Psychoeducation (FPE) Family-To Family Education Program (NAMI) Supported Employment (SE) Illness Management & Recovery (IMR) ACT Supported Education Supported Housing
Major Depression	Medication: TMAP ECT Family Psychoeducation (FPE) Family-To Family Education Program (NAMI) Supported Employment (SE) Illness Management & Recovery (IMR) ACT Supported Education Supported Housing
Borderline Personality Disorder	Family Psychoeducation (FPE) Dialectical Behavior Therapy (DBT)
Obsessive Compulsive Disorder	Medication Family Psychoeducation (FPE)
Postpartum Depression	Interpersonal Therapy Medication
Dual Disorders (mental illness and substance use disorder)	IDDT
Dysthymia	CBT Interpersonal Therapy Medication
Posttraumatic Disorders	Cognitive-Behavioral Therapy (CBT) Exposure therapy Medication EMDR SFBT
Sex Offenders	Antiandrogen treatment Buspirone CBT
Eating Disorders	IPT Fluoxetine SFBT

APPENDIX B: EXAMPLES OF FIDELITY SCALES

- Dartmouth Assertive Community Treatment Scale (DACTS)
- Supported Employment (SE) Fidelity Scale
- Family Psychoeducation (FPE) Fidelity Scale
- Illness Management and Recovery (IMR) Fidelity Scale
- Integrated Dual Disorders Treatment (IDDT) Fidelity Scale
- Medication Treatment Fidelity Scale: Prescriber Level
- Medication Treatment Fidelity Scale: Organization Level
- General Organizational Index (GOI) Scale

Assertive Community Treatment Fidelity Scale

DACTS Score Sheet

Program:_____
Date of Visit:_____ Rater 1 initials:_____ Rater 2 initials:_____

		Rater 1	Rater 2	Consensus	ACTUAL VALUE
H1	Small Caseload				
H2	Team Approach				
H3	Program Meeting				
H4	Practicing Team Leader				
H5	Continuity of Staffing				
H6	Staff Capacity				
H7	Psychiatrist on Staff				
H8	Nurse on Staff				
H9	Substance Abuse Specialist on Staff				
H10	Vocational Specialist on Staff				
H11	Program Size				
	HUMAN RESOURCES MEAN:				
O1	Explicit Admission Criteria				
O2	Intake Rate				
O3	Full Responsibility for Treatment Services				
O4	Responsibility for Crisis Services				
O5	Responsibility for Hospital Admissions				
O6	Responsibility for Hospital Discharge Planning				
O7	Time-Unlimited Services				
	ORGANIZATONAL BOUNDARIES MEAN:				
S1	In-Vivo Services				

S2	No Drop-Out Policy				
S3	Assertive Engagement Mechanisms				
S4	Intensity of Service				
S5	Frequency of Contact				
S6	Work with Support System				
S7	Individualized Substance Abuse Treatment				
S8	Dual Disorder Treatment Groups				
S9	Dual Disorders (DD) Model				
S10	Role of Consumers on Treatment Team				
	NATURE OF SERVICES MEAN:				
	TOTAL MEAN SCORE				

Supported Employment Fidelity Scale*

Rater: _____ **Site:** _____ **Date:** _____ **Total Score:** _____

Directions: Circle one anchor number for each criterion.

Criterion		Data Source**	Anchor
Staffing			
1.	**Caseload size:** Employment specialists manage vocational caseloads of up to 30 clients.	VL, MIS, DOC, INT	1 = Ratio of 81 or more clients/employment specialist. Or Cannot rate due to no fit. 2 = Ratio of 61-80 clients/employment specialist. 3 = Ratio of 41-60 clients/employment specialist. 4 = Ratio of 26-40 clients/employment specialist. 5 = Ratio of 25 or less clients/employment specialist 9 = Insufficient data to rate.
2.	**Vocational services staff:** Employment specialists provide only vocational services.	MIS, DOC, INT	1 = Employment specialists provide nonvocational services such as case management 80% of the time or more. Or Cannot rate due to no fit. 2 = Employment specialists provide nonvocational services such as case management about 60% time. 3 = Employment specialists provide nonvocational services such as case management about 40% time. 4 = Employment specialists provide nonvocational services such as case management about 20% time. 5 = Employment specialists provide only vocational services. 9 = Insufficient data to rate.
3.	**Vocational generalists:** Each employment specialist carries out all phases of vocational service, including engagement, assessment, job placement, and follow - along supports.	VL, MIS, DOC, INT	1 = Employment specialist only provides vocational referral service to vendors and other programs. Or Cannot rate due to no fit. 2 = Employment specialist maintains caseload but refers clients to other programs for vocational service. 3 = Employment specialist provides one aspect of the vocational service (e.g. engagement, assessment, job

			development, job placement, job coaching, and follow-along supports). 4 = Employment specialist provides two or more phases of vocational service but not the entire service. 5 = Employment specialist carries out all phases of vocational service (e.g. engagement, assessment, job development, job placement, job coaching, and follow-along supports). 9 = Insufficient data to rate.
Organization			
1.	**Integration of rehabilitation with mental health treatment:** Employment specialists are part of the mental health treatment teams with shared decision-making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.	VL, MIS, DOC, INT	1 = Employment specialists are part of a vocational program, separate from the mental health treatment. No regular direct contact with mental health staff, only telephone or one face-to-face contact per month. Or Cannot rate due to no fit. 2 = Employment specialists attend treatment team meetings once per month. 3 = Employment specialists have several contacts with treatment team members each month and attend one treatment team meeting per month. 4 = Employment specialists are attached to one or more case management treatment teams with shared decision making. Attend weekly treatment team meetings. 5 = Employment specialists are attached to one or more case management treatment teams with shared decision making. Attend one or more treatment team meetings per week and have at least three client-related case manager contacts per week. 9 = Insufficient data to rate.
2.	**Vocational unit:** Employment specialists function as a unit rather than a group of practitioners. They have group supervision, share information, and help each other with cases.	MIC, INT	1 = Employment specialists are not part of a vocational unit. Or Cannot rate due to no fit. 2 = Employment specialists have the same supervisor but do not meet as a group. 3 = Employment specialists have the same supervisor and discuss cases between each other. They do not provide services for each other's cases. 4 = Employment specialists form a vocational unit and discuss cases between each other. They provide services for each other's cases. 5 = Employment specialists form a vocational

			unit with group supervision at least weekly. Provide services for each other's cases and backup and support for each other. 9 = Insufficient data to rate.
3.	**No eligibility** requirements such as job readiness, lack of substance abuse, no violent behavior, minimal intellectual functioning, and mild symptoms.	DOC, INT	1 = Clients are screened out on the basis of job readiness, substance use, history of violence, low level of functioning, etc. Referrals first screened by case managers. history of Or Cannot rate due to no fit. 2 = Some eligibility criteria. Screened by vocational staff who make client referrals to other vocational programs. 3 = Some eligibility criteria. Screened by vocational staff of the program that will provide the vocational service. 4 = All adult clients with severe mental disorders are eligible, including dual disorders of substance abuse and mental illness. Services are voluntary. 5 = All clients are encouraged to participate. Referrals solicited by several sources (self-referral, family members, self-help groups, etc.). 9 = Insufficient data to rate.
	Services		
1.	**Ongoing, work-based vocational assessment:** Vocational assessment is an ongoing process based on work experiences in competitive jobs.	DOC, INT	1 = Vocational evaluation is conducted prior to job placement with emphasis on office-based assessments, standardized tests, intelligence tests, work samples. Or Cannot rate due to no fit. 2 = Client participates in a prevocational assessment at the program site (e.g. work units in a day program). 3 = Assessment occurs in a sheltered setting where clients carry out work for pay. 4 = Most of the assessment is based on brief, temporary job experiences in the community that are set up with the employer. 5 = Vocational assessment is ongoing. Occurs in community jobs rather than through a battery of tests. Minimal testing may occur but not as a prerequisite to the job search. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. 9 = Insufficient data to rate.

2.	**Rapid search for competitive job:** The search for competitive jobs occurs rapidly after program entry.	DOC, INT, ISP	1 = First contact with an employer about a competitive job is typically more than one year after program entry. Or Cannot rate due to no fit. 2 = First contact with an employer about a competitive job is typically at more than nine months and within one year after program entry. 3 = First contact with an employer about a competitive job is typically at more than six months and within nine months after program entry. 4 = First contact with an employer about a competitive job is typically at more than one month and within six months after program entry. 5 = First contact with an employer about a competitive job is typically within one month after program entry. 9 = Insufficient data to rate.
3.	**Individualized job search:** Employer contacts are based on clients' job preferences (relating to what they enjoy and their personal goals) and needs (including experience, ability, symptomatology, and health, etc., and how they affect a good job and setting match) rather than the job market (i.e., what jobs are readily available).	DOC, INT, ISP	1 = Employer contacts are based on decisions made unilaterally by the employment specialist. These decisions are usually driven by the nature of the job market. Or Cannot rate due to no fit. 2 = About 25% employer contacts are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 3 = About 50% employer contacts are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 4 = About 75% employer contacts are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 5 = Most employer contacts are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 9 = Insufficient data to rate.
4.	**Diversity of jobs developed:** Employment specialists provide job options that are and are in different settings.	DOC, INT, ISP	1 = Employment specialists provide options for either the same types of jobs for most clients, e.g., janitorial, or jobs at the same diverse work settings most of the time. Or Cannot rate due to no fit. 2 = Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings

			about 75% of the time. 3 = Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings about 50% of the time. 4 = Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings about 25% of the time. 5 = Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings less than 10% time. 9 = Insufficient data to rate.
5.	**Permanence of jobs developed:** Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status, e.g., TEPs.	DOC, INT, ISP	1 = Employment specialists usually do not provide options for permanent, competitive jobs. Or Cannot rate due to no fit. 2 = Employment specialists provide options for permanent, competitive jobs about 25% of the time. 3 = Employment specialists provide options for permanent, competitive jobs about 50% of the time. 4 = Employment specialists provide options for permanent, competitive jobs about 75% of the time. 5 = Virtually all of the competitive jobs offered by employment specialists are permanent. 9 = Insufficient data to rate.
6.	**Jobs as transitions:** All jobs are viewed as positive experiences on the path of vocational growth and development. Employment specialists help clients end jobs when appropriate and then find new jobs.	VL, DOC, INT, ISP	1 = Employment specialists prepare clients for a single lasting job, and if it ends, will not necessarily help them find another one. Or Cannot rate due to no fit. 2 = Employment specialists help clients find another job 25% time. 3 = Employment specialists help clients find another job 50% time. 4 = Employment specialists help clients find another job 75% time. 5 = Employment specialists help clients end jobs when appropriate and offer to help them all find another job. 9 = Insufficient data to rate.
7.	**Follow-along supports:** Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job	VL, DOC, INT	1 = Follow-along supports are nonexistent. Or Cannot rate due to no fit. 2 = Follow-along supports are time-limited and provided to less than half of the working clients.

	coaching, job counseling, job support groups, transportation, treatment changes (medication), networked supports (friends/family).		3 = Follow-along supports are time-limited and provided to most working clients. 4 = Follow-along supports are ongoing and provided to less than half the working clients. 5 = Most working clients are provided flexible follow-along supports that are individualized and ongoing. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), networked supports (friends/family). 9 = Insufficient data to rate.
8.	**Community-based services:** Vocational services such as engagement, job finding and follow-along supports are provided in natural community settings.	VL, MIC, DOC, INT	1 = Employment specialist spends 10% time or less in the community. Or Cannot rate due to no fit. 2 = Employment specialist spends 11-39% time in community. 3 = Employment specialist spends 40-59% time in community. 4 = Employment specialist spends 60-69% time in community. 5 = Employment specialist spends 70% or more time in community. 9 = Insufficient data to rate.
9.	**Assertive engagement and outreach:** assertive engagement and outreach (telephone, mail, community visit) are conducted as needed.	VL, MIC, DOC, INT	1 = Employment specialists do not provide outreach to clients as part of initial engagement or to those who stop attending the vocational service. Or Cannot rate due to no fit. 2 = Employment specialists make one telephone or mail contact to clients as part of initial engagement or to those who stop attending the vocational service. 3 = Employment specialist makes one or two outreach attempts (telephone, mail, community visit) as part of initial engagement and also within one month that client stops attending the vocational service. 4 = Employment specialist makes outreach attempts (telephone, mail, community visit) as part of initial engagement and at least every two months on a time limited basis when client stops attending. 5 = Employment specialists provide outreach (telephone, mail, community visit) as part

			of initial engagement and at least monthly on a time unlimited basis when clients stop attending the vocational service. Staff demonstrate tolerance of different levels of readiness using gentle encouragement. 9 = Insufficient data to rate.

**Data sources:

VL Vocational Logs
MIS Management Information System
DOC Document review: clinical records; agency policy and procedures
INT Interviews with clients, employment specialists, mental health staff ISP Individualized Service Plan

Fidelity Scale Score Sheet

Rater: _____ **Site:** _____ **Date:** _____

Staffing

1. Caseload _____
2. Vocational services staff _____
3. Vocational generalists _____

Organization

1. Integration of rehab. with MH treatment _____
2. Vocational unit _____
3. Zero exclusion criteria _____

Services

1. On-going, work-based assessment _____
2. Rapid search for competitive job _____
3. Individualized job search _____
3. Individualized job search _____
4. Diversity of jobs developed _____
5. Permanence of jobs developed _____
6. Jobs as transitions _____
7. Follow-along supports _____
8. Community-based services _____
9. Assertive engagement and outreach _____

Total: _____

Items Not Rated Due To Insufficient Data: _____

66-75 = Good Supported Employment Implementation

56-65 = Fair Supported Employment Implementation

55 and below Not Supported Employment

Program Descriptors

Agency name: _____

Location: _____**urban** _____**rural**

Targeted population: specify
_____

Parent organization type:

____mental health center
____rehabilitation agency (SMI only)
____rehabilitation agency (other)
____N/A - free standing agency

VR contact:
____none
____minimal
____regular

Agency's vocational emphasis:
____minimal
____moderate
____major

Number of vocational staff: _____

Number of clients served last year: _____

Recency of program:
_____ less than one year
_____ more than one year

*The New York State Office of Mental Health

Family Psychoeducation Fidelity Scale*

	1	2	3	4	5
1. Family Intervention Coordinator. One clinical administrator is designated as overseer of the family psychoeducation program for a substantial portion of his/her job (time depends on size of program). This person's role should include activities such as setting up FPE services, removing barriers to implementation, overseeing training and supervision, including family members in planning and oversight activities, linking with NAMI.	Agency does not have a designated position	Agency has a designated position who performs 1 of the tasks	Agency has a designated position who performs 2 or 3 of the tasks	Agency has a designated position who performs 4 or 5 of the tasks	Agency has a designated position who performs all tasks
2. Session Frequency for Family Psychoeducation	< 3 months	Every 3 months	Every 2 months	Monthly	At least twice a month
3. Long-Term FPE	Most families receive at less than 6 months of FPE sessions	Most families receive between 6-7 months of FPE sessions	Most families receive between 7-8 months	Most families receive between 8-9 months of FPE sessions	Excluding dropouts, >90% families receive at least 9 months of FPE sessions
4. Quality of Practitioner-Family Alliance. In individual or group sessions (approximately three sessions), the practitioner engages family members and consumer with warmth, empathy, acceptance and attention to each individual's needs and desires.	Sources consistently indicate poor practitioner-family alliance (e.g., all members of family and consumer decline services or drop-out)	Sources indicate that practitioner-family-consumer alliance often poor.	Sources indicate alliance is inconsistent or barely adequate, or information is inconsistent	Sources indicate a fairly strong practitioner-family-consumer alliance.	Sources consistently indicate a strong practitioner-family-consumer alliance
5. Detailed Family Reaction. In single-family Joining sessions, the clinician(s) identify and specify the family's reaction to their relative's mental illness.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
6. Precipitating Factors. In single-family Joining sessions, the clinician(s) identify and specify precipitating factors to their	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families,

relative's mental illness.					corroborated by coordinator, supervisor, clinicians, and families.
7. Prodromal Signs. In single-family Joining sessions, the clinician(s) help families to identify and specify prodromal signs and symptoms of their relative's mental illness.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
8. Coping Strategies. In single-family Joining sessions, the clinician(s) help to identify, describe, clarify, and teach coping strategies that are used by families.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
9. Educational Curriculum. In individual or group sessions, the clinician(s) use a standardized curriculum to teach families about mental illness. The curriculum covers at least six topics: psychobiology, diagnosis, treatment and rehabilitation, reactions to experiencing psychosis as a family, relapse prevention, and family guidelines.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
10. Multimedia Education. Educational materials on illness, treatment, and guidelines are provided with choices in several formats (e.g., written, video, web sites).	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
11. Structured Sessions. Multiple- or single-family sessions follow a structured procedure that includes socialization, go-round, response to each family, problem solving, and socialization.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor,

					clinicians, and families.
12. Structured Problem-Solving Techniques. In individual or group sessions, the clinician(s) use a standardized approach (identify the problem, define the problem for one patient/family, generate >7 solutions, review pros and cons, select a solution, develop specific and individualized tasks and plans) to help families with problem-solving.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.

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Illness Management and Recovery Fidelity Scale*

	1	2	3	4	5
1. # People in a Session or Group: IMR is taught individually or in groups of 8 or less consumers.	Some sessions taught with over 15 consumers	Some sessions taught with 13-15 consumers	Some sessions taught with 11 or 12 consumers	Some sessions taught with 9 or 10 consumers	All IMR sessions taught individually or in groups of 8 or less
2. Program Length: Consumers receive at least 3 months of weekly IMR sessions or equivalent (e.g., biweekly for at least 6 months).	<20% of IMR clients receive at least 3 months of weekly sessions	20%-39% of IMR clients receive at least 3 months of weekly sessions	40%-69% of IMR clients receive at least 3 months of weekly sessions	70%-89% of IMR clients receive at least 3 months of weekly sessions	•90% of IMR clients receive at least 3 months of weekly sessions
3. Comprehensiveness of the Curriculum: • Recovery strategies • Mental illness facts • Stress-vulnerability model • Social support • Using medication • Preventing relapse • Stress management • Coping symptoms • Mental health system	Curriculum materials include only 1 topic, or educational handouts are not available	Curriculum materials include 2 or 3 topic areas	Curriculum materials include 4 or 5 topic areas	Curriculum materials include 6or 7 topic areas	Curriculum materials include 8 or 9 topic areas
4. Provision of Educational Handouts: All consumers participating in IMR receive IMR handouts.	<20% of IMR clients receive educational handouts	20%-39% of IMR clients receive educational handouts	40%-69% of IMR clients receive educational handouts	70%-89% of IMR clients receive educational handouts	•90% of IMR clients receive educational handouts
5. Involvement of Significant Others: At least one IMR-related contact in the last month OR involvement with the consumer in pursuit of goals (e.g., assisting with homework assignments).	<20% of IMR clients have significant other(s) involved	20%-29% of IMR clients have significant other(s) involved	30%-39% of IMR clients have significant other(s) involved	40-49% of IMR clients have significant other(s) involved	•50% of IMR clients have significant other(s) involved
6. IMR Goal Setting • Realistic and measurable • Individualized • Pertinent to recovery process • Linked to IMR plan	<20% of IMR clients have at least 1 personal goal in chart	20%-39% of IMR clients have at least 1 personal goal in chart	40%-69% of IMR clients have at least 1 personal goal in chart	70%-89% of IMR clients have at least 1 personal goal in chart	•90% of IMR clients have at least 1 personal goal in their chart
7. IMR Goal Follow-up: Practitioners and consumers collaboratively follow up on goal(s) (See examples in the IMR	<20% of IMR clients have follow-up on goal(s) documented in	20%-39% of IMR clients have follow-up on goal(s) documented in	40%-69% of IMR clients have follow-up on goal(s) documented in	70%-89% of IMR clients have follow-up on goal(s) documented in	70%-89% of IMR clients have follow-up on goal(s) documented in

Practitioner Workbook)	chart	chart	chart	chart	chart
8. Motivation-Based Strategies: • New info & skills • Positive perspectives • Pros & cons of change • Hope & self-efficacy	<20% of IMR sessions use at least 1 motivation-based strategy	20-39% of IMR sessions use at least 1 motivation-based strategy	30-39% of IMR sessions use at least 1 motivation-based strategy	40-49% of IMR sessions use at least 1 motivation-based strategy	•50% of IMR sessions use at least 1 motivation-based strategy
9. Educational Techniques: • Interactive teaching • Checking for understanding • Breaking down info • Reviewing info	<20% of IMR sessions use at least 1 educational technique	20%-39% of IMR sessions use at least 1 educational technique	30%-39% of IMR sessions use at least 1 educational technique	40%-49% of IMR sessions use at least 1 educational technique	•50% of IMR sessions use at least 1 educational technique
10. Cognitive-Behavioral Techniques: • Reinforcement • Shaping • Modeling • Role playing • Cognitive restructuring • Relaxation training	<20% of IMR sessions use at least 1 cognitive-behavioral technique	20%-39% of IMR sessions use at least 1 cognitive-behavioral technique	30%-39% of IMR sessions use at least 1 cognitive-behavioral technique	40%-49% of IMR sessions use at least 1 cognitive-behavioral technique	•50% of IMR sessions use at least 1 cognitive-behavioral technique
11. Coping Skills Training: • Review current coping • Amplify current coping or develop new coping skills • Behavioral rehearsal • Review effectiveness • Modify as necessary	Few or none of the practitioners are familiar with the principles of coping skills training	Some of the practitioners are familiar with the principles of coping skills training, with a low level of use	Some of the practitioners are familiar with the principles of coping skills training, with a moderate level of use	The majority of the practitioners are familiar with the principles of coping skills training and use it regularly	All practitioners are familiar with the principles of coping skills training and use it regularly
12. Relapse Prevention Training: • Identify triggers • Identify early warning signs • Stress management • Ongoing monitoring • Rapid intervention as needed	Few or none of the practitioners are familiar with the principles of relapse prevention training	Some of the practitioners are familiar with the principles of relapse prevention training, with a low level of use	Some of the practitioners are familiar with the principles of relapse prevention training, with a moderate level of use	The majority of the practitioners are familiar with the principles of relapse prevention training and use it regularly	All practitioners are familiar with the principles of relapse prevention training and use it regularly

What is Rated

The scale is rated on current behavior and activities, not planned or intended behavior. For example, in order to get full credit for Item 3 (“Comprehensiveness of Curriculum”), it is not enough that the program is currently developing a curriculum.

How the Rating Is Done

The fidelity assessment is conducted through a site visit. It requires a minimum of 4 hours to complete, although a longer period of assessment will offer more opportunity to collect information and hence should result in a more valid assessment. The data collection procedures include chart review, review of educational handouts, and semi-structured interviews with the IMR program leader,

IMR practitioners, and IMR consumers. When feasible, fidelity assessors should observe one or more IMR sessions (either live or a videotaped session).

The IMR fidelity assessment is primarily based on documentation in progress notes. Consequently, if these notes do not exist or are not easily available, the fidelity assessment will take a very different course. The goal is to examine the charts and 5 most recent progress notes of IMR sessions for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. If a practitioner has fewer than 5 IMR consumers, then use the charts and progress notes for all IMR consumers for that practitioner. If the site has more than 3 IMR practitioners, then the program leader should select 3 IMR practitioners for review. The fidelity assessors should aim to interview at least 3 consumers (one each per practitioner) for whom progress notes available.

The ideal is that the consumers chosen for review are randomly selected. It is also possible that the progress notes will not be integrated into the consumer charts (although this is optimal). In any situation, both the charts and the progress notes should be reviewed.

Who Does the Ratings

Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, interviewers need to have an understanding of the nature and critical ingredients of IMR. We strongly recommend that all fidelity assessments be conducted by at least two assessors.

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Integrated Dual Disorders Treatment Fidelity Scale*

	1	2	3	4	5
1a. Multidisciplinary Team: Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team	< 20% of clients receive care from multidisciplinary team (i.e., most care follows a brokered CM or traditional outpatient approach)	21% - 40% of clients receive care from a multidisciplinary team	41% - 60% of clients receive care from a multidisciplinary team	61% -79% of clients receive care from a multidisciplinary team	≥80% of clients receive care from a fully multidisciplinary team with a strong emphasis on accessing a broad range of services and excellent communication between all disciplines
1b. Integrated Substance Abuse Specialist: Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT	No substance abuse specialist connected with agency	IDDT clients are referred to a separate substance abuse department within the agency (e.g., referred to drug and alcohol staff)	Substance abuse specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	Substance abuse specialist is assigned to the team, but is not fully integrated; attends some meetings; may be involved in treatment planning but not systematically	Substance abuse specialist is a fully integrated member of the treatment team; attends all team meetings; involved in treatment planning for IDDT clients; models IDDT skills and trains other staff in IDDT
2. Stage-Wise Interventions: Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)	≤20% of interventions are consistent with client's stage of recovery	21%- 40% of interventions are consistent	41%- 60% of interventions are consistent	61% - 79% of interventions are consistent	≥80% of interventions are consistent with client's stage of recovery
3. Access for IDDT Clients to Comprehensive DD Services • Residential services • Supported employment • Family psychoeducation • Illness management • ACT or ICM	Less than 2 services are provided by the service provider that IDDT clients can access	2 services are provided by the service provider and IDDT clients have genuine access to these services	3 services are provided by the service provider and IDDT clients have genuine access to these services	4 services are provided by the service provider and IDDT clients have genuine access to these services	All 5 services are provided by the service provider and IDDT clients have genuine access to these services
4. Time-Unlimited Services • Substance abuse counseling • Residential services • Supported	≤20% of available services are provided on a time-unlimited basis (e.g., clients are closed out of most services after a defined period of time)	21%- 40% of available services are provided on a time-unlimited basis	41%- 60% of available services are provided on a time-unlimited basis	61%- 79% of available services are provided on a time-unlimited basis	≥80% of available services are provided on a time-unlimited basis with intensity modified according to each client's needs

employment • Family psychoeducation • Illness management • ACT or ICM					
5. Outreach: Program demonstrates consistently well-thought-out strategies and uses outreach to community whenever appropriate: • Housing assistance • Medical care • Crisis management • Legal aid	Program is passive in recruitment and re-engagement; almost never uses outreach mechanisms	Program makes initial attempts to engage but generally focuses efforts on most motivated clients	Program attempts outreach mechanisms only as convenient	Program usually has plan for engagement and uses most of the outreach mechanisms that are available	Program demonstrates consistently well-thought-out strategies and uses outreach whenever appropriate
6. Motivational Interventions: Clinicians who treat IDDT clients use strategies such as: • Express empathy • Develop discrepancy between goals and continued use • Avoid argumentation • Roll with resistance • Instill self-efficacy and hope	Clinicians providing IDDT treatment do not understand motivational interventions and ≤20% of interactions with clients are based on motivational approaches	Some clinicians providing IDDT treatment understand motivational interventions and 21%-40% of interactions with clients are based on motivational approaches	Most clinicians providing IDDT treatment understand motivational interventions and 41%-60% of interactions with clients are based on motivational approaches	All clinicians providing IDDT treatment understand motivational interventions and 61%-79% of interactions with clients are based on motivational approaches	All clinicians providing IDDT treatment understand motivational interventions and ≥80% of interactions with clients are based on motivational approaches
7. Substance Abuse Counseling: Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse counseling that include: • Teaching how to manage cues to use and consequences to	Clinicians providing IDDT treatment do not understand basic substance abuse counseling principles and ≤20% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	Some clinicians providing IDDT treatment understand basic substance abuse counseling principles and 21%- 40% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	Most clinicians providing IDDT treatment understand basic substance abuse counseling principles and 41%- 60% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	All clinicians providing IDDT treatment understand basic substance abuse counseling principles and 61% - 79% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	All clinicians providing IDDT treatment understand basic substance abuse counseling principles and ≥80% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling

use • Teaching relapse prevention strategies • Drug and alcohol refusal skills training • Problem-solving skills training to avoid high-risk situations • Challenging clients' beliefs about substance abuse • Coping skills and social skills training					
8. Group DD Treatment: DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems	<20% of DD clients regularly attend a DD group	20% - 34% of DD clients regularly attend a DD group	35% - 49% of DD clients regularly attend a DD group	50% - 65% of DD clients regularly attend a DD group	>65% of DD clients regularly attend a DD group
9. Family Psychoeducation on DD: Clinicians provide family members (or significant others): • Education about DD • Coping skills training • Collaboration with the treatment team • Support	<20% of families (or significant others) receive family psychoeducation on DD	20% - 34% of families (or significant others) receive family psychoeducation on DD	35% - 49% of families (or significant others) receive family psychoeducation on DD	50% - 65% of families (or significant others) receive family psychoeducation on DD	>65% of families (or significant others) receive family psychoeducation on DD
10. Participation in Alcohol & Drug Self-Help Groups: Clients in the *action* stage or *relapse prevention* stage attend self-help programs in the community	<20% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	20% - 34% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	35% - 49% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	50% - 65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	>65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community
11. Pharmacological Treatment: Prescribers for IDDT clients: • Prescribe psychiatric	Prescribers have virtually no contact with treatment team and make no apparent efforts to	Approximately 2 of 5 strategies used, e.g., prescribers have minimal contact with treatment	Approximately 3 of 5 strategies used, e.g., there is little evidence that prescribers function	4 of 5 strategies used, e.g., prescribers typically receive some minimal input from IDDT team to	Evidence that all 5 strategies used; prescribers receive pertinent input from the treatment team regarding

medications despite active substance use • Work closely with team/client • Focus on increasing adherence • Avoid benzodiazepines and other addictive substances • Use clozapine, naltrexone, disulfiram	increase adherence OR prescribers require abstinence prior to prescribing psychiatric medications	team; no apparent efforts to increase adherence or to decrease substance use via pharmacological management	with team/client input, but there is evidence that prescribers make efforts to increase adherence and reduce substance use	maximize adherence; there is evidence that prescribers make efforts to decrease addictive meds and increase use of meds that help reduce addictive behavior	medication decisions and strategies to maximize adherence. No prohibitions on antipsychotic use due to substance use; offers medications known to be effective for decreasing substance use
12. Interventions to Promote Health: Examples include: • Teaching how to avoid infectious diseases • Helping clients avoid high-risk situations and victimization • Securing safe housing Encouraging clients to pursue work, medical care, diet, & exercise	Staff offer no form of services to promote health	No structured program, staff may have some knowledge of reducing negative consequences of substance abuse but use concepts rarely	Less than half of all DD clients receive services to promote health; clinicians providing IDDT treatment use concepts unsystematically	50%- 79% of clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences	≥80% of clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences
13. Secondary Interventions for Substance Abuse Treatment Non-Responders: Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as: • Clozapine, naltrexone, disulfiram • Long-term residential care • Trauma treatment • Intensive family intervention • Intensive monitoring	≤20% of non-responders are evaluated and referred for secondary interventions OR No recognition of a need for secondary interventions for nonresponders	21%- 40% of non-responders are evaluated and referred for secondary interventions OR Secondary interventions, if available, are not systematically offered to nonresponders	Program has protocol and 41%- 60% of non-responders are evaluated and referred for secondary interventions OR No formal method for identifying nonresponders	Program has protocol for identifying nonresponders and 61%- 79% of non-responders are evaluated and referred for secondary interventions	Program has protocol for identifying nonresponders and >80% of non-responders are evaluated and referred for secondary interventions

*SAMHSA IDDT Implementation Resource Kit

Medication Treatment Fidelity Scale: Prescriber Level*

	1	2	3	4	5
P1. Initial Documentation	Complete documentation done for ≤ 10% of patients	Complete documentation done for 11-49% of patients	Complete documentation done for 50-69% of patients	Complete documentation done for 70-89% of patients	Complete documentation done for ≥90% of patients
P2. Treatment of All Conditions	A psycho-pharmacological or other treatment plan is documented for each psychiatric condition for ≤ 10% of patients.	A psycho-pharmacological or other treatment plan is documented for each psychiatric condition for 11-49% of patients.	A psycho-pharmacological or other treatment plan is documented for each psychiatric condition for 50-69% of patients.	A psycho-pharmacological or other treatment plan is documented for each psychiatric condition for 70-89% of patients.	A psycho-pharmacological or other treatment plan is documented for each psychiatric condition for ≥90% of patients.
P3. Simplification of Medication Regimen and Optimization of Medication Burden	Justification for each medication choice or continuation is clearly documented and updated quarterly for ≤ 10% of patients	Justification for each medication choice or continuation is clearly documented and updated quarterly for 11-49% of patients	Justification for each medication choice or continuation is clearly documented and updated quarterly for 50-69% of patients	Justification for each medication choice or continuation is clearly documented and updated quarterly for 70-89% of patients	Justification for each medication choice or continuation is clearly documented and updated quarterly for ≥90% of patients
P4. Documentation of Outcomes	Prescriber documents systematic ratings of target symptom severity at each medication visit ≤ 10% of the time	Prescriber documents systematic ratings of target symptom severity at each medication visit 11-49% of the time	Prescriber documents systematic ratings of target symptom severity at each medication visit 50-69% of the time	Prescriber documents systematic ratings of target symptom severity at each medication visit 70-89% of the time	Prescriber documents systematic ratings of target symptom severity at each medication visit ≥90% of the time
P5. Documentation of Side Effects	Prescriber (or patient, when appropriate) rates severity of side effects and tolerability at each medication visit for ≤ 10% of patients.	Prescriber (or patient, when appropriate) rates severity of side effects and tolerability at each medication visit for 11-49% of patients.	Prescriber (or patient, when appropriate) rates severity of side effects and tolerability at each medication visit for 50-69% of patients.	Prescriber (or patient, when appropriate) rates severity of side effects and tolerability at each medication visit for 70-89% of patients.	Prescriber (or patient, when appropriate) rates severity of side effects and tolerability at each medication visit for ≥90% of patients.
P6. Treatment of Side Effects	Prescriber reviews needs for medication treatment for side effects at least quarterly for ≤ 10% of patients	Prescriber reviews needs for medication treatment for side effects at least quarterly for 11-49% of patients	Prescriber reviews needs for medication treatment for side effects at least quarterly for 50-69% of patients	Prescriber reviews needs for medication treatment for side effects at least quarterly for 70-89% of patients	Prescriber reviews needs for medication treatment for side effects at least quarterly for ≥90% of patients
P7. Treatment Guided by Outcomes	Treatment plan specifies desired outcomes from each medication and a systematic rating method on target outcomes occurs for ≤ 10% of	Treatment plan specifies desired outcomes from each medication and a systematic rating method on target outcomes occurs for 11-49%	Treatment plan specifies desired outcomes from each medication and a systematic rating method on target outcomes occurs for 50-69%	Treatment plan specifies desired outcomes from each medication and a systematic rating method on target outcomes occurs for 70-89%	Treatment plan specifies desired outcomes from each medication and a systematic rating method on target outcomes occurs for ≥90% of

	patients at each medication visit	of patients at each medication visit	of patients at each medication visit	of patients at each medication visit	patients at each medication visit
P8. Rational Sequencing	Initial medication choices consistent with agency (or other recently published) guidelines ≤ 10% of the time. Subsequent medication changes justified ≤ 10% of the time	Initial medication choices consistent with agency (or other recently published) guidelines 11-49% of the time. Subsequent medication changes justified 11-49% of the time	Initial medication choices consistent with agency (or other recently published) guidelines 50-69% of the time. Subsequent medication changes justified 50-69% of the time	Initial medication choices consistent with agency (or other recently published) guidelines 70-89% of the time. Subsequent medication changes justified 70-89% of the time	Initial medication choices consistent with agency (or other recently published) guidelines ≥90% of the time. Subsequent medication changes justified ≥90% of the time
P9. Patient and Family Education	Medication education checklist completed for each medication (or comparative charting) for ≤ 10% of clients	Medication education checklist completed for each medication (or comparative charting) for 11-49% of clients	Medication education checklist completed for each medication (or comparative charting) for 50-69% of clients	Medication education checklist completed for each medication (or comparative charting) for 70-89% of clients	Medication education checklist completed for each medication (or comparative charting) for ≥90% of clients
P10. Patient and Family Involvement in Treatment Planning	Prescriber documents process of shared decision making with patient (and families when appropriate) in treatment planning ≤ 10% of the time	Prescriber documents process of shared decision making with patient (and families when appropriate) in treatment planning 11-49% of the time	Prescriber documents process of shared decision making with patient (and families when appropriate) in treatment planning 50-69% of the time	Prescriber documents process of shared decision making with patient (and families when appropriate) in treatment planning 70-89% of the time	Prescriber documents process of shared decision making with patient (and families when appropriate) in treatment planning ≥90% of the time
P11. Patient Medication Adherence Strategies • Behavioral Tailoring • Motivational Strategy	Medication adherence is evaluated at each visit, and there is evidence of use of at least one evidence-based strategy for promoting medication adherence for ≤10 % of the patients.	Medication adherence is evaluated at each visit, and there is evidence of use of at least one evidence-based strategy for promoting medication adherence for 11-49% of the patients.	Medication adherence is evaluated at each visit, and there is evidence of use of at least one evidence-based strategy for promoting medication adherence for 50-69% of the patients.	Medication adherence is evaluated at each visit, and there is evidence of use of at least one evidence-based strategy for promoting medication adherence for 70-89% of the patients.	Medication adherence is evaluated at each visit, and there is evidence of use of at least one evidence-based strategy for promoting medication adherence for ≥90% of the patients.
P12. Recommended Dose Range	Doses are within recommended ranges (or when dose falls outside the recommended range, prescriber documents rationale for deviation) ≤ 10% of the time	Doses are within recommended ranges (or when dose falls outside the recommended range, prescriber documents rationale for deviation) 11-49% of the time	Doses are within recommended ranges (or when dose falls outside the recommended range, prescriber documents rationale for deviation) 50-69% of the time	Doses are within recommended ranges (or when dose falls outside the recommended range, prescriber documents rationale for deviation) 70-89% of the time	Doses are within recommended ranges (or when dose falls outside the recommended range, prescriber documents rationale for deviation) ≥90% of the time
P13. Duration of	Prescriber	Prescriber	Prescriber	Prescriber	Prescriber

Trial	documents rationale for continuation of any antipsychotic medication administered for 3 months or longer ≤ 10% of the time	documents rationale for continuation of any antipsychotic medication administered for 3 months or longer 11-49% of the time	documents rationale for continuation of any antipsychotic medication administered for 3 months or longer 50-69% of the time	documents rationale for continuation of any antipsychotic medication administered for 3 months or longer 70-89% of the time	documents rationale for continuation of any antipsychotic medication administered for 3 months or longer ≥90% of the time
P14. Treating Refractory Patients	Prescriber monitors anti-psychotic target symptoms and offers clozapine to ≤ 10% refractory patients.	Prescriber monitors anti-psychotic target symptoms and offers clozapine to 11-49% refractory patients.	Prescriber monitors anti-psychotic target symptoms and offers clozapine to 50-69% refractory patients.	Prescriber monitors anti-psychotic target symptoms and offers clozapine to 70-89% refractory patients.	Prescriber monitors anti-psychotic target symptoms and offers clozapine to ≥90% refractory patients.
P15.Treatment Frequency	Patients are seen no more often than every three months, even when medications are being changed.	Patients are seen no more often than every two months, even when medications are being changed.	When primary medications are being changed or when prescriber requests they be seen weekly, patients are seen monthly, and at least every 3 months when stable.	When primary medications are being changed or when prescriber requests they be seen weekly, patients are seen bi-weekly, and at least every 3 months when stable.	When primary medications are being changed or when prescriber requests they be seen weekly, patients are seen weekly, and at least every 3 months when stable.
P16. Attendance in Treatment Team Meetings	Prescriber attends ≤ 10% of scheduled treatment planning meetings	Prescriber attends 11-49% of scheduled treatment planning meetings	Prescriber attends 50-69% of scheduled treatment planning meetings	Prescriber attends 70-89% of scheduled treatment planning meetings	Prescriber attends ≥90% of scheduled treatment planning meetings
P17. Prescriber Updating Knowledge	Prescribers complete less than 34 hrs. of education per year.	Prescribers complete 35-39 hrs. of education per year.	Prescribers complete 40-44 hrs. of education per year.	Prescribers complete 45-49 hrs. of education per year.	Prescribers complete at least 50 hrs. of education per year.

*The New York State Office of Mental Health

Medication Treatment Fidelity Scale: Organization Level*

	1	2	3	4	5
O1. Standardized comprehensive admission form.	Agency has no standardized admission form	Agency has a standardized admission form covering less than 6 areas	Agency has a standardized admission form covering 6-7 areas	Agency has a standardized admission form covering 8-9 areas	Agency has a standardized admission form covering all 10 areas
Aggregated P1: Agency-wide compliance on documentation	< 60% of prescribers score a 3 on P1	60-79% of prescribers score 3 or more on P1	80% or more of prescribers score 3 or more on P1	60-79% of prescribers score 4 or more on P1	80% or more of prescribers score 4 or more on P1
O2. Standardized ongoing documentation form	Agency has no standardized ongoing documentation form	Agency has a standardized ongoing documentation form covering less than 7 areas	Agency has a standardized ongoing documentation form covering 7-8 areas	Agency has a standardized ongoing documentation form covering 9-10 areas	Agency has a standardized ongoing documentation form covering all 11 areas
Aggregated P2: Agency-wide compliance on documentation	< 60% of prescribers score a 3 on P2	60-79% of prescribers score 3 or more on P2	80% or more of prescribers score 3 or more on P2	60-79% of prescribers score 4 or more on P2	80% of more of prescribers score 4 or more on P2
O3. Prescriber access to relevant information at ongoing documentation	<59% of charts are available at time of admission	60-69% of charts are available at time of admission	70-79% of charts are available at time of admission	80-89% of charts are available at time of admission	≥90% of charts are available at time of admission
O4. Prescriber access to relevant information at each visit	<59% of charts are available at time of appointment	60-69% of charts are available at time of appointment	70-79% of charts are available at time of appointment	80-89% of charts are available at time of appointment	≥90% of charts are available at time of appointment
O5. Formulary	Formulary contains one or fewer of the FDA- approved 2nd generation antipsychotics (within 6 mo. of release)	Formulary does not contain clozapine and/or it contains < 50% of the FDA-approved 2nd generation antipsychotics (within 6 mo. of release)	Formulary contains clozapine and 50% of other FDA-approved 2nd generation antipsychotics (within 6 mo. of release)	Formulary contains clozapine and 75% of the FDA-approved 2nd generation antipsychotics (within 6 mo. of release)	Formulary contains clozapine and 100% of other FDA- approved 2nd generation antipsychotics (within 6 mo. of release)
O6. Medication Availability	Severe barriers which are typically insurmountable	Moderate amount of barriers which are difficult to surmount	Minor barriers that present some obstacle, but do not severely slow down medication practice	Minor barriers that do not slow down or change medication practice	No barriers to prescribers in prescribing an indicated medication
O7. Quality Control	No quality improvement system	Quality improvement system meets 1 of the criteria	Quality improvement system meets 2 of the criteria	Quality improvement system meets 3 of the criteria	Agency has system for continuous quality improvement that meets 4 criteria: a) timely (at least

					quarterly). b) comprehensive (includes all prescriber-level standards), c) translated into aggregated statistics, and d) informs policy decisions (corrective actions when deficiencies noted)
O8. Treatment Refractory	Agency has no criteria or process for identifying inadequately responsive patients.	Agency has a system for identifying inadequately responsive patients, but it falls short on all three standards	Agency has a system for identifying inadequately responsive patients, but it fails to satisfy two of the three standards	Agency has a system for identifying inadequately responsive patients, but it fails to fully satisfy one of the three standards (e.g., the review process is annual)	Agency has a system for identifying inadequately responsive patients. The system includes a) specific criteria, b) a regular review process (at least every 6 mo.), and c) a method for informing prescribers.
O9. Patient Education	Agency has no educational materials to distribute	Agency has educational materials, but the client must request them from the prescriber	Agency has educational materials which are distributed to < 70% of patients	Agency has educational materials which are distributed to 70-89% of patients	Agency has educational materials which are distributed to $\geq$ 90% of patients
O10. Agency Medication Guidelines	Agency has no written guidelines	Agency has written guidelines which are reviewed every 3 years or more	Agency has written guidelines which are reviewed every 2-3 years	Agency has written guidelines which are reviewed every 1-2 years	Agency has written guidelines which are reviewed annually
011. Scheduling Flexibility	No prescribers' schedules allot time for unscheduled/urgent visits	Prescribers' schedules have a 30-minute time slot reserved for an unscheduled/urgent visit within 10 work days	Prescribers' schedules have a 30-minute time slot reserved for an unscheduled/urgent visit within 7 work days	Prescribers' schedules have a 30-minute time slot reserved for an unscheduled/urgent visit within 5 work days	Prescribers' schedules have a 30-minute time slot reserved for an unscheduled/urgent visit within 3 work days
O12. Integration of Services	Treatment teams (including prescriber) do not meet on any regular schedule	Treatment teams (including prescriber) have bi-monthly contact for at least 1 hour (face to face or equivalent)	Treatment teams (including prescriber) have monthly contact for at least 1 hour (face to face or equivalent contact)	Treatment teams (including prescriber) have twice monthly contact for at least 1 hour (face to face or equivalent contact)	Treatment teams (including prescriber) have weekly contact for at least 1 hour (face to face or equivalent contact)
O13. Staff	Staff involved in	Staff involved in	Staff involved in	Staff involved in	Staff involved in

Updating (training/retraining)	medication treatment do not meet regularly for ongoing training and supervision	medication treatment meet annually for ongoing training and supervision	medication treatment meet quarterly for ongoing training and supervision	medication treatment meet bi-monthly for ongoing training and supervision	medication treatment meet at least monthly for ongoing training and supervision

*The New York State Office of Mental Health

General Organizational Index (GOI) Scale*

	1	2	3	4	5
G1. Program Philosophy. The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources: ? Program leader ? Senior staff (e.g., executive director, psychiatrist) ? Practitioners providing the EBP ? Clients and/or families receiving EBP ? Written materials (e.g., brochures)	No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy	2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy	3 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one major area of discrepancy	4 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy	All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP
***G2. Eligibility/Client Identification.** All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible clients in a systematic fashion.	= or <20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility	21%-40% of clients receive standardized screening and agency systematically tracks eligibility	41%-60% of clients receive standardized screening and agency systematically tracks eligibility	61%-80% of clients receive standardized screening and agency systematically tracks eligibility	>80% of clients receive standardized screening and agency systematically tracks eligibility
***G3. Penetration.** The maximum number of eligible clients are served by the EBP, as defined by the ratio: # clients receiving EBP # clients eligible for EBP	Ratio = or <.20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80
G4. Assessment. Full standardized assessment of all clients who receive EBP services. Assessment includes history and treatment of medical/psychiatric/ substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.	Assessments are completely absent or completely non-standardized	Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	61%-80% of clients receive standardized, high quality assessments at least annually OR Information is deficient for one or two assessment domains	>80% of clients receive standardized, high quality assessments, the information is comprehensive across all assessment domains, and updated at least annually
G5. Individualized Treatment Plan. For all EBP clients, there is an explicit, individualized treatment plan related to the EBP that is consistent with assessment and updated every 3 months.	= or <20% of clients served by EBP have an explicit individualized treatment plan, related to the EBP, updated every 3 mos.	21%-40% of clients served by EBP have an explicit individualized treatment plan, related to the EBP, updated every 3 mos.	41%-60% of clients served by EBP have an explicit individualized treatment plan, related to the EBP, updated every 3 mos. OR Individualized treatment plan is updated every 6 mos.	61%-80% of clients served by EBP have an explicit individualized treatment plan, related to the EBP, updated every 3 mos.	>80% of clients served by EBP have an explicit individualized treatment plan related to the EBP, updated every 3 mos.

			for all clients		
G6. Individualized Treatment. All EBP clients receive individualized treatment meeting the goals of the EBP.	= or <20% of clients served by EBP receive individualized services meeting the goals of the EBP	21%-40% of clients served by EBP receive individualized services meeting the goals of the EBP	41%-60% of clients served by EBP receive individualized services meeting the goals of the EBP	61% - 80% of clients served by EBP receive individualized services meeting the goals of the EBP	>80% of clients served by EBP receive individualized services meeting the goals of the EBP
G7. Training. All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) within 2 months of hiring. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).	= or <20% of practitioners receive standardized training annually	21%-40% of practitioners receive standardized training annually	41%-60% of practitioners receive standardized training annually	61%-80% of practitioners receive standardized training annually	>80% of practitioners receive standardized training annually
G8. Supervision. EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application to specific client situations.	= or <20% of practitioners receive supervision	21% - 40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis	41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly	61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month	>80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions that explicitly address the EBP model and its application
G9. Process Monitoring. Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators.	No attempt at monitoring process is made	Informal process monitoring is used at least annually	Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 mos.; (3) Used to guide program improvements OR Standardized monitoring done annually only	Process monitoring is deficient on one of these three criteria: (1) Comprehensive and standardized; (2) Completed every 6 months; (3) Used to guide program improvements	Standardized comprehensive process monitoring occurs at least every 6 mos. and is used to guide program improvements
G10. Outcome Monitoring. Supervisors/program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome related to the EBP, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners
G11. Quality Assurance (QA). The agency has a QA Committee or implementation	No review or no committee	QA committee has been formed, but no reviews have been	Explicit QA review occurs less than annually OR	Explicit QA review occurs annually	Explicit review every 6 months by a QA group or

steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.		complete	QA review is superficial		steering committee for the EBP
G12. Client Choice Regarding Service Provision. All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.	Client-centered services are absent (or all EBP decisions are made by staff)	Few sources agree that type and frequency of EBP services reflect client choice	Half sources agree that type and frequency of EBP services reflect client choice	Most sources agree that type and frequency of EBP services reflect client choice OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

*These two items coded based on all clients with SMI at the site or sites where the EBP is being implemented; all other items refer specifically to those receiving the EBP.

_____ Total # clients in target population

_____ Total # clients eligible for EBP

% eligible: _____%

_____ Total # clients receiving EBP

Penetration rate: _____

*SAMHSA Implementation Resource Kits

Appendix C: National Center for Cultural Competence Conceptual Frameworks, Definitions and Guiding Values & Principles

Culture

Culture is an integrated pattern of human behavior, which includes but is not limited to – thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group, the ability to transmit the above to succeeding generations, dynamic in nature.

Cultural Competence

Cultural competence requires that organizations:

- Have a defined se of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve; and
- Incorporate the above into all aspects of policy-making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural continuum.

Linguistic Competence

Linguistic competence is the capacity of an organization and it personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. This may include, but is not limited to, the use of:

- Bilingual/bicultural staff
- Cultural brokers
- Foreign language interpretation services including distance technologies
- Sign language interpretation services including distance technologies
- Multilingual telecommunication systems
- TTY or TDD
- Assertive technology devices
- Computer assisted real-time translation (CART) or viable real-time transcriptions (VRT)
- Print materials in alternative formats (e.g., audiotape, Braille, and enlarged print)
- Varied approaches to share information with individuals who experience cognitive disabilities
- Materials developed and tested for specific cultural, ethnic and linguistic groups
- Translation services including those of:
    - Legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, and applications)
    - Signage
    - Health education materials
    - Public awareness materials and campaigns
- Ethnic media in languages other than English (e.g., television, radio, internet, newspapers, and periodicals)

The organization must have policies, structures, practices, procedures, and dedicated resources to support this capacity.

Guiding Values & Principles

Organizational

- Systems and organizations must sanction, and in some cases mandate the incorporation of cultural knowledge into policy-making infrastructure and practice.
- Cultural competence embraces the principles of equal access and nondiscriminatory practices in service delivery.

Practice & Service design

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals. Children, families, organizations, and communities served.
- Practice is driven in service delivery systems by consumer-preferred choices, not by culturally blind or culturally free intervention.
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

Community Engagement

- Cultural competence extends the concept of elf-determination to the community.
- Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic and advocacy association, local/neighborhood merchants and alliance groups, ethnic, social, and religious organizations, and spiritual leaders and healers).
- Communities determine their won needs.
- Community members are full partners in decision-making.
- Communities should economically benefit from collaboration.
- Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.

Family & Consumers

- Family is defined differently by different cultures.
- Family as defined by each culture is usually the primary system of support and preferred intervention.
- Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.

Adapted from the National Center for Cultural Competence – Georgetown University Center for child and Human Development – April 2004 [http://www.gucchd.georgetown.edu//nccc/]