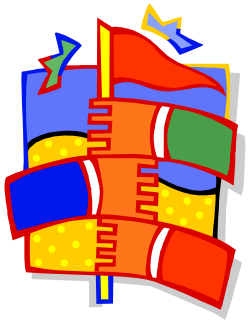
A Literature Review & Resource Guide

for Evidence Based Best and Promising Mental Health Practices

September 2003



The Washington Institute for Mental Illness Research and Training

Washington State University Spokane

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Introduction

Introduction

The following document is a compilation of literature reviews and resource guides for evidence-based mental health practices for specific sub-populations. The Mental Health Division identified the following groups as being particularly vulnerable and in need of best practices.

- children
- American Indian/Alaska Native children
- ethnic minorities
- gay, lesbian, bisexual and transgender individuals
- people with co-occurring mental health and substance disorders, and
- older adults or "geriatric" clients

Increasing demands and limited resources have directed policy makers and service providers to seek more benefit from limited resources. Over the past decade, considerable attention has been given to the identification, implementation and dissemination of evidence based mental health services/practices in an attempt to create programs that are more effective. To date, most of the research and programs have focused on the needs of mainstream and/or adult consumers. Less published information exists for so-called special populations such as children and adolescents, older adults, and ethnic and sexual minorities. Compared to 20 years ago, today there is increasing value placed on outcomes and proven practices. Many of those controlling funds now require outcome evaluation and prefer to fund programs that have evidence of positive outcomes. The terms "evidence based practice", "best practice" and "promising practice" are common in our vocabulary yet the meanings of terms are not consistent across disciplines or within the same field. Funding agents often require providers to use a "best" practice yet few are adequately documented. They are often expensive to operate and they may not fit the population in need. Providers struggle to find appropriate programs, gain the training and recruit staff for these programs. Information on practices is sometimes difficult to find. All these concerns provided impetus to the Washington State Department of Social and Health Services Mental Health Division (MHD) for this project.

The authors and MHD view this document as a starting point for sharing information on best practices. It is our first attempt to summarize the literature on mental health practices for the named population groups. Researchers had only a few months to complete this review. There are far more promising than best practices. Researchers included programs they felt had merit and warranted further study even though hard evidence was lacking. Due to time limitations, each researcher exercised liberty to use their best judgment in deciding to include a practice. We anticipate that there may be debate over some issues and practices identified. We hope that this debate will result in more attention to these population groups and eventually more research on services. Review of the literature for these population groups demonstrate the need for more research that addresses age, sexual orientation and cultural identity and where people of color are included in research design and implementation.

Identifying best and promising practices was a challenge for the researchers. The following general definitions gave a starting point for their research. The definitions were adapted from the Western Regional Center for the Application of Prevention Technologies (www.unr.edu/westcapt).

> *Best Practice are strategies and programs that are deemed research-based by scientists and researchers through a number of organizations, including: the National Institute of Mental Health, National Institute for Drug Abuse (NIDA), American Psychological Association, National Association of Social Workers, the national Center for Substance Abuse Prevention (CSAP), National Center for the Advancement of Prevention (NCAP), National Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the national Department of Education (DOE).*
>
> *Promising Practices are programs that seem effective, but do not have enough outcome data or have not been sufficiently evaluated to be deemed a best practice. Ideally, these programs or strategies have some quantitative data showing positive outcomes over a period, but do not have enough research or replication to support generalized outcomes.*

While a number of evidence (science) based practices exist, few are available for the population groups under study for this document. As expected, each group of individuals has its unique needs, yet certain treatment themes carry across groups. The following desirable characteristics of treatment programs should be considered:

- clearly identifying the target population
- adapting the evidence based practice to the specific population
- the need for understanding the culture of the group
- need for planning, coordination and collaboration among service providers
- need for multi-disciplinary team and cross training
- involvement of natural support system as much as possible

In addition to universal themes, researchers acknowledged that each population group had unique challenges. Below is a summary of the literature review for each population group:

CHILDREN

A federal report by the Joint Commission on Mental Health of Children in 1969 brought nationwide attention to the multiple and complex needs of children in the United States. In the 1980's, a major study documented the extent of these needs across the county. A framework called Systems of Care emerged during this time. Childcare clinicians continue to use the Systems of Care model today. While professionals and the general population have a greater recognition of mental health needs of children, evidence based practices remain scarce and the number of children in need of services is still unknown. Many documented best practices are not applicable to infants and children because they fail to address some of the contextual issues, such as, rapid developmental changes, family dynamics and the array of

service providers serving infants and children. The researchers chose only one *best* and *five* promising practices that seemed appropriate for this document.

AMERICAN INDIAN/ALASKA NATIVE CHILDREN

The authors stress reasons why best practices designed for Caucasian children may not be appropriate for Alaska Native and American Indian children(AN/AI). History and treatment of Native Americans has had multi-generational impact on their mental health. Likewise, each tribe, nation and culture has its own traditions, legions and practices that require consideration in treatment. The authors looked at evidence-based practices superficially adapted to Native children and culturally grounded practices originating from Native Americans. Neither type of program has been scientifically studied nor evaluated. The authors propose some solutions to developing and evaluating treatment models and they provide information on indigenous programs. The chosen programs focus on post-traumatic stress disorder, boarding school trauma, intergenerational transfer of trauma, co-occurring mental health and substance abuse. The authors include indigenous healing practices such as story telling, spirituality, talking circles and other techniques more congruent with the culture.

ETHNIC MINORITIES

Programs for people of color are placed under the term "ethnic minorities" in this document. The individuals comprising each group have unique needs and cultural factors to consider when providing mental health services. Historically, people of color have experienced disparities in the delivery and reception of mental health services. As different ethnic groups increase in prevalence, the need for culturally appropriate services becomes ever more critical. The western medical model sometimes conflicts with holistic and family oriented approaches favored by many ethnic minorities. Furthermore, few persons of color are involved in directing research projects or developing measurement instruments. Thus, findings often do not capture the nuances of the minority groups under study. While there is much indigenous wisdom and many effective treatment programs existing in communities of color, rarely are the programs researched, published or replicated. Thus, few practices, no matter how successful, become "evidence based practices." While there is quite a range of programs listed in the resource guide, they reflect services for several different minority populations.

GAY LESBIAN, BISEXUAL AND TRANSGENDER INDIVIDUALS

A main thrust for professionals working with gay, lesbian, bisexual and transgender individuals has been to separate sexuality from psychiatric diagnosis. Even though research in the 1950's began to demonstrate that homosexuality per se was not a mental disorder, it was not until the late 1980s that homosexuality was removed from the Diagnostic Statistical Manual of Mental Disorders (DSM). Gender identity issues remain in the DSM and sometimes this is of benefit to individuals. The American Psychological Association (APA) has guidelines for psychotherapy and the Harry Benjamin International Gender Dysphoria Association has developed standards of care for Gender Identify disorders. Although the data are scarce, research is emerging to suggest that gay, lesbian and bisexual men and women have specific psychiatric problems at a higher rate than the general population. Stigma and societal oppression are suggested correlates to these problems that include depression,

anxiety and panic disorders and substance abuse. A task force of the APA's Society of Clinical Psychology (Division 12) has supported research-based practices. This resource guide presents endorsed practices.

CO-OCCURRING DISORDERS

While the terms vary, in this document the focus is on services for persons with a dual diagnosis of mental and substance use disorders. Experts in the area argue that the occurrence of dual diagnoses should be expected rather than considered an exception and that both disorders require treatment as the "primary" disorder. In addition, experts who work with co-occurring disorders believe longer-term integrated mental health and substance abuse care is essential to recovery. More professionals are "cross training" in both mental health and substance abuse now. Integrated motivational Interviewing, Cognitive Behavior Therapy, Family Intervention are common treatment techniques. Frequently treatment addresses post-traumatic stress disorder and social phobia. The resource guide contains several promising practice models for the integrated treatment of dual disorders among adults and adolescents.

OLDER ADULTS

Regardless of ethnic or sexual identify, as the US population grows older, many geriatric adults will need mental health care. Often, medical conditions complicate their treatment. Depression, anxiety disorders, Alzheimer's and other dementias are common among the older population. Often, older people fail to get treatment because they do not seek help due to a number of factors such as stigma, memory loss, paranoia, cultural differences and lack of transportation. Service system factors also limit access to mental health services. Many older adults see only primary care providers and they rarely are trained to identify and treat mental disorders. Complicated and limited funding mechanisms create barriers proper care. Facing the lack of evidence based practices the researchers chose to present a range promising practices worth notice. The authors grouped promising and best practices into twelve categories representing a range of program types including outreach, caregivers' support and multi-service programs with a mental health component.

This document reflects our researchers' compilation of the literature on best and promising practices for a wide group of consumers. This document will give the reader an overview of issues affecting different consumer groups and provide a brief summary of mental health treatment programs and services. Also provided is contact information for each program listed in the resource guide so those wishing to learn more about a program can talk to people who have used it before. Clearly, we know that clinicians must be sensitive to language, culture, stigma and trauma regardless of age, color, race or sexual preferences of an individual. Failure to address these issues may hinder the consumers' ability to receive the care they need. In addition, we know that more population specific research is needed to provide the evidence needed for best practice declaration... Researchers need to develop culturally appropriate instruments and methods to evaluate these programs.

The website for the Eastern Branch of the Washington Institute for Mental Illness: Research and Training's (WIMIRT) contains the entire collection of literature reviews and resource guides for each sub-population reviewed for this document. Readers will be able to access

this website and down load sections at http://www.spokane.wsu.edu/research&service/WIMIRT/. A brief summary of each identified best and promising practice will be listed on the State Mental Health Division's website (http://www1.dshs.wa.gov/Mentalhealth/.

We at the Washington Institute hope that this document will be a valuable resource for educating interested parties on key issues and services for these at-risk populations. Moreover, we hope that the identified best and promising practices will help guide more effective service delivery. It has been a pleasure to work with the researchers on this document. We also appreciate the opportunity to do this work with the State Mental Health Division.

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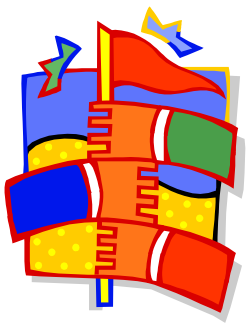
Children's Mental Health



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A Review of the Literature

The congressional Joint Commission on the Mental Health of Children (1969) made the first major national statement of the problem of unmet mental health needs in children. The Joint Commission reported that many children of all ages suffered from significant mental health problems but were either unable to adequately access services or were served in excessively restrictive settings. Critically, the Joint Commission also emphasized that many children have complex needs that would require a coordinated response across multiple systems in the health and social service sectors (Lourie, 2003).

Nevertheless, children's mental health treatment as a field of study received scant attention in the professional literature prior to the early 1980s and even less attention in the practice field. In the landmark study of children's mental health, *Unclaimed Children*, Knitzer and Olson (1982) reported some three million US children had significant mental health needs and two-thirds either received no or inappropriate services; further, fewer than half the states had even one mental health professional devoted to serving children (Duchnowski, Kutash, & Friedman, 2002; Knitzer & Olson, 1982; Lourie, 2003). This study significantly raised public awareness and concern regarding children's mental health, and contributed to a significant increase in national attention from researchers and policymakers alike. Subsequently, the advent of the Children and Adolescent Service System Project (CASSP) movement in 1984 gave rise to the system of care concept (SOC) (Duchnowski, et al., 2002; Neill, 1997; Stroul, 1996; Lourie, Stroul, & Friedman, 1998) and the development of the first national effort to create a system of care around children with mental health needs. To a great degree, system of care principles forms the framework in which the development of public mental response to children is defined.

SYSTEMS OF CARE

A consensus description of the key elements of a 'system of care' developed from the CASSP efforts and serves as a guide for most current policies and programs addressing complex needs in children. Rather than prescribing the specific components of care that had to be in place, system of care describes a set of core values and principles that are recommended to guide communities' and providers' efforts (Lourie, Stroul & Friedman, 1998; Neill, 1997; Stroul, 1996; Stroul & Friedman, 1996).

Systems of care concepts define a model for what good services should look like but not what the services should be. Grounded in clinical experience and a democratic humanistic philosophy, public agencies[1] and providers adopted systems of care standards as a 'best

[1] For example, the mission statement of SAMSHA's Child Adolescent and Family Branch is, "Systems of care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around these principles: child-centered, family-driven, strength-based, and culturally competent with interagency collaboration. The Child, Adolescent and Family Branch embraces and promotes these core principles of systems of care." http://www.mentalhealth.org/cmhs/ChildrensCampaign/default.asp

practice' guide in the absence of an empirically validated service and outcome literature. The system of care concept purports a philosophy built on three core values:

1. The inclusion of families in planning services for their children.
2. Integration of cultural competence into children's services.
3. The encouragement of cross-system efforts to meet the range of needs experienced in children.

The model additionally asserts ten guiding principles:

1. Seriously, Emotionally Disturbed (SED) children should have access to services that address their individual physical, emotional, social, and educational needs.
2. Each child should receive individualized services.
3. Services should be the least restrictive available.
4. Family's participation in service planning and delivery is vital.
5. Services should be integrated and coordinated between child-serving agencies.
6. Case management is fundamental to service coordination and integration of services.
7. The system of care should promote early identification to maximize the likelihood of positive outcomes.
8. The system of care should plan for a smooth transition to the adult system if necessary.
9. The rights of SED children should be protected.
10. Children with emotional disturbance should receive services regardless of gender, ethnicity, race, income status, etc. (Paster, 1997; Stroul, 1996; Lourie, Stroul & Friedman, 1998; Winters & Pumariega, 2001).

STRUCTURAL STRATEGIES TO IMPLEMENT SYSTEMS OF CARE SERVICES

In response to the evidence of major gaps in mental health services to children, the federal government in 1984 funded the Child and Adolescent Service System Program (CASSP) to encourage and fund states to develop systems of care for children with severe mental health problems. In this broader effort, the creation of the Child and Adolescent Service System Program (CASSP) is significant because CASSP became the vehicle and organizing force for the federal policy initiative to encourage states to develop policy, cross-system coordination, and local infrastructure in the provision of mental health services to children and adolescents. To this end, a series of federal, state, and private foundation efforts invested in SOC, which included technical assistance to several demonstration projects in independent but complimentary SOC programs in a small number of communities and states. These activities share common approaches in encouraging education, policy development, eligibility and fiscal waivers, and coordination strategies across systems serving children and families

(Lourie, 2003; Lourie, Stroul & Friedman, 1998; Stroul, 1996; Stroul & Friedman, 1996; Winters & Pumariega, 2001).

During the late 1980s and early 1990s, these program principles subsequently were more broadly initiated through the Community Mental Health Services for Children Program, which since 1993 has completed or supports SOC demonstrations in 85 communities. Currently, this work continues through the SAMSHA Center for Mental Health Services in the Planning and System Development Program. SOC principles now are the presumptive "best practice" in public mental health (Lourie, 2003).

In addition to the federal effort, demonstration program investments came from the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, and state-funded demonstrations (e.g., Ventura County California and Kentucky IMPACT). Programs varied in size from single communities to full state programs (Illback, Neill, Call, & Andis, 1993; Lourie, 2003). The early CASSP programs that formed the knowledge base for the broader dissemination of SOC practice shared a focus on changing the structure in which services are provided. Programs focused on coordination of a range of services to meet participant need (including the creation of intermediate level alternative community placement services in some projects), increased planning and coordination across professional systems, reduction of financial barriers to service access, creation of multi-disciplinary teams, and an emphasis on care coordination as a critical professional function. The programs did not address innovation in individual services although arguably the emphasis on multi-disciplinary teams and intensive care coordination around individuals could be called service innovations. All of the programs focused on older children and adolescents and services to children under age 8-10 were rare. Programs addressed a range of problems although most programs shared a common focus on youth who had demonstrated risk or a history of restrictive placements and had needs that cut across multiple systems.

Consistent with SOC values, the demonstration projects were tailored to the community target and did not result in common strategies, common scale in the identified size of the community, or common impact/outcome measures. As a result, it is fair to say that there have been multiple uncontrolled demonstrations of the SOC principles rather than a common body of research studies. Because of the variety of demonstration projects that supported experimentation in the use of SOC principles to structure services, we now have a body of studies that provide evidence of benefit through uncontrolled program evaluations. These studies suggest important implementation lessons in funding, system coordination, and outcome evidence and lessons learned from structural approach to SOC. However, while CASSP-funded and other programs produced several formative evaluation reports that suggested the promise of SOC-inspired programs, the projects were not designed as outcome experiments. CASSP's legacy program, the Comprehensive Community Mental Health Services for Children Program, has committed to more intensive longitudinal follow-ups of children in services in a multi-site repeated measures study including quasi-experimental comparisons with matched communities that were not systematically implementing SOC reforms and services (Center for Mental Health Services, 1999). As of this review in 2003, no outcome results are available from this CMHS cross-site study.

Stroul, McCormack, and Zaro (1996) and Rosenblatt (1998) have provided reviews of the technical reports and small number of peer-reviewed studies (Burchard & Clarke, 1990; Goldman, 1992; Illback, Neill, Call, & Andis, 1993; Jordan & Hernandez, 1990; Lourie, 1992; Rosenblatt & Attkisson, 1997) that comprise the literature on SOC demonstration programs. Two or more programs have contributed evaluation impact results that support the conclusion that SOC practices are associated with the following benefits to participating youth:

1. Reduced use of restrictive placements with particular attention to juvenile justice recidivism and psychiatric inpatient stays.
2. Reduced costs of services primarily associated with the reduction in high-cost restrictive placements.
3. Improved functional and symptom status in participating youth.
4. Improved academic retention and performance.
5. Increased satisfaction with services.

In the last 15 years, multiple demonstration projects evolved with the intention of building the evidence base for the SOC model. 'Integrated services' within the context of SOC-inspired service programs were usually funded as demonstration programs to create the evidence for clinical innovations that challenge our deeply rooted policies of categorical funding and service specialization. As stated above, the shared set of 'systems of care' values and program principles has engendered both broad policy initiatives and specific local service coordination efforts. Within integrated services, we can again distinguish two levels of service delivery effort. Several SOC integrated service programs are efforts to modify the intensity and quality of agency coordination; in these cases, the act of coordination across systems is the distinctive intervention. Other SOC integrated service models have focused on specific clinical techniques that offer distinctive services to families. However, this inclusive use of the 'integrated services' and 'system of care' terms has contributed to confusion about strategies and definition of outcomes. Rosenblatt (1998) has made this point effectively in discussing systems, program, and clinical levels of SOC efforts. In large measure, these specific service and coordination strategies have not significantly informed each other in the existing literature, the system of care movement has not resulted in a standard language and its variable application to levels of thought, and practice has led to ambiguous use of multiple terms.

The demonstration programs of the past 15-20 years have shown that staff in multiple systems can change their practice and act with 'system-ness' to assist high risk children. Across most of the major demonstrations, there have been statistically significant and frequently individually meaningful changes in the lives of very complex children. Changes in cost, quality of access to services, reductions in the level of restriction in care, and functional resources of children are consistent with the intent of the SOC interventions. Families and children like the model of service better and satisfaction with services may be associated with greater participation and as a result greater therapeutic benefit (Rosen, Heckman, Carro, & Burchard, 1994). These are encouraging results but they do not meet the scientific standards

required to identify SOC structural reform interventions as either 'well-established' or 'probably efficacious' according to APA guidelines. The demonstration programs do not provide a standard of evidence to justify the broad adoption of SOC as a model of practice. Currently, it may be appropriate to claim SOC as a conceptual and values-based model for how care should be provided but the tests to date have not permitted a standard of evidence to say that SOC principles can be supported on scientific grounds as best practice.

The Fort Bragg and Start Ohio Studies. The Fort Bragg Study (Bickman, Bryant, & Summerfelt, 1993, 1995; Bickman 1996) has generated more debate and controversy than any other test of the SOC structural approach to practice. The Fort Bragg design is a good reflection of most of the policy elements of SOC that set the structure if not the content of care. In the Fort Bragg community, clinicians and agencies were recruited to provide a range of mental health and support services through a single point of contact agency. Services in the program included a range of services including outpatient psychotherapy, community-based support services (crisis response, home-based counseling, and after-school and day treatment), and more restrictive services for severe problems (specialized group homes, therapeutic homes, and inpatient mental health treatment). Clinicians were assigned families and given freedom to determine the scope and nature of care provided under a cost reimbursement structure with no cost limits. The nature of the interventions and a strategy for integration were not specified and left to the individual decision of the clinician.

Fort Bragg was a quasi-experimental repeated measures study comparing an experimental SOC service program in the Fort Bragg community with existing services in two comparison communities. The Fort Bragg experimental group consisted of 574 children and their families. There were 410 families enrolled across the two comparison communities. Families and children were followed for five years at six-month intervals. The dependent measures included measures of psychological functioning, health status, social functioning, and service satisfaction (Bickman et al., 1993, 1995; Bickman 1996).

The Fort Bragg study findings did not support superior outcomes for children involved in the experimental system of care. Service utilization, quality of service response (duration, speed of access), and service satisfaction all increased in the experimental group. The use of restrictive inpatient services was reduced but children with complex needs were more likely to receive more intensive community services such as therapeutic home care, which negated any cost-savings. Despite these indications of more intensive and flexible services, there were at best marginal increases in the outcomes for children in the experimental group and roughly, an equal number of child level gains were observed to favor the control communities (Bickman et al., 1993, 1995; Bickman 1996).

The Stark County Ohio system of care study (Bickman, Noser, & Summerfelt, 1999) is a companion study to the Fort Bragg research. The Stark County study addressed some of the methodological concerns of the Fort Bragg design. Specifically, the intervention in Stark County described a coordinated effort across providers whereas the Fort Bragg study provided a continuum of services managed by a single principal provider. In a general community sample, children with mental health needs were randomly assigned to a system of care services with professional coordination or families were responsible for finding and

initiating care on their own through the same providers. Experimental families received a higher level of services but again the researchers found no differences in symptom level or functional state 12 months after baseline and found that the cost of services was higher overall for the SOC intervention.

It would be hard to under-estimate the furor Bickman et al.'s findings introduced in the SOC research community. Bickman has argued that the research has demonstrated that system level efforts (changing payment, access, coordination, and range of services) resulted in system level benefits. He has also concluded that these system level indicators of better services are not tied to demonstrable clinical benefits to children and their families. The Fort Bragg/Stark County conclusions challenge the fundamental purpose of systems of care approaches and the proposition that these more intensive, expensive services can be justified by superior outcomes. While SOC values are deeply infused into our thinking about mental health service delivery to children, it appears that broad system strategies are not the solution but rather smaller scale and intensive work to develop specific treatment strategies informed by SOC principles is called for. Several of the best practice strategies identified in this paper (Wraparound, Multisystemic Therapy) reflect the value of using SOC principles to focus on the content and not exclusively the structure of services.

PREVALENCE RATES AND CHARACTERISTICS FOR CHILDREN WITH MENTAL HEALTH DISORDERS

Prevalence Rates

There has been only minimal research regarding the prevalence rates of mental health disorders and characteristics of children needing mental health services. Moreover, there has yet to be a national epidemiological study to document officially the number of children needing mental health services and "Little consensus has been achieved in defining emotional and mental disorders in children" (Duchnowski, et al., 2002, p. 19). Current estimates suggest an estimated 20% of the child and adolescent population suffer from a diagnosable mental health disorder. Within this population, 7-13% of these children suffer from severe emotional disturbance that greatly affects functioning during daily living (Center for Mental Health Services, 1998; Costello et al., 1996a, 1996b; Duchnowski, et al., 2002; Roberts, Attkisson, & Rosenblatt, 1998; Narrow et al., 1998; USDHHS, 1999; USPHS, 2002). Despite the high prevalence rates for psychological disorders and SED in children, annually only 10-20% of SED children receive specialized mental health services (Buckner & Bassuk, 1997; Colpe, 2000; Leaf et al., 1996; US DHHS, 1999). Using the estimate that 7% of children ages 0-18 in the US receive some level of mental health services, 2000 US Census population figures result in an estimated 5,633,000 children in mental health services annually. With 1.2 million children receiving some level of service intervention annually because of child welfare investigations, it is probable that the child welfare system is a principal source of referrals to the mental health system for children in the United States.

Characteristics of Children with a Serious Emotional Disturbance

Perhaps the greatest influence of SOC concepts and program has been in the area of understanding children's mental health within an ecological context in which the presence of risk factors may greatly affect the development of mental health disorders in children. Rutter (1990) suggests that risk factors have a negative and aggregating exponential effect if more

than two or three are present. Studies indicate that children with serious emotional disturbances (SED) share a number of characteristics and common risk factors including:

1. Minority status; socio-emotional and behavioral problems in multiple contexts including school, home, peer relationships, and community.
2. Low-normal to normal intellectual functioning and academic performance.
3. A history of abuse, neglect, and/or witnessing violence at home and in the community.
4. A diagnosis of a mood disorder including conduct disorder and/or oppositional defiance disorder.
5. Significant truancy and school retention difficulties.
6. Adjudication through the juvenile justice system (Duchnowski, et al., 2002; Quinn & Epstein, 1997).

Quinn and Epstein (1997) further found in their studies that few families of SED children were intact and half were single-parent households. In addition, families frequently had contact with the child welfare system, juvenile, and/or family courts; a substantial history of mental illness, substance abuse, and criminality; and numerous contacts with multiple social service agencies for a number of years. Similarly, Dulmus & Rapp-Paglicci (2000) found that children with mental health disorders and SED encounter numerous community and familial risk factors including the aggregating presence of parental marital strife, low socio-economic status, overcrowding in family size relative to living space, paternal criminality, maternal psychiatric disorder (particularly depression), and out-of-home foster care placement.

DEFINING EVIDENCED-BASED PRACTICE (EBP)

There is significant debate and a lack of consensus about what constitutes an 'evidence-based practice' within the field of mental health and children's mental health in particular. According to Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001), "the use of the term 'evidence-based practice' presupposes agreement as to how the evidence was generated, what the evidence means, and how or when the practice can be implemented" (p. 1179). Still several authors and organizations have put forth varying definitions for evidence-based practice. The American Psychological Association's (APA) Task Force on the Promotion and Dissemination of Psychological Procedures (1995) provides standards for the development, testing, and dissemination of empirically based psychotherapies, has established criteria for "well established" or "probably efficacious" practices in mental health, which are described in tables 1 and 2 below.

Table 1 - *American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures Criteria for Well-Established Treatments.*

I. At least two good group design studies, conducted by different investigators, demonstrating efficacy in one or more of the following ways:

   A. Superior to pill or psychological placebo or to another treatment.

   B. Equivalent to an already established treatment in studies with adequate statistical power.

OR

II. A large series of single case design studies demonstrating efficacy. These studies must have:

   A. Used good experimental design and

   B. Compared the intervention to another treatment as in I. A.

Further Criteria for Both I and II:

III. Studies must be conducted with treatment manuals.

IV. Characteristics of the client samples must be clearly specified.

Note: Adapted from Task Force (1995, p. 22)

Table 2 - *American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures Criteria for Probably Efficacious Treatments.*

I. Two studies showing the treatment is more effective than a waiting-list control group.
OR
II. Two studies otherwise meeting the 'well-established treatment' criteria I, III, and IV, but both are conducted by the same investigator
OR
One good study demonstrating effectiveness by these same 'well-established treatment' criteria.
OR
III. At least two good studies demonstrating effectiveness but flawed by heterogeneity of the client samples.
OR
IV. A small series of single case design studies otherwise meeting the well-established treatment criteria II, III, and IV.
Note: Adapted from Task Force (1995, p. 22)

Similarly, the Interdisciplinary Committee on Evidence-Based Youth Mental Health Care (with participation from the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the American Psychological Association) has suggested criteria consistent with the APA definition but is more broadly defined. They suggest that a treatment is an evidence-based practice if it has generated a body of research allowing meta-analyses to support the efficacy of the treatment. Criteria for an evidence-based treatment should include a minimum of two studies using a between-group design of at least 30 participants that are of the same age and receiving the same treatment, or a minimum of two studies using a within-group design or single-case design, or a combination of these designs (Hoagwood, et al., 2001).

However, Hoagwood, et al. (2001) assert that these definitions of evidence-based practice may not be entirely relevant to children. Research studies tend to focus on the efficiency of a treatment and do not address contextual issues unique to the population such as rapid developmental changes, the nature of familial relationships, and the wide-variety of treatment settings that children experience (e.g., school, home, mental health facility). The contrary environmental factors of different venues are likely to affect service delivery for both the clinician and recipient and what constitutes EBP in one setting such as school is not necessary transferable as an EBP to another setting such as home. Hoagwood et al. contend that efficacy is a relative concept as

> *The central problem is that treatments that have been validated in efficacy studies cannot be assumed effective when implemented under routine practice conditions. For example, the use of treatment manuals, special training by clinicians, and continual clinical monitoring to ensure treatment fidelity are characteristics of many research-based interventions but few community-based treatment practices (2001, p. 1186).*

Additionally, controlled studies regarding treatment do not often typically consider the presence and effect nuisance variables such as organizational culture, comorbidity, parental psychopathology and/or substance abuse, and reimbursement structures pose to treatment dissemination and fidelity (Hoagwood et al., 2001; Rogers, 2003).

PROMISING TREATMENT APPROACHES IN CHILDREN'S MENTAL HEALTH

When evaluating 'promising' and 'best' practices in children's mental health, one must do so with the knowledge that there is significant lack of consensus around the origins and factors associated with mental health disorders in children, appropriate treatment modalities, and the meaning of 'evidence-based practice' (Owens, et al., 2002). Because of the emergent nature of the field, to state unequivocally that any intervention is a 'best practice' is presumptuous at best. The scarcity of programs and evaluative research, particularly relating to young children, would indicate that few practices in children's mental health meet the APA guidelines for a probably efficacious treatment let alone a well-established one.

Definitional issues notwithstanding, there has been progress in the development of potentially promising interventions in children's mental health. Of the nearly 300 sources examined to conduct this literature review, six promising practices were identified including the *Diagnostic Classification Of Mental Health and Development Disorder of Infancy and Early Childhood (DC: 0-3),* Parent-Infant Psychotherapy, the Wraparound Process, the Fast Track Project, Functional Family Therapy, and Multisystemic Therapy. Criteria used to determine if a treatment intervention is promising includes its basis in established theory , a well-articulated model of treatment, the capacity for the intervention to address multi-dimensional problems, quality of evaluative research, and the potential to be replicated and/or implemented at the agency level. Currently only one intervention, Multi-Systemic Therapy, meets the APA criteria for a well-established practice. Nevertheless, the interventions described below are innovative in nature and incorporate the spirit and intent of the Systems of Care movement by being strengths- based, acknowledging the centrality of the child and family as partners in the treatment process, providing individualized and culturally appropriate treatment, and recognizing the importance of community-based services to ensure relevance and maximize effectiveness of the intervention for the child.

The DC: 0-3

Prior to the *Diagnostic Classification of Mental Health and Developmental Disorders or Infancy and Early Childhood (DC: 0-3)*, there was no classification system describing the mental health disorders of infancy and early childhood. The purpose of the *DC: 0-3* is to provide a basis from which a clinician and/or researcher may identify, assess, and classify early childhood disorders and to develop appropriate treatment interventions. Based in developmental, psychodynamic, family systems, relationship, and attachment theories, it

seeks to create a common language among clinicians and researchers to better understand the nature of early childhood disorders, and finally, to be an initial framework that serves as a first step in the development of a comprehensive classification system. Its basis is in the psychodynamic and psychoanalytical traditions including developmental, family systems, relationship, and attachment theories. The *DC: 0-3* is a multi-axial categorization system that was designed to compliment the *DSM-IV*, which is focused mainly on adolescents and adults rather than young children. However, unlike the DSM-IV which concentrates on the pathology of the individual, the assessment process of the DC: 0-3 employs a bio/psychosocial and developmental approach by examining the relational context of the child, particularly the primary care-giving dyad. Each axis has equal weight in the diagnostic process that emphasizes the identification of risk factors that contribute to the development of psychopathology, and resilience or protective factors that can help define potential treatment interventions (Eppright, Bradley, & Sanfacon, 1998; Guédeney & Maestro, 2003; Keren, Feldman, Tyano, 2001; Thomas & Guskin, 2001; Zero-to-Three, 1994).

Initial studies addressing the reliability and validity of the *DC: 0-3* are promising albeit significantly limited considering its publication in 1994. Indeed prior to July 2003 with the publishing of a special DC: 0-3 issue of the *Infant Mental Health Journal*, there were only three published studies in the literature. With the publishing of this special issue, twelve clinical studies are available for review but are primarily descriptive and exploratory in nature (Aoki, Zeanah, Heller, & Bakshi, 2002; Cesari, et al., 2003; Cordeiro, Caldeira da Silva, & Goldschmidt, 2003; Emde & Wise, 2003; Guédeney, et al., 2003; Keren, Feldman, & Tyano, 2001; Keren, Feldman, & Tyano, 2003; Luby & Morgan, 2003; Minde & Tidmarsh, 1997; Scheer, Dunitz-Scheer, Schein, & Wilken, 2003; Stafford, Zeanah, Scheeringa, 2003; Stafford, Zeanah, & Scheeringa, 2003; Thomas & Guskin, 2001; Weston, et al., 2003). Nevertheless, the DC: 0-3 is the first manual of its kind that seeks to address and classify disorders of early life and will no doubt be an impetus for further research and development in the field of infant mental health (Zeanah, Boris, Larrieu, 1997).

Parent-Infant Psychotherapy

Developed in the 1980s, parent-infant psychotherapy is based on the premise that caregivers tend to replicate their insecure early childhood attachments and parenting behaviors that they experienced with their own parents. The purpose of parent-infant psychotherapy is to protect the infant-toddler's developing mental health by changing a caregiver's developmentally inappropriate perceptions and care giving behaviors towards their child (Lieberman, 2002; Lieberman, Silverman, & Pawl, 2000; Marvin, Cooper, Hoffman, & Powell, 2002; Weatherston, 2001). Theoretical foundations of parent-infant psychotherapy include relational-support, attachment, inter-subjective, object relations, and self-psychology theories. Using a combination of interpretive and empathic support techniques, clinicians assist caregivers in linking their past experiences with the current behavioral transactions occurring with their infants. Generally, the caregiver and child are present during the treatment sessions but the therapeutic emphasis is towards the parent to assist them in recognizing and integrating previously unresolved histories of past negative experiences to facilitate improvement and development of parenting abilities. Very often, interactive guidance in the form of videotaping the dyad during a play session is used as well. Treatment may last from two to six months with 10-20 sessions (Beebe, 2003; Cordeiro, 1997; Lieberman, 2002; Lieberman, Silverman, & Pawl, 2000; Marvin, Cooper, Hoffman, &

Powell, 2002; McDonough, 1995; McDonough, 2000; Sexson, Glanville, & Kaslow, 2001; Weatherston, 2001).

Outcome evaluation and research are in the earliest stages and somewhat limited as a randomized control design has not yet been employed. Nevertheless, initial trials have demonstrated that improved maternal empathy achieved through therapeutic integration were significantly linked to decreased child avoidant and angry behavior, more secure care giving-child attachment, and improved goal-corrected partnership behavior within the dyad. Current research is focusing on children from Head Start and on those preschoolers who have witnessed domestic violence. (Lieberman, Silverman, & Pawl, 2000; Marvin, Cooper, Hoffman, & Powell, 2002).

Wraparound Services

Wraparound is a philosophy and service process that of all the practices described by this paper most closely resembles the systems of care concept. It purports a philosophy of integrated and collaborative service provision that is child-centered and family focused, community-based versus institutional in nature, and culturally competent. Using a strengths-based approach, the child and caregivers are a vital part of the treatment planning process. To this end, services are highly individualized, tailored, and comprehensive to meet the specific needs of the child and ensure that child continues to reside in their community with their family. This model is particularly effective when a comprehensive plan is necessary to address emotional and behavioral issues in the school, home, and community environments. Service plans are need-based rather than service-based and focus on the needs of the child in several life domains including family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, safety, and others. Since the practice is a "process" versus a "model", service duration is one to three years. (Borduin, Heiblum, Jones, & Grabe, 2000; Burchard, Bruns, & Burchard, 2002; Huffine, 2002; Kendziora, Burns, Osher, Pachhiano, & Meija, 2001; Malysiak, 1997; VanDenBerg & Grealish, 1996; Woolston, 1998).

Structured training materials and studies that document fidelity in training and oversight support the Wraparound Service model. Although fidelity and oversight vary across locations, there are published curricula with common core elements and implementation manuals to guide fidelity. As a result, Wraparound Services may meet one of the qualifying conditions (a treatment manual) to be considered as 'potentially efficacious' or 'well-established' treatment approach (Epstein, et al., 1998; Overstreet, Casel, Saunders, & Armstrong, 2001). Additionally, several quantitative and qualitative studies demonstrated positive outcomes associated with the implementation of wraparound services. Quantitative studies have used pre/post, randomized clinical trials, and quasi-experimental designs. Findings indicate seriously emotionally disturbed children and youth served through wraparound demonstrate improvements in their behavior, academics, and social and familial relationships and are less likely to need out-of-home placements (Burchard, Bruns, & Burchard, 2002; Clark, et al., 1998; Myaard, Crawford, Jackson, & Alessi, 2000; Yoe, Sqantarcangelo, Atkins, & Burchard, 1996).

The Fast Track Model

The Fast Tract Project is a ten-year, school-based prevention and intervention program based on developmental theory that suggests antisocial behavior results from a multitude of determining risk factors such as ineffective parenting, high community crime rates, poverty, and negative peer influences. The primary hypothesis of Fast Track is that by intervening with school-age children to promote and augment protective factors will prevent and/or mitigate the occurrence of antisocial behavior. The intervention thus focuses on effective parenting, promoting pro-social peer contacts, improving communication between school and caregivers, and improving child competencies (Conduct Problems Prevention Group [CPPG], 2002; Fast Track Project Overview, para. 1, n.d.; Hinshaw, 2002; Prinz, 2002). The first intervention phase components include a standard curriculum called PATHS (Providing Alternative Thinking Strategies, Kusche & Greenberg, 1994); parent training groups that target teaching parents behavior management; home visits to assist caregivers in problem-solving, self-efficacy, and life skills management, child social skill training groups; child tutoring if necessary; and child friendship enrichment in the classroom (CPPG, 2002; Prinz, 2002).

Initial three-year outcome trials indicate that fewer children are receiving special education diagnoses a modest to moderate improvement in conduct-related behavior including aggression and disruptiveness at home and at school. The first three cohorts of children from the ten-year longitudinal study are scheduled to conclude the Fast Track intervention in August 2003 (CPPG, 2002; Fast Track Project Overview, para. 4, n.d.; Prinz, 2002).

Functional Family Therapy (FFT)

Functional Family Therapy is a family-based, multi-systemic prevention/intervention treatment model for at-risk youth and adolescents with complex, multidimensional mental health and/or substance abuse issues. Its foundation is established clinical theory, evidence-based treatments, and clinical experience. Using culturally competent practices, FFT is a short-term treatment intervention that seeks to identify and maximize the positive and protective factors within the youth and their family (Bourduin, Heiblum, Jones, & Grabe, 2000; Kashani, Bumby, & Thomas, 1999; Kumpfer, 1999; Sexton & Alexander, 2000; Sexton & Alexander, 2002). The structure of FFT is systematic using a three-stage intervention schema called the "Phase Task Analysis" to provide services which includes the early phase of engagement and motivation, a middle phase of behavior change, and a third phase of treatment generalization. The three-phase process allows the clinician to focus on the specific treatment context but ensures flexibility to accommodate families' changing needs. Assessment occurs throughout the process and is relevant to the specific treatment phase, which follows a set of established precepts set forth in a manual (Sexton & Alexander, 2000; Sexton & Alexander, 2002). Sexton and Alexandria (2000) assert that FFT has demonstrated promising outcomes from 1973 to present. In randomized and non-randomized trials, FFT is more effective at reducing juvenile offender recidivism (Alexander, Robbins, & Sexton, 2000; Alexander et al., cited in Sexton and Alexander, 2000).

Multisystemic Therapy (MST)

Multisystemic therapy (MST) is a family- and community-based treatment model that addresses the mental health needs of children and adolescents. Developed in the 1970s, MST

initially targeted juvenile offenders with antisocial behaviors and mental health issues. Its purpose was to reduce long-term rearrests and out-of-home placement for chronic juvenile offenders. Currently, the target population is children and adolescents who exhibit serious emotional disturbance, anti-social behavior, and mental health and/or substance abuse problems that are at imminent risk for out-of-home placement. The use of MST is indicated for youth with multidimensional issues rather than a single-issue problem. Based on Broffenbrenner's theory of social ecology, MST assumes that the emotional and behavioral problems in children and adolescents are multidimensional and multi-determined, thus these problems are best understood within the context of the child's social environment using a risk and protective factor framework. The model predicates that a child's behavior is influenced by their interaction with their primary social systems including family, peer groups, school, neighborhood, and community. Nine principles (table 3) serve as the basis of MST intervention (Borduin, Heiblum, Jones, & Grabe, 2000; Brown, et al., 1997; Brown, Henggeler, 1997; Henggeler, 2001; Henggeler, Schoenwald, Brondino, & Pickrel, 1999; Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Henggeler, 1999; Henggeler, et al., 1996; Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996; Henggeler, Lee, & Burns, 2002; Henggeler, Schoenwald, Rowland, & Cunningham, 2002; Pickrel & Henggeler, 1996; Rogers, 2003; Schoenwald & Rowland, 2002; Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998).

Of all the promising practices in children's mental health, MST is arguably the only well-established or truly evidenced-based practice that exists within the children's mental health field. MST Services of the MUSC have conducted eight experimental trials and one quasi-experimental trial that were cross-sectional and longitudinal in nature. Outcome effects have been quite strong that demonstrate the efficacy of the MST program for improved family functioning and relationships, decreased adolescent mental health and chemical dependency symptoms, increased adolescent school attendance, decreased re-arrest rates with juvenile offender populations, and out-home-placement rates. Additionally, four studies were recently completed by other community-based providers and universities to determine the efficacy of the model when implemented in a "real-world" location (Borduin, et al., 1995; Brown, Henggeler, 1999; Henggeler, et al., 1996; Henggeler, et al., 1999; Henggeler, et al., 2003; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Henggeler, Pickrel, Brondino, & Crouch, 1996; Henggeler, et al., 2002; Randall, Henggeler, Cunningham, Rowland, & Swenson, 2001; Huey, Henggeler, Brondino, & Pickrel, 2000; Schoenwald, Borduin, & Henggeler, 1998; Schoenwald, Ward, Henggeler, & Rowland, 2000; Rowland, et al., 2000).

Table 3 – *MST Treatment Principles*

American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures Criteria for Well-Established Treatments.

1. The primary purpose of the assessment is to understand the "fit' between the identified problems and their broader systemic context.
2. Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.
3. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions should target sequences of behavior within and between multiple systems that maintain the identified problem.
6. Interventions should be developmentally appropriate and fit the developmental needs of the youth.
7. Interventions should be designed to require daily or weekly effort by family members
8. Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple system contexts (Henggeler, 1999, p. 3).

CONCLUSION

Twenty years after *Unclaimed Children*, significant disparities and barriers affect the quality and capacity of our social service response to children. Currently, no primary mental health system for children exists and service is provided through a highly fragmented process by various sectors including education, child welfare, juvenile justice, health care, pediatric health care, and specialty health care (Owens, et al., 2002). Further, recent national surveys (National Workgroup, 2001) demonstrate that the service access disparity for young children is particularly acute, "…between 5 percent and 7 percent of children used any mental health specialty services in a year. This average rate is similar to the rate among adults, but it obscures the major differences across age groups**.** Only 1 to 2 percent of preschoolers used any services; the average rates increased in older children—6 to 8 percent of children ages 6 to 11, and 8 to 9 percent of adolescents ages 12 to 17." (National Workgroup, 2001; p 34). Diagnostic challenges and the traditional orientation of public systems to adult mental health needs contribute to these service gaps. The lack of evidence-based treatments for children has contributed to reluctance by public systems to adopt services to children and may account in part for the gap between children's need and service access (Lonigan et al, 1998).

Although there have been some promising developments in children's mental health during the last decade there is still significant work to do. The author examined over 300 articles and books for this review. The literature and systems of care concepts typically target children above the age of nine. Specifically, there is far less emphasis and research concerning infants and latency-age children than for adolescents (Knitzer, 1996). Further, to effectively treat children with multidimensional and multi-determined mental health and behavioral problems, the gap between research and practice must be narrowed by altering "business as usual" through the adoption of clearly effective and innovative child-centered, family-focused interventions in which services are delivered in the community or home versus the traditional center-based model. In doing so, there will be "reason to hope in the field of children's mental health" (Burns, 2002, p. 3).

References

Alexander, J. F., Robbins, M. S., & Sexton, T. (2000). Family-based interventions with older, at-risk youth: From promise to proof to practice. *Journal of Primary Prevention, 21*(*2*), 185-205.

Aoki, Y., Zeanah, C. H., Heller, S. S., & Bakshi, S. (2002). Parent-Infant Relationship Global Assessment Scale: A study of its predictive validity. *Psychiatry & Clinical Neurosciences, 56*(*5*), 493-497.

Beebe, B. (2003). Brief mother-infant treatment: Psychoanalytically informed video feedback. *Infant Mental Health Journal, 24*(*1*), 24-52.

Bickman, L. (1996). A continuum of care: More is not always better. *American Psychologist, 51,* 921-933.

Bickman, L., Bryant, D., & Summerfelt, W.T. (1993). *Final report of the quality study of the Fort Bragg evaluation project.* Nashville, TN: Center for Mental Health Policy, Vanderbilt University.

Bickman, L., Guthrie, P.R., Foster, E.M., Lambert, E.W., Summerfelt, W.T., Breda, C.S., and Heflinger, C.A. (1995). *Evaluating managed mental health services: The Fort Bragg Experiment.* New York: Plenum Press.

Bickman, L., Noser, K., & Summerfelt, W. (1999). Long-term effect of a system of care on children and adolescents. *Journal of Behavioral Health Services and Research, 26,* 185-202.

Birch, M. (1999). Psychological issues and infant-parent psychotherapy. In D. B. Kessler & P. Dawson (Eds.), *Failure to thrive and pediatric undernutrition: A transdisciplinary approach* (pp. 395-410). Baltimore, MD: Paul H. Brookes Publishing Co.

Borduin, C. M., Heiblum, N., Jones, M. R., & Grabe, S. A. (2000). Community-based treatments of serious antisocial behavior in adolescents. In W. E. Martin, Jr. & J. L. Swartz-Kulstad (Eds.), *Person-environment Psychology and mental health: Assessment and intervention* (pp. 113-141). Mahwah, NJ: Lawrence Erlbaum Associates.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., & et al. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting & Clinical Psychology, 63*(*4*), 569-578.

Brown, T. L., Henggeler, S. W., Schoenwald, S. K., Brondino, M. J., & Pickrel, S. G. (1999). Multisystemic treatment of substance abusing and dependent juvenile delinquents: Effects on school attendance at post-treatment and 6-month follow-up. *Children's Services: Social Policy, Research, and Practice, 2*(*2*), 81-93.

Brown, T. L., Swenson, C. C., Cunningham, P. B., Henggeler, S. W., Schoenwald, S. K., & Rowland, M. D. (1997). Multisystemic treatment of violent and chronic juvenile offenders: Bridging the gap between research and practice. *Administration & Policy in Mental Health Special Issue: Assertive community treatment, 25*(*2*), 221-238.

Buckner, J. C., & Bassuk, E. L. (1997). Mental disorders and service utilization among youths from homeless and low-income housed families. *Journal of the American Academy of Child and Adolescent Psychiatry, 36* (7), 890-900.

Burchard, J. D., Bruns, E. J., & Burchard, S. N. (2002). The Wraparound approach. In B. J. Burns, & Hoagwood, K. (Ed.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 69-90). New York: Oxford University Press.

Burchard, J.D. & Clarke, R.T. (1990). The role of individualized care in a service delivery system for children and adolescents with severely maladjusted behavior. Journal of *Mental Health Administration, 17*, 48-98.

Burns, B. J. (2002). Reasons for hope for children and families: A perspective and overview. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: evidence-based interventions for severe emotional and behavioral disorders* (pp. 3-15). New York: Oxford University Press.

Burns, B. J., & Hoagwood, K. (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioural disorders*. New York: Oxford University Press.

Burns, B. J., Schoenwald, S. K., Burchard, J. D., Faw, L., & Santos, A. B. (2000). Comprehensive community-based interventions for youth with severe emotional disorders: Multisystemic therapy and the wraparound process. *Journal of Child & Family Studies, 9*(*3*), 283-314.

Center for Mental Health Services. (1998*). Children with serious emotional disturbance; estimation methodology.* Federal Register: July 17, 1998.

Cesari, A., Maestro, S., Cavallaro, C., Chilosi, A., Pecini, C., Pfanner, L., Muratori, F. (2003). Diagnostic boundaries between regulatory and multi-system developmental disorders: A clinical study. *Infant Mental Health Journal, 24*(*4*), 365-377.

Colpe, L. (2000). Estimates of mental and emotional problems, functional impairments, and associated disability outcomes for the U.S. child population in households. In R.W. Manderscheid and M. J. Henderson (Eds.), *Mental Health, United States, 2000.* U.S. DHHS, SAMHSA, Center for Mental Health Services.

Conduct Problems Prevention Group. (2002). Evaluation of the first 3 years of the Fast Track prevention trial with children at high risk for adolescent conduct problems. *Journal of Abnormal Child Psychology, 30 (1),* 19-35.

Cordeiro, M. (1997). Treating infants and mothers in psychic distress: A mental health program for infancy. *Infant Mental Health Journal, 18*(*2*), 145-157.

Cordeiro, M. J., Caldeira da Silva, P., & Goldschmidt, T. (2003). Diagnostic classification: Results from a clinical experience of three years with DC: 0-3. *Infant Mental Health Journal, 24*(*4*), 349-364.

Costello, E. J., Angold, A., Burns, B. J., Erkanli, A., Stangl, D. K. & Tweed, D, L. (1996a). The Great Smoky Mountains study of youth: Functional impairment and serious emotional disturbance. *Archives of General Psychiatry, 53,* 1137-1143.

Costello, E., J., Angold, A., Burns, B. J., Stangle, D. K., Tweed, D. L., Erkanlin, A., & Worthman, C. M. (1996b). The Great Smoky Mountains study of youth: Goals, design, methods, and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry, 53*

Duchnowski, A. J., Kutash, K., & Friedman, R. M. (2002). Community-based interventions in a system of care and outcomes framework. In B.J. Burns and K. Hoagwood (Eds.),

Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders (pp. 16-37). New York: Oxford University Press.

Dulmus, C. N., & Rapp-Paglicci, L. A. (2000). The Prevention of Mental Disorders in Children and Adolescents: Future Research and Public-Policy Recommendations. *Families in Society: The Journal of Contemporary Human Services, 81*(*3*), 294-303.

Emde, R. N., & Wise, B. K. (2003). The cup is half-full: Initial clinical trials of DC: 0-3 and a recommendation for revision. *Infant Mental Health Journal, 24*(*4*), 437-446.

Eppright, T. D., Bradley, S., & Sanfacon, J. A. (1998). The diagnosis of infant psychopathology: Current challenges and recent contributions. *Child Psychiatry & Human Development, 28*(*4*), 213-222.

Epstein, M., Jayanthi, M., McKelvey, J., Frankenberry, E., Hary, R., Potter, K., & Dennis, K. (1998). Reliability of the Wraparound observation form: An instrument to measure the Wraparound Process. *Journal of Child and Family Studies, 7(2),* 161-170.

Epstein, M. H., Kutash, K., & Duchnowski, A. J. (Eds.). (1998). *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices*. Austin, Tex.: PRO-ED.

Fast Track Data Center (n.d.). *Fast Track Data Collection.* Retrieved June 11, 2003, from http://www.Fasttrackproject.org/datacollection.htm.

Fast Track Data Center (n.d.). *Fast Track Project Overview.* Retrieved June 11, 2003, from http://www.Fasttrackproject.org/Fasttrackoverview.htm.

Goldman, S. (1992). Ventura County, California. In B. Stroul, S, Goldman, I. Lourie, J. Katz-Leavy, & C, Zeigler-Dendy. (Eds.). *Profiles of local systems of care for children and adolescents with severe emotional disturbances.* Washington, DC: CASSP Technical Assistance Center, pp. 287-337.

Guedeney, A., & Maestro, S. (2003). Introduction to a special issue: The use of the Diagnostic Classification 0-3. *Infant Mental Health Journal, 24*(*4*), 310-311.

Guédeney, N., Guédeney, A., Rabouam, C. Mintz, A., Danon, G., Huet, M.M., & Jacquemain, F. (2003). The Zero-to-Three diagnostic classification: A contribution to the validation of this classification from a sample of 85 under-threes. *Infant Mental Health Journal, 24*(*4*), 313-336.

Henggeler, S. W. (1999). Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implications. *Child Psychology & Psychiatry Review, 4*(*1*), 2-10.

Henggeler, S. W. (2001). Multisystemic therapy. *Residential Treatment for Children & Youth Special Issue: Innovative mental health interventions for children: Programs that work, 18*(*3*), 75-85.

Henggeler, S. W., Cunningham, P. B., Pickrel, S. G., Schoenwald, S. K., et al. (1996). Multisystemic therapy: An effective violence prevention approach for serious juvenile offenders. *Journal of Adolescence, 19*(*1*), 47-61.

Henggeler, S. W., Lee, T., & Burns, J. A. (2002). What happens after the innovation is identified? *Clinical Psychology: Science & Practice, 9*(*2*), 191-194.

Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & et al. (1993). Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. *Journal of Child & Family Studies, 2*(*4*), 283-293.

Henggeler, S. W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry, 153*(*3*), 427-428.

Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Sheidow, A. J., Ward, D. M., Randall, J., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(*5*), 543-551.

Henggeler, S. W., Rowland, M. D., Pickrel, S. G., Miller, S. L., Cunningham, P. B., Santos, A. B., et al. (1997). Investigating family-based alternatives to institution-based mental health services for youth: Lessons learned from the pilot study of a randomized field trial. *Journal of Clinical Child Psychology, 26*(*3*), 226-233.

Henggeler, S. W., Rowland, M. D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., et al. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(*11*), 1331-1339.

Henggeler, S. W., Schoenwald, S. K., Rowland, M.D., & Cunningham, P.B. (2002). *Serious emotional disturbance in children and adolescents: Multisystemic treatment*. New York: Guilford Publishers, Inc.

Hinshaw, S. P. (2002). Commentary: Prevention/Intervention Trials and Developmental Theory: Commentary on the Fast Track Special Section. *Journal of Abnormal Child Psychology, 30*(*1*), 7.

Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52*(*9*), 1179-1189.

Hoagwood, K., Burns, B. J., & Weisz, J. R. (2002). A profitable conjunction: From science to service in children's mental health. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: evidence-based interventions for severe emotional and behavioral disorders* (pp. 327-338). New York: Oxford University Press.

Huey, S. J., Jr., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting & Clinical Psychology, 68*(*3*), 451-467.

Huffine, C. (2002). Child and adolescent psychiatry: Current trends in the community treatment of seriously emotionally disturbed youths. *Psychiatric Services, 53*(*7*), 809-811.

Illback, R. J., Cobb, C.T., & Joseph Jr., H. M. (Eds.). (1997). *Integrated services for children and families: Opportunities for Psychological Practice.* Washington, DC: American Psychological Association.

Illback, R., Neill, T., Call, J., & Andis, P. (1993). Description and formative evaluation of the Kentucky IMPACT program for children with serious emotional disturbance. *Special Services in the Schools*, 7 (2), 87-109.

Jordan, D.D. & Hernandez, M. (1990). The Ventura planning model: A proposal for mental health reform. *The Journal of Mental Health Administration, 17*, 26-47.

Kashani, J. H., Jones, M. R., Bumby, K. M., & Thomas, L. A. (1999). Youth violence: Psychosocial risk factors, treatment, prevention, and recommendations. *Journal of Emotional & Behavioral Disorders, 7*(*4*), 200-210.

Kendziora, K., Burns, E., Osher, D., Pachhiano, D., & Meija, B. (2001). *Systems of Care: Promising practices in children's mental health, 2001 series, Volume 1*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Keren, M., Feldman, R., & Tyano, S. (2001). Diagnoses and interactive patterns of infants referred to a community-based infant mental health clinic. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(*1*), 27-35.

Keren, M., Feldman, R., Tyano, S. (2003). A five-year Israeli experience with the DC: 0-3 classification system. *Infant Mental Health Journal, 24*(*4*), 337-348.

Knitzer, J., & Olson, L. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, D.C.: Children's Defense Fund.

Knitzer, J. (1996). Meeting the mental health needs of young children and their families. In *Children's mental health: Creating systems of care in a changing society* (pp. 553-572). Baltimore, MD: P.H. Brookes Publishing.

Kusche, C. A. & Greenberg, M. T. (1994) The PATHS Curriculum. Seattle: Developmental Research and Programs.

Kumpfer, K. L. (April 1999). *Strengthening America's families: Exemplary parenting and family strategies for delinquency prevention*. Washington, DC: Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Leaf, P. J., Alergia, M., Cohen, P., Goodman, S. H., Horwitz, S. M., Hoven, C. W., Narrow, W. E., Vaden-Kiernan, M., & Regier, D. (1996). Mental health service use in the community and schools: Results from the four-community MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry, 35 (7),* 889-897.

Lieberman, A. F. (2002). Treatment of attachment disorders in infant-parent psychotherapy. In J. M. Maldonado-Duran (Ed.), *Infant and toddler mental health: Models of clinical intervention with infants and their families* (pp. 105-128). Washington, DC: American Psychiatric Publishing, Inc.

Lieberman, A. F., Silverman, R., & Pawl, J. H. (2000). Infant-parent psychotherapy: Core concepts and current approaches. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (2nd ed., pp. 472-484). New York, NY: Guilford Press.

Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology,* 27(2), 138-145.

Lourie, I. (1992). Northumberland County, Pennsylvania. In B. Stroul, S, Goldman, I. Lourie, J. Katz-Leavy, & C. Zeigler-Dendy (Eds.). *Profiles of local systems of care for children and adolescents with severe emotional disturbances.* Washington, DC: CASSP Technical Assistance Center, pp. 287-337.

Lourie, I. S. (2003). A history of community child mental health. In A. J. Pumariega & N. C. Winters (Eds.), *The handbook of child and adolescent systems of care: The new community psychiatry* (pp. 1-16). San Francisco, CA: Jossey-Bass.

Lourie, I. S., Stroul, B. A., & Friedman, R. M. (1998). Community-based systems of care: From advocacy to outcomes. In M. H. Epstein & K. Kutash (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 3-19). Austin, TX: PRO-ED, Inc.

Luby, J. L., & Morgan, K. (1997). Characteristics of an infant/preschool psychiatric clinic sample: Implications for clinical assessment and nosology. *Infant Mental Health Journal, 18*(*2*), 209-220.

Maldonado-Durán, M., Helmig, L., Moody, C., Fonagy, P., Fulz, J., Lartigue, T., Sauceda-Garcia, J. M., Karacostas, V., Millhuff, C., Glinka, J. (2003). The Zero-to-Three diagnostic classification in an infant mental health clinic: Its usefulness and challenges. *Infant Mental Health Journal, 24*(*4*), 378-397.

Malysiak, R. (1997). Exploring the theory and paradigm base for wraparound. *Journal of Child & Family Studies, 6*(*4*), 399-408.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development, 4*(*1*), 107-124.

McDonough, S. C. (1995). Promoting positive early parent-infant relationships through interaction guidance. *Child & Adolescent Psychiatric Clinics of North America, 4*(*3*), 661-672.

McDonough, S. C. (2000). Interaction guidance: Understanding and treating early infant-caregiver relationship disturbances. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (2nd, ed., pp. 414-426). New York, NY: Guilford Press.

Minde, K., & Tidmarsh, L. (1997). The changing practices of an infant psychiatry program: The McGill experience. *Infant Mental Health Journal, 18*(*2*), 135-144.

Myaard, M. J., Crawford, C., Jackson, M., & Alessi, G. (2000). Applying behavior analysis within the wraparound process: A multiple baseline study. *Journal of Emotional & Behavioral Disorders, 8*(*4*), 216-229.

Narrow, W. E., Regler, D. A., Goodman, S. H., Rae, D. S., Roper, M. T., Bourdon, K. H., Hoven, C., & Moore, R. (1998). A comparison of federal definitions of severe mental illness among children and adolescents in four communities. *Psychiatric Services, 49* (12), 1601-1608.

National Work Group: The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Heath Intervention Development and Deployment. (2001). *Blueprint for Change: Research on Child and Adolescent Mental Health*. Washington, D.C.: DHHS/NIH.

Neill, T. K. (1997). Integrating services for children with severe emotional disabilities through coordination. In R.J. Illback, C. T. Cobb, & H. M. Joseph, Jr. (Eds.), *Integrated services for children and families: Opportunities for psychological practice* (pp. 157-190). Washington, DC: American Psychological Association.

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., et al. (2002). Barriers to Children's Mental Health Services. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(*6*), 8.

Overstreet, D.W., Casel, G., Saunders, T., & Armstrong, M.I. (2001). Florida's use of accountable innovation. In Hernandez, Mario (Ed.), *Developing outcome strategies in children's mental health.* Baltimore, MD. Paul H. Brookes Publishing.

Paster, V. S. (1997). Emerging perspectives in child mental health services. In R. J. Illback, C. T. Cobb & et al. (Eds.), *Integrated services for children and families: Opportunities for psychological practice* (pp. 259-279): American Psychological Association.

Pickrel, S. G., & Henggeler, S. W. (1996). Multisystemic therapy for adolescent substance abuse and dependence. *Child & Adolescent Psychiatric Clinics of North America, 5*(*1*), 201-211.

Prinz, R. J. (2002). Commentary: The Fast Track Project: A seminal intervention efficacy trial. *Journal of Abnormal Child Psychology, 30*(*1*), 61-63.

Pumariega, A. J., & Winters, N. C. (Eds.). (2003). *The handbook of child and adolescent systems of care: The new community psychiatry*. San Francisco, CA: Jossey-Bass.

Quinn, K. P., & Epstein, M. H. (1998). Characteristics of children, youth, and families served by local interagency systems of care. In M. H. Epstein, K. Kutash & et al. (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 81-114). Austin, TX: Pro-Ed.

Randall, J., Henggeler, S. W., Cunningham, P. B., Rowland, M. D., & Swenson, C. C. (2001). Adapting multisystemic therapy to treat adolescent substance abuse more effectively. *Cognitive & Behavioral Practice, 8*(*4*), 359-366.

Roberts, R. E., Attkisson, C. C., & Rosenblatt, A. (1998). Prevalence of Psychopathology Among Children and Adolescents. *The American journal of psychiatry, 155*(*6*), 11.

Rogers, K. (2003). Evidence-based community-based interventions. In A. J. Pumariega & N. C. Winters (Eds.), *The handbook of child and adolescent systems of care: The new community psychiatry* (pp. 149-170). San Francisco, CA: Jossey-Bass.

Rosen, L. D., Heckman, T., Carro, M. G., & Burchard, J. D. (1994). Satisfaction, involvement, and unconditional care: The perceptions of children and adolescents receiving wraparound services. *Journal of Child & Family Studies, 3*(*1*), 55-67.

Rosenblatt, A. (1996). Bows and ribbons, tape and twine: Wrapping the wraparound process for children with multi-system needs. *Journal of Child & Family Studies, 5*(*1*), 101-116.

Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with serious emotional disturbance. In M. H. Epstein & K. Kutash (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 329-362). Austin, TX: PRO-ED, Inc.

Rosenblatt, A. & Attkisson, C.C. (1997). Integrating systems of care in California for youth with severe emotional disturbance IV: Educational attendance and achievement. *Journal of Child and Family Studies,* 6(1), 113-129.

Rowland, M. D., Henggeler, S. W., Gordon, A. M., Pickrel, S. G., Cunningham, P. B., & Edwards, J. E. (2000). Adapting multisystemic therapy to serve youth presenting psychiatric emergencies: Two case studies. *Child Psychology & Psychiatry Review, 5*(*1*), 30-43.

Rutter, M. (1990). Psychological resilience and protective mechanisms. In J. E. Rolf, A. S. Masten, D. Cicchetti, K. H. Nuechterlein & S. Weintraub (Eds.), *Risk and protective*

factors in the development of psychopathology (pp. 181-214). New York, NY, US: Cambridge University Press.

Scheer, P., Dunitz-Scheer, M., Schein, A., Wilken, M. (2003). DC: 0-3 in pediatric liaison work with early eating behavior disorders. *Infant Mental Health Journal, 24*(*4*), 428-436.

Schoenwald, S. K., Borduin, C. M., & Henggeler, S. W. (1998). Multisystemic therapy: Changing the natural and service ecologies of adolescents and families. In M. H. Epstein & K. Kutash (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 485-511). Austin, TX: US PRO-ED.

Schoenwald, S. K., & Rowland, M.D. (2002). Multisystemic Therapy. In B. J. Burns, & Hoagwood, K. (Ed.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 69-90). New York: Oxford University Press.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. (2000). Multisystemic therapy versus hospitalization for crisis stabilization of youth: Placement outcomes 4 months post referral. *Mental Health Services Research, 2*(*1*), 3-12.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., Pickrel, S. G., & et al. (1996). Multisystemic therapy treatment of substance abusing or dependent adolescent offenders: Costs of reducing incarceration, inpatient, and residential placement. *Journal of Child & Family Studies, 5*(*4*), 431-444.

Sexson, S. B., Glanville, D. N., & Kaslow, N. J. (2001). Attachment and depression: Implications for family therapy. *Child & Adolescent Psychiatric Clinics of North America, 10*(*3*), 465-486.

Sexton, T. L., & Alexander, J. F. (December 2000). Functional Family Therapy. *Office of Juvenile Justice & Delinquency Prevention, Juvenile Justice Bulletin*, 1-7.

Sexton, T. L., & Alexander, J. F. (2002). Family-based empirically supported interventions. *Counseling Psychologist, 30*(*2*), 238-261.

Stafford, B., Zeanah, C.H., Scheeringa, M. (2003). Exploring psychopathology in early childhood: PTSD and attachment disorders in DC: 0-3 and DSM-IV. *Infant Mental Health Journal, 24*(*4*), 398-409.

Stroul, B. A. (1996). *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD P.H. Brookes Publishing: P.H. Brookes Publishing.

Stroul, B. & Friedman, R.M. (1996). The system of care concept and philosophy. In B. Stroul (Ed.). *Children's Mental Health: Creating system of care in a changing society.* Baltimore: Brookes Publishing, pp. 3-22.

Stroul, B., McCormack, M., & Zaro, S.M. (1996). Measuring Outcomes in Systems of Care. In B. Stroul (Ed.). *Children's Mental Health: Creating systems of care in a changing society.* Baltimore, MD: Brookes, pp. 313-336.

Swenson, C. C., Henggeler, S. W., Schoenwald, S. K., Kaufman, K. L., & Randall, J. (1998). Changing the social ecologies of adolescent sexual offenders: Implications of the success of multisystemic therapy in treating serious antisocial behavior in adolescents. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children Special Issue: Interventions with adolescent sexual abusers and children with sexual behavior problems, 3*(*4*), 330-338.

Task Force for the Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. Clinical Psychology, 48(1), 3-23.

Thomas, J. M., & Guskin, K. A. (2001). Disruptive behavior in young children: What does it mean? *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(*1*), 44-51.U. S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Author.U. S. Public Health Service. (2002). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, DC: Department of Health and Human Services.

VanDenBerg, J. E., & Grealish, E. M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child & Family Studies, 5*(*1*), 7-21.

Weatherston, D. J. (2001). Infant mental health: A review of relevant literature. *Psychoanalytic Social Work, 8*(*1*), 39-69.

Weston, D. R., Thomas, J.M., Barnard, K.E., Wieder, S., Clark, R., Carter, A.S., Fenichel, E. (2002). DC: 0-3 Assessment Protocol Project: Defining a comprehensive information set to support DC: 0-3 diagnostic formulation. *Infant Mental Health Journal, 24*(*4*), 410-427.

Winters, N. C., & Pumariega, A. J. (2001). Systems of care for children and adolescents with serious emotional disturbance. In H. B. Vance & A. Pumariega (Eds.), *Clinical assessment of child and adolescent behavior* (pp. 513-532). New York, NY: John Wiley & Sons, Inc.

Woolston, J. L., Berkowitz, S. J., Schaefer, M. C., & Adnopoz, J. A. (1998). Intensive, integrated, in-home psychiatric services: The catalyst to enhancing outpatient intervention. *Child & Adolescent Psychiatric Clinics of North America, 7*(*3*), 615-633.

Yoe, J. T., Santarcangelo, S., Atkins, M., & Burchard, J. D. (1996). Wraparound care in Vermont: Program development, implementation, and evaluation of a statewide system of individualized services. *Journal of Child & Family Studies, 5*(*1*), 23-37.

Zeanah, C. H., Boris, N. W., & Scheeringa, M. S. (1997). Psychopathology in infancy. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 38*(*1*), 81-99.

Zeanah, C. H. (Ed.). (2000). *Handbook of infant mental health (2nd ed.)*. New York, NY: Guilford Press.

Zeanah, C. H., Boris, N. W., & Larrieu, J. A. (1997). Infant development and developmental risk: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(*2*), 165-178.

Zero-to-Three. (1994). Diagnostic classification: 0-3: Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Arlington, VA: Author.

Resource Guide

The Diagnostic Classification of Mental Health and Developmental Disorders or Infancy and Early Childhood (DC:0-3)

Description:

1. **Primary purpose:** Prior to *the Diagnostic Classification of Mental Health and Developmental Disorders or Infancy and Early Childhood (DC: 0-3)*, there was no classification system describing the mental health disorders of infancy and early childhood. The purpose of the *DC: 0-3* is to provide a basis from which a clinician and/or researcher may identify, assess, and classify early childhood disorders and to develop appropriate treatment interventions. Additionally, it seeks to create a common language among clinicians and researchers to better understand the nature of early childhood disorders, and finally, to be an initial framework that serves as a first step in the development of a comprehensive classification system. It is based in both psychodynamic and psychoanalytical traditions including developmental, family systems, relationship, and attachment theories. However, unlike the DSM-IV which concentrates on the pathology of the individual, the assessment process of the DC: 0-3 employs bio/psychosocial and developmental approach by examining the relational context of the child, particularly the primary care-giving dyad.

   The *DC: 0-3* is a multi-axial categorization system that was designed to compliment the *DSM-IV*, which is focused mainly on adolescents and adults rather than young children. Each axis is given equal weight in the diagnostic process that emphasizes the identification of risk factors that contribute to the development of psychopathology, and resilience or protective factors that can help define potential treatment interventions. The five axes are as follows:

   - Axis I – Primary diagnosis: The child's primary diagnosis which may include traumatic stress disorder; disorders of affect including anxiety, mood, gender identity, and reactive attachment deprivation/maltreatment, and adjustment regulatory disorders including hypersensitive, under-reactive, and motorically disorganized and

impulsive disorders; sleep disorders; eating behavior disorders; and disorders of relating and communicating.

- Axis II – Relationship classification: Examines the behavioral quality of the interaction between child and caregiver, affective tone of the dyad, and the type of psychological involvement between the dyad. Relationships are classified as over involved, under involved, anxious/tense, angry/hostile, mixed, or abusive. The Parent-Infant Relationship Global Assessment Scale (PIR-GAS) is the instrument used to rate the nature of the care giving dyad.
- Axis III – Co-existing medical and developmental disorders that were determined through the DSM-IV and/or diagnoses from OT, PT, and special education providers.
- Axis IV – Psychosocial stressors: Axis IV seeks to identify stressors and risk factors present in a child's environment and the overall effects these risk factors have on the child. Stressors may be predominately acute or predominately enduring depending on the chronicity of the problem. The overall impact may be diagnosed as mild, moderate, or severe.
- Axis V – Functional Emotional Developmental Level: This axis describes the manner in which an infant or young child organizes experience to determine if the child has acquired appropriate capacities, skills, and maturity for their age level.

1. **Target population:** Infants and young children ages zero to five.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Although the DC: 0-3 was published in 1994, there have been few outcomes studies conducted to address its reliability and validity as a diagnostic and classification system. Moreover, since the traditional American funding sources do not yet support its use as an assessment and treatment instrument, most of the research to date has been conducted in Canada, Europe, S. America, and Israel. Despite limited research, however, preliminary outcome studies have been positive.

2. **Qualitative evaluation**: None known.

Evidence supporting practice:

1. **Peer-reviewed research:** Initial studies addressing the reliability and validity of the *DC: 0-3* are promising and indicate that inter-rater reliability for Axis II (relationship classification) diagnoses are strong particularly when using the Parent Infant Relationship Global Assessment Scale (PIR-GAS). Additionally, the PIR-GAS has been shown to share concurrent validity with the Achenbach CBCL ages 1½- 5.

2. **Other supporting documents:** There is an accompanying casebook manual that illustrates appropriate use of the various diagnostic categories of the DC: 0-3.

Practice implementation:

1. **Staffing requirements:** There are no specific staffing requirements to implement the *DC: 0-3*.
2. **Training requirements:** The Zero-to-Three organization and the research literature do not delineate a training protocol associated with the implementation of the *DC: 0-3*.
3. **Cost of program:** There is no information available on the costs associated with the implementation of the *DC: 0-3*. The *DC: 0-3* manual costs $27.00 and the accompanying casebook is $37.00.
4. **Use of natural funding:** The traditional funding sources do not yet support its use as an assessment and treatment instrument.

Other considerations:

The *DC: 0-3* has been criticized for failing to provide enough specific descriptive criteria of the various disorders and syndromes, which results in seemingly ambiguous boundaries, and overlap between the diagnoses.

Contact information:

Zero to Three: National Center for Infants, Toddlers, and Families
2000 M Street, NW, Suite 200
Washington, DC 20036
(202) 638-1144

Relevant websites:

Zero-to-Three: http://www.zerotothree.org/

References:

Guedeney, A., & Maestro, S. (2003). Introduction to a special issue: The use of the Diagnostic Classification 0-3. *Infant Mental Health Journal, 24*(*4*), 310-311.

Keren, M., Feldman, R., & Tyano, S. (2001). Diagnoses and interactive patterns of infants referred to a community-based infant mental health clinic. *Journal of the American Academy of Child & Adolescent Psychiatry, 40(1),* 27-35.

Zero-to-Three. (1994). National Center for Clinical Infant Programs/Zero-to-Three. *Diagnostic classification of mental health and developmental disorders in early childhood*. Arlington, VA: Author.

Zero-to-Three. National Center for Clinical Infant Programs/Zero-to-Three. *The DC:0-3 Casebook: A guide to the use of ZERO TO THREE's diagnostic classification of mental health and developmental disorders of Infancy and early childhood in assessment and treatment planning.* Arlington, VA: Author.

Parent-Infant Psychotherapy

Description:

1. **Primary purpose:** Developed in the 1980s, parent-infant psychotherapy is based on the premise that caregivers tend to replicate their insecure early childhood attachments and parenting behaviors that they experienced with their own parents. The infant, in essence, becomes the representative and an object of transference of negative past experiences, which may result in the infant-toddler absorbing this dysfunction, which could engender psychopathology. Therefore, the purpose of parent-infant psychotherapy is to protect the infant-toddler's developing mental health by changing a caregiver's developmentally inappropriate perceptions and care giving behaviors towards their child.

   Theoretical foundations of parent-infant psychotherapy include relational-support, attachment, intersubjective, object relations, and self-psychology theories. Using a combination of interpretive and empathic support techniques, clinicians assist caregivers in linking their experiences with the current behavioral transactions occurring with their infants. Generally, the caregiver and child are present during the treatment sessions. However, the therapeutic emphasis is towards the parent to assist them in recognizing and integrating previously unresolved histories of past negative experiences to facilitate improvement and development of parenting abilities.

   The provision of parent-infant psychotherapy may be center-based or home-based. Center-based models may use either individual dyad or a group psycho-educational design. Difficult to engage families are more likely to participate in home-based services; observation and assessment of the dyad in a home-based setting may yield a more accurate picture of the relational context within the dyad. Very often, interactive guidance in the form of videotaping the dyad during a play session is used to facilitate the caregiver's understanding of their relational behaviors with their child. Treatment may last from two to six months with 10-20 sessions.

2. **Target population:** Parent and infant-toddler dyads with dysfunctional attachment and relational problems are the main target population. However, if a second caregiver and/or siblings are present they may be included in the therapeutic process.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Outcomes are measured by the improvement in the social-emotional wellbeing of the infant-toddler achieved through the improved parenting skills of their caregiver.

2. **Qualitative evaluation**: Case study descriptions of treatment sessions are embedded in the literature describing parent-infant psychotherapy models.

Evidence supporting practice:

1. **Peer-reviewed research:** Outcome evaluation and research are in the earliest stages and somewhat limited as a randomized control design has not yet been employed. Nevertheless, initial trials have demonstrated that improved maternal empathy achieved through therapeutic integration were significantly linked to decreased child avoidant and angry behavior, more secure care giving-child attachment, and improved goal-corrected partnership behavior within the dyad.

   Current research is focusing on children from Head Start and on those preschoolers who have witnessed domestic violence.

2. **Other supporting documents:** The infant-mother relationship is often assessed through the Strange Situation procedure by Ainsworth, Blehar, Waters, & Wall (1978).

Practice implementation:

1. **Staffing requirements:** There are no specific staffing requirements to implement the parent-infant psychotherapy.

2. **Training requirements:** The research literature does not delineate an agency-based training protocol associated with this treatment model for professionals currently working in the field. Professional training is available through degree/certification programs offered through higher education institutions.

3. **Cost of program:** The literature does not specify costs associated with this treatment.

4. **Use of natural funding:** Using a DSM-IV "V" code [V61.90 (relational problem related to a mental disorder); V61.20 (parent-child relational problem); V61.1 (partner relational problem); V61.8 (sibling relational problem); V61.81 (relational problem not otherwise specified)], parent-infant psychotherapy is usually a reimbursable activity through third-party insurance providers and public funding sources.

Other considerations:

Contact information and relevant websites:

Because this treatment modality is not owned by any one organization or agency, there is no central contact location or website available.

References:

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: Assessed in the Strange Situation and at home*. Hillsdale, NJ: Erlbaum.

Lieberman, A. F., Silverman, R., & Pawl, J. H. (2000). Infant-parent psychotherapy: Core concepts and current approaches. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (2nd ed, pp. 472-484). New York, NY: Guilford Press.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development, 4*(*1*), 107-124.

McDonough, S. C. (2000). Interaction guidance: An approach for difficult-to-engage families. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (2nd ed*,* pp. 485-493). New York, NY: Guilford Press.

Weatherston, D. J. (2001). Infant mental health: A review of relevant literature. *Psychoanalytic Social Work, 8*(*1*), 39-69.

The Wraparound Process

Description:

1. **Primary purpose:** Wraparound is a philosophy and service process that is based on the systems of care concept that purports a philosophy of integrated and collaborative service provision that is child-centered and family focused, community-based versus institutional in nature, and culturally competent. This strengths-based approach focuses on the strengths of families in contract to focusing on a child's deficits. The child and caregivers are a vital part of the treatment planning process and services are highly individualized, tailored, and comprehensive to meet the specific needs of the child and ensure that child continues to reside in their community with their family.

   This model is particularly effective when a comprehensive plan is necessary to address emotional and behavioral issues in the school, home, and community environments. Service plans are need-based rather than service-based and focus on the needs in several life domains including family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, safety, and others. Since the practice is a "process" versus a "model", services duration is one to three years.

   Wraparound has a set of elements that serve as a philosophical basis for the process:
   - Wraparound efforts must be based in the community.
   - Services and supports must be individualized to meet the needs of the children and families and not designed to reflect the priorities of the service systems.
   - The process must be culturally competent and build on the unique values, strengths, and social and racial make-up of children and families.
   - Parents must be included in every level of development of the process.
   - Agencies must have access to flexible, non-categorized funding.
   - The process must be implemented on an inter-agency basis and be owned by the larger community.

- Services must be unconditional. If the needs of the child and family change, the child and family are not to be rejected from services. Instead, the services must be changed.
- Outcomes must be measured.

Additionally, the wraparound philosophy suggests implementing the following steps to create a wraparound process:

- Develop a team with broad representations that includes both informal and formal resources from the community. Develop subcommittees to define identification, referral, and confidentiality issues.
- Identify a designated agency or agencies and a wraparound coordinator serve as a "broker" to work with referral agencies and manage a pool of flexible funding.
- Once a child and family are identified, conduct a strengths assessment to determine the values and preferences of the family. Create a plan that is based on the needs and preferences of the family.
- Create an individualized team of four to ten members that are comprised of the family, child, and any other individuals the family deems appropriate. The team should be no more than half professionals.
- Ensure regular team contact during plan implementation and set outcomes indicators that are frequently evaluated.

2. **Target population:** The target population are children of all ages with emotional and behavioral disturbances and their families. Emotional and behavioral disturbances may include depression, attention- deficit/hyperactivity disorder, anxiety disorders, conduct and oppositional disorders, and eating disorders.

   The Substance Abuse and Mental Health Administration have designated the wraparound process as a promising practice.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Several quantitative and qualitative studies have been undertaken that demonstrate positive outcomes associated with wraparound. Quantitative studies have used pre/post, randomized clinical trials, and quasi-experimental designs. Findings indicate children and youth served through wraparound demonstrate improvements in their behavior, academics, and social and familial relationships. Further, children who receive wraparound services are less likely to need out-of-home placements.

   Because the wraparound approach is a philosophy embedded in the system of care concept, it is not "owned" by any one organization and the process has been implemented in numerous states and other countries. As such, outcomes studies have been undertaken by numerous researchers rather than one individual or group, which operates as 'principal investigator'.

2. **Qualitative evaluation:** Qualitative evaluations indicate that clients and families have a high level of satisfaction with wraparound because they are an integral part of the team.

Evidence supporting practice:

1. **Peer-reviewed research:** See section 2(a) above.

2. **Other supporting documents:** Numerous articles, books, and manuals are available that describe the wraparound model. Some of the most comprehensive monographs regarding wraparound services are available through SAMHSA's publication web site. See address below.

Practice implementation:

1. **Staffing requirements:** The family team is typically organized and led by a designated family team coordinator working for a broker agency. The process relies heavily upon case management services.

2. **Training requirements:** There are no specific training requirements.

3. **Cost of program:** In a five-year study conducted in Kentucky, cost ranged from a mean of $1,224 per child in the first year of service to a mean of $2,455 per child in the fifth year of service. Expenses are consistent across ages 0-21 years.

4. **Use of natural funding:** Blended funding is the most conducive mechanism to developing integrated services for children to avoid duplication of services by providers. However, the development of flexible funding pools is a complicated undertaking as state legislation, the application of waivers, and the development of administrative structures to oversee the funding pool is usually necessary. To some, flexible funding is only truly flexible if readily available for use within one hour. Additionally, within the context of a wraparound service delivery model, the use of flexible funding is generally a last resort after all other categorical funding mechanisms are exhausted.

Contact information:

None available

Relevant websites:

Center for Effective Collaboration and Practice – Wraparound Planning:
http://cecp.air.org/wraparound/default.htm

Substance Abuse and Mental Health Administration Services:
http://www.mentalhealth.org/publications/publications_browse.asp?ID=14&Sort=

References:

Malysiak, R. (1997). Exploring the theory and paradigm base for wraparound. *Journal of Child & Family Studies, 6*(4), 399-408.

Oliver, R. D., Nims, D. R., Hughey, A. W., & Somers, J. R. (1998). Case management wraparound expenses: Five-year study. *Administration & Policy in Mental Health, 25*(5), 477-491.

VanDenBerg, J. E., & Grealish, E. M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child & Family Studies, 5*(1), 7-21.

The Fast Track Project

Description:

1. **Primary purpose:** The Fast Tract Project is a ten-year, school-based prevention and intervention program based on developmental theory that suggests antisocial behavior results from a multitude of determining risk factors such as ineffective parenting, high community crime rates, poverty, and negative peer influences. The primary hypothesis of Fast Track is that by intervening with school-age children to promote and augment protective factors will prevent and/or mitigate the occurrence of antisocial behavior. The intervention thus focuses on effective parenting, promoting pro-social peer contacts, improving communication between school and caregivers, and improving child competencies. Program content is modified to ensure the appropriate developmental context.

   The first intervention phase targeting children in grades 1-5 includes six components:
   - A standard curriculum (PATHS; grades 1-3) conducted by the teacher focusing on emotional concepts, self control, social understanding, and problem solving;
   - Parent training groups that target teaching parents behavior management skills and the development of positive school-caregiver relationships;
   - Home visits to assist caregivers in problem-solving, self-efficacy, and life skills management;
   - Child social skill training groups;
   - Child tutoring if necessary;
   - Child friendship enrichment in the classroom.

   The adolescent phase targets children in grades 6-10. This phase is more individualized in content and de-emphasizes group-based interactions to discourage deviant peer relationships. Staff and families identify risk factors specific to the individual and counter these risk factors with a strategy that may include tutoring, home visiting, mentoring, positive peer-group associations and social networks, family problem solving, and increasing communication between home and school.

The following agencies are currently providing funding for the Fast Track project: the National Institute of Mental Health (NIMH), the Center for Substance Abuse Prevention, National Institute of Drug Abuse, and the Department of Education Safe and Drug Free Schools Program.

2. **Target population:** School-age children from first grade through the tenth grade.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** There are currently four Fast Track school sites in the United States including Durham, NC; Nashville, TN; Seattle, WA; and Central PA. Schools, rather then the children, were the unit of randomization and were chosen based upon community risk for poverty and crime. Within these four schools, 10,000 kindergarten children were screened and 891 children identified who were at high risk for developing conduct and oppositional disorders. Four-hundred forty-five children were assigned to the intervention group and 446 were assigned to the control group.

   To monitor behavioral development, standardized assessments are conducted with caregivers and the at-risk youth at the end of grades 3, 5, 6, 9, and 12. Other data collection strategies include parent and teacher report, self-report, peer-review, and archival review of school, police, and court records.

2. **Qualitative evaluation:** None available.

Evidence supporting practice:

1. **Peer-reviewed research**: Three-year outcome trials indicate that children receiving the intervention demonstrated a modest to moderate but statistically significant improvement in conduct-related behavior including aggression and disruptiveness at home and at school. By grade three, 37% of the intervention group was free of conduct-related problems versus 27% in the control group. Notably, those in the intervention group received 25% fewer special education diagnoses than those in the control group. Further, intervention children exhibited improved cognitive, academic, and social skills and that their parents used considerably less harsh discipline at home. The first three cohorts of children from the ten-year longitudinal study will conclude the Fast Track intervention in August 2003.

2. **Other supporting documents:** The PATHS (Providing Alternative Thinking Strategies) Curriculum is available from the Channing Bete Company. See contact information and homepage web address below.

Practice implementation:

1. **Staffing requirements.** Information regarding staffing requirements in the Fast Track literature is limited. A Fast Track consultant provides support to the teacher during implementation of the PATHS curriculum. In addition to the teacher to conduct the PATHS curriculum, staff are necessary to conduct home visits and group-based activities for the caregivers.

2. **Training requirements:** Information regarding training requirements is limited. Fast Track staff in the PATHS Curriculum train teachers in the intervention group.

3. **Cost of program:** To date, there are no cost-benefit data available. However, the investigators have included a cost-benefit review as part of the longitudinal research component that will focus on the effect the program has on participants' use of traditional and expensive services including inpatient hospitalization, juvenile detention, and special education.

4. **Use of natural funding.** None identified.

Other considerations:

The Conduct Problems Prevention Research Group, a collaborative partnership between Duke University, Pennsylvania State University, University of Washington, and Vanderbilt University, is conducting the Fast Track research.

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Web-site: www.channing-bete.com

Relevant websites:

The Fast Track Project: http://Fasttrackproject.org

National Institute of Mental Health: http://www.nimh.nih.gov/publicat/violenceresfact.cfm

PATHS Curriculum Homepage: http://www.prevention.psu.edu/PATHS/

References:

Fast Track Data Collection. Fast Track Data Center. Retrieved June 11, 2003, from http://www.Fasttrackproject.org/datacollection.htm.

Fast Track Project Overview. Fast Track Data Center. Retrieved June 11, 2003, from http://www.Fasttrackproject.org/Fasttrackoverview.htm.

Prinz, R. J. (2002). Commentary: The Fast Track Project: A seminal intervention efficacy trial. *Journal of Abnormal Child Psychology, 30*(1), 61-63.

The Conduct Problems Prevention Group. (2002). Evaluation of the first 3 years of the Fast Track prevention trial with children at high risk for adolescent conduct problems. *Journal of Abnormal Child Psychology, 30*(1), 19-35.

This research is based on data from the study entitled ["Fast Track," or "Multi-Site Prevention of Adolescent Problem Behaviors," or "Multisite Prevention of Conduct Disorder"], supported by National Institute of Mental Health (NIMH) Grants R18 MH48043, R18 MH50951, R18 MH50952, R18 MH50953, and R01 MH62988. The Center for Substance Abuse Prevention and the National Institute on Drug Abuse also have provided support through a memorandum of agreement with the NIMH. Department of Education Grant S184U30002 and NIMH Grants K05MH00797 and K05MH01027 also supported the study. The study was designed by the Conduct Problems Prevention Research Group, which currently includes, in alphabetical order, Karen L. Bierman, Pennsylvania State University; John D. Coie, Duke University; Kenneth A. Dodge, Duke University; Mark T. Greenberg, Pennsylvania State University; John E. Lochman, University of Alabama; Robert J. McMahon, University of Washington; Ellen E. Pinderhughes, Vanderbilt University; and E. Michael Foster, Pennsylvania State University.

Functional Family Therapy

Description:

1. **Primary purpose:** Functional Family Therapy is a family-based, multi-systemic prevention/intervention treatment model for at-risk youth and adolescents with complex, multidimensional mental health and/or substance abuse issues. The model is based on established clinical theory, evidenced-based treatments, and clinical experience. Using culturally competent practices, FFT is a short-term treatment intervention involving approximately 8-12 sessions for mild cases and up to 30 hours over a three-month period for severe cases. FFT seeks to identify and maximize family strengths and protective factors while mediating risk factors.

   The structure of FFT is systematic using a three-stage intervention schema called the "Phase Task Analysis" to provide services which includes the early phase of engagement and motivation, a middle phase of behavior change, and a third phase of treatment generalization. The three-phase process allows the clinician to focus on the specific treatment context but ensures flexibility to accommodate families' changing needs. Assessment occurs throughout the process and is relevant to the specific treatment phase. Assessments should follow a set of establish precepts:

   - Assessment should focus on how the family relational systems are associated with the presenting problem or behavior.
   - Using formal assessment instruments and informal observation assessment should identify risk and protective factors to determine the multi-dimensional context of problem behaviors and family contextual issues subsequently to engage in treatment planning.
   - Observance of the assessment protocol will enable positive treatment outcomes.

   Individual therapists in the homes of the clients provide services.

2. **Target population:** Youth and adolescents ages 11-18 diagnosed with emotional and behavioral problems including conduct disorders, substance abuse, and aggressive behavior. Additionally, FFT will also engage younger siblings of the referred youth.

Evaluating this practice:

1. **Outcome measures**: Randomized and non-randomized trials indicate that FFT is an effective treatment method as it decreases recidivism and/or the onset of delinquency by 25 to 60% compared to other programs such as residential treatment or juvenile probation services.

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer-reviewed research**: There are over 50 certified FFT sites in 15 states. Certified sites disseminate research and practice information.

2. **Other supporting documents**: All training protocols are available through the FFT Practice Research Network (FFT-PRN).

Practice implementation:

1. **Staffing requirements:** An FFT team is comprised of three to eight master-level and/or highly qualified bachelor-level therapists. Therapists come from a variety of professional backgrounds including public health nursing, clinical psychology, social work, marriage and family therapy, criminology, recreation therapy, and psychiatry.

2. **Training requirements:** Training requirements for FFT are intensive. During the first year, the FFT work group (3-8 staff) receives a three-day, on-site clinical training; an externship for the clinical group leader, three follow-up visits a year of two days each; and four hours a month of phone consultation per month.

3. **Cost of program**: According to the Washington State Institute for Public Policy, the cost of providing FFT to youths averaged approximately $2,161 per program participant compared to $14,149 in potential criminal justice expenditures; a cost savings of $11,988. Moreover, the Institute estimated that up to $59,067 in crime victim costs could be offset per program participant. Therefore, the cost-benefit ratio of $28.81 per dollar spent for FFT.

   First year start-up and implementation costs average approximately $20,000 not including travel for one work group to become certified as a FFT provider. Thereafter, only a small yearly fee is necessary to maintain certification.

4. **Use of natural funding:** The guiding principles, goals, and techniques of FFT ensures its flexibility to respond to a variety of funding mechanisms including managed care.

Other considerations:

The FFT Practice Research Network (FFT-PRN) owns the Functional Family Therapy model. Dissemination sites must be certified and trained through the FFT-PRN to operate a FFT agency. Certification entails clinical on-site training, on-site follow-up and supervision, ongoing phone supervision and consultation, clinical externship through the University of Nevada, and FFT-CCS (clinical services system for client assessment, tracking, and monitoring system) training and use.

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Relevant websites:

Functional Family Therapy Homepage: http://www.fftinc.com/

References:

Alexander, J. F., Robbins, M. S., & Sexton, T. L. (2000). Family-based interventions with older, at-risk youth: From promise to proof to practice. *Journal of Primary Prevention, 21*(2), 185-205.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. . (2001). *The comparative costs and benefits of programs to reduce crime, Version 4*. Olympia, WA: The Washington State Institute for Public Policy.

Sexton, T. L. a. A., J. F. (December 2000). Functional Family Therapy. *Office of Juvenile Justice & Delinquency Prevention, Juvenile Justice Bulletin*, 1-7.

Multisystemic Therapy (MST)

A Best Practice

Description

1. **Primary purpose:** Multisystemic therapy (MST) is a family- and community-based treatment model that addresses the mental health needs of children and adolescents. Developed in the 1970s, MST initially targeted juvenile offenders with antisocial behaviors and mental health issues. Its purpose was to reduce long-term rearrest and out-of-home placement for chronic juvenile offenders. Based on Broffenbrenner's theory of social ecology, MST assumes that the emotional and behavioral problems in children and adolescents are multidimensional and multi-determined, thus these problems are best understood within the context of the child's social environment. The model predicates that a child's behavior is influenced by their interaction with their primary social systems including family, peer groups, school, neighborhood, and community. Six core elements serve as the basis of the MST intervention. These include a commitment to comprehensive services, ecological validity, use of evidence-based intervention, the empowerment of caregivers, and finally, the assurance of quality in service provision throughout the intervention process. Additionally, MST has nine treatment principles that are fundamental to the success of the intervention:

   I. The primary purpose of the assessment is to understand the "fit' between the identified problems and their broader systemic context.

   II. Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.

   III. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.

   IV. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.

   V. Interventions should target sequences of behavior within and between multiple systems that maintain the identified problem.

   VI. Interventions should be developmentally appropriate and fit the developmental needs of the youth.

   VII. Interventions should be designed to require daily or weekly effort by family members.

   VII. Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.

   IX. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple system contexts.

2. **Target population:** The target population is children and adolescents(ages 11-17) who exhibit serious emotional disturbance, anti-social behavior, mental health and/or substance abuse problems that are at imminent risk for out-of-home placement. The use of MST is indicated for youth with multidimensional issues rather than a single issue problem.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** MST Services of the MUSC have conducted seven experimental trials and one quasi-experimental trial that were cross-sectional and longitudinal in nature. Outcome effects have been quite strong that demonstrate the efficacy of the MST program. Trials with over 800 families with a variety of populations including urban youth, violent juvenile offenders, substance abusing/dependent juvenile offenders with co morbid mental health disorders, youth with acute psychiatric emergencies, juvenile sexual offenders, and maltreating families were completed. Consistently, the model has resulted in improved family functioning and relationships, decreased adolescent mental health and chemical dependency symptoms, increased adolescent school attendance, decreased rearrest rates with juvenile offender populations by 25-75%, decreased in out-of-home-placement rates by 47-64%. Additionally, study attrition has been quite low with 97% of participants completing treatment.

   Approximately a dozen studies are now in the process of implementation at a number of national and international sites. These studies target a range of areas including SED youth, abused and maltreated children and adolescents, youth involved with juvenile drug court, school-based prevention, an MST-based continuum of care, and neighborhood-based intervention.

2. **Qualitative evaluation**: None known. All studies to date have been experimental and quasi-experimental in nature.

Evidence supporting practice:

1. **Peer-reviewed research:** Four studies were recently completed by other community-based providers and universities to determine the efficacy of the model when implemented in a "real-world" location. Again, MST demonstrated significant positive outcomes in juvenile offenders and their families. However, in one study when quality assurance and treatment fidelity measures were not closely monitored the effects, although present, were demonstratively smaller then those studies in which fidelity was strictly observed.

2. **Other supporting documents**: The MST treatment and supervision model is highly "manualized". All manuals and instruments are only available through MST Services, Medical University of South Carolina.

Practice implementation:

1. **Staffing requirements:** Each MST program typically has two to three teams of three master-level or highly qualified bachelor-level therapists that receive supervision from an

on-site doctoral level clinician. These doctoral-level clinicians spend minimally 75% (approximately 25% per team) of their work allocation engaged in supervision. MST sites may also employ a full- or part-time administrator. Caseloads are intentionally low with an average caseload of four to six families for each clinician. Treatment length is approximately four months per family so each clinician works with approximately 15 families per year.

2. **Training requirements**: To ensure model fidelity and adherence to the nine MST treatment principles, the Medical University of South Carolina solely owns the model and each MST site must obtain the appropriate license to operate a MST program. Accordingly, the Family Services Research Center of MUSC provides on-site, five-day training for all new MST programs. Supervisors receive training in the MST supervisory procedures as well. Additionally, each site receives one-and-a-half day quarterly trainings and ongoing case consultations with MST experts.

3. **Cost of program**: In 2001, The Washington State Institute for Public Policy examined several interventions used with juvenile offender populations. It determined that MST ensured the greatest net savings of all programs by preventing long-term placements in juvenile justice facilities. The cost of providing MST to a targeted juvenile offender and their family averaged approximately $4,743 compared to $31,661 in potential criminal justice costs per program participant. Moreover, the Institute estimated that up to $131,918 in crime victim costs could be offset per program participant. Therefore, the cost-benefit ratio of $28.33 per dollar spent for MST.

   MUSC recently conducted a four-month follow-up study in 2000 comparing the use of MST as a psychiatric crisis stabilization strategy versus psychiatric hospitalization for SED children who were not juvenile offenders. Overall, researchers found that the program was more expensive to operate for those with acute psychiatric problems compared to those children in the juvenile justice system. Additional costs were incurred because of the addition of a licensed psychiatrist to conduct clinical supervision, a reduction in caseload to three families per therapist, and increased 24/7 support to address psychiatric crises. Nevertheless, MST prevented hospitalization for 57% of the participants and decreased the number of days of hospitalization by 72% overall. Average cost per youth in the MST group averaged $5,954 compared to $6,174 for the hospitalized group. It is not yet clear if MST will reduce future hospitalization rates with a psychiatric population.

4. **Use of natural funding:** Clearly, the cost of MST will vary depending upon the funding structure of each state. Potential funding sources for MST services include Medicaid reimbursement under family preservation, the reallocation of state funds from out-of-home-placement resources (e.g., foster care, juvenile justice, etc.), and the use of continuum of care.

Other considerations:

The Multisystemic Therapy model, owned by MST Services, Inc., has a licensing agreement with the Medical University of South Carolina for dissemination purposes. To ensure

treatment and quality assurance standards dissemination is allowed only through MST Services, Inc. MST Services has partnered with the NIMH and Office of Juvenile and Delinquency Prevention to promulgate programs in 20 states, Canada, and Norway.

Contact information regarding program development and training:

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Relevant websites:

MST Institute: http://www.mstinstitute.org/
DOJ/OJJDP: http://www.ncjrs.org/txtfiles/165151.txt
WA State Institute for Public Policy: http://www.wa.gov/wsipp

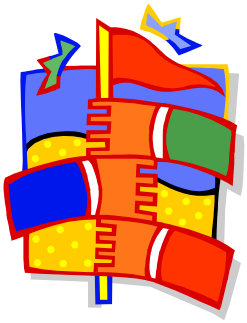
References:

Brown, T. L., Swenson, C. C., Cunningham, P. B., Henggeler, S. W., Schoenwald, S. K., & Rowland, M. D. (1997). Multisystemic treatment of violent and chronic juvenile offenders: Bridging the gap between research and practice. *Administration & Policy in Mental Health Special Issue: Assertive community treatment, 25*(2), 221-238.

Henggeler, S. W., Rowland, M. D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., et al. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(11), 1331-1339.

Henggeler, S. W., Schoenwald, S. K., Rowland, M.D., & Cunningham, P.B. (2002). *Serious emotional disturbance in children and adolescents: Multisystemic treatment*. New York: London.

Native American Children



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A Review of the Literature

Healing the *Wakanheja*[2]: Evidence Based, Promising, and Culturally Appropriate Practices for American Indian/Alaska Native Children with Mental Health Needs

INTRODUCTION

American Indian and Alaska Native (AI/AN) children experience a myriad of risk factors for developing psychopathology, yet there is a paucity of evidence based prevention and intervention practices specifically addressing their needs. There is a dichotomy between evidence based models alleged to be effective with AI/AN, which are not culturally grounded nor sufficiently tested with the population, and culturally grounded AI/AN models whose efficacy have not been demonstrated. There are a number of evidence-based practices assumed effective for AI/AN children because they were utilized with diverse ethnic groups. These practices are then applied to AI/AN children with minimal, superficial and often stereotypical "cultural adaptation" including such things as substituting Native names or themes in the curriculum content and serving fry bread at a meal. The result in this first scenario is that the practice remains inherently based upon the culture of the non-Native developers with "Indian window-dressing" so that the model appears AI on the outside but is internally flawed and culturally irrelevant on a deeper more meaningful and more profoundly important level. This is akin to a non-Native person dressing up in an "Indian" costume for Halloween.

The opposite scenario is the culturally based, culturally congruent, and culturally grounded practice that emerges from traditional AI/AN worldviews. Native philosophies, behavioral norms, relationships and attributes are included and Natives develop the program for their own population. Such practices often have never been evaluated or adequately replicated. Claims of success are based upon observations and anecdotal information. While these observations plausibly reflect participant experience of the Native model as effective, the model has not advanced to the level of being promising or evidence based.

We are proposing some solutions to this dichotomous dilemma: (a) one must facilitate culturally congruent research and evaluation of Native-driven practices. Ideally, AI/AN evaluators lead the efforts utilizing empowerment and participatory action research or other evaluation approaches that promote AI/AN involvement and ownership. These methods would incorporate the needs of and consideration for the AI/AN community; (b) Native-developed and designed practice models should be encouraged and fostered, rather than simply applying practices developed with other populations; (c) culturally appropriate and Native-developed models should be chronicled and then resources should be devoted to conduct evaluations that lead to declaration of promising or evidence based practices.; d) evidence based and promising practices, with potential to be effective with AI/AN population, should be adapted and evaluated. Program fidelity could be maintained while

[2] Wakanheja is a Lakota (Teton Sioux) word meaning "children who are sacred beings."

augmenting components that suit AN/AI children. Evaluation methods would incorporate culturally appropriate research instruments and methods and utilize focus groups of AI/AN community members, key informants, and consultants.

This paper divides practices into three categories. First is a review of the evidence based and promising practices that have reported use with American Indians, without noting cultural adaptation. Second are evidence-based practices that may show promise for cultural adaptation for AI/AN communities because of the issues they address and their relevance for the risk factors AI/AN children face. Third, are culturally appropriate practices that AI/AN communities are using, whether or not these are deemed promising practices. We conclude with recommendations for further research and development of best practices for AI/AN children. Because of the diverse tribal AI/AN groups represented in the Washington State, we also present diverse models, which can potentially be adapted and tailored to meet the needs of AI/AN groups in the state.

In keeping with the same format used in a previous literature review that examined measurement with American Indians (Moran & Yellow Horse, 2000), we first sought out best practice programs in NIMH, NIH, SAMHSA, OJJDP, NIDA, Office of Education, and NCAP Web Sites and found 34 programs listed. We also attempted a "backdoor approach" by seeking information about best practices through Indian research literature. Using the PsycINFO, Social Work Abstracts and Social Science Index databases, we identified approximately six programs that specifically addressed the mental health needs of American Indian children and families. We then proceeded to narrow this list to research based best practices, promising practices, and promising alternatives. The outcome produced approximately 40 practices related to mental health needs of American Indian children. The authors reviewed the program for their relevance to mental health needs for American Indian/Alaska Native children, which and entered them into the attached resource guide.

EVIDENCE BASED AND PROMISING PRACTICES WITH AMERICAN INDIANS

Few studies focus specifically on Alaska Native or American Indian children. They are usually combined with other populations and the actual number participating is lost. The degree of cultural adaptation is rarely presented thus it is difficult to asses efficacy for American Indian and Alaska Natives. Practices included in this section may reflect this condition. Most practices address substance abuse and/or mental health risk and protective factors.

Greenberg, Domitrovich, & Bumbarger (1999) advocate for the use of preventive interventions prior to the development of significant symptomology in children. A variety of practices target individual behavior disorders and engage family, peers and teachers in the treatment process designed to decrease risk factors and to increase protective factors. Several models focus on parents as the target for intervention, addressing the child's relationship with them as a way to reduce risk factors, such as communication problems, family disorganization, and poor bonding and increasing protective factors, such as improving the quality of the child's interaction with the environment.

Parenting Wisely, a SAMHSA designated Effective Program is a self-administered computer-based program that teaches parents and their children important skills for combating substance abuse. Practitioners can use this versatile program alone or in a group in a variety of situations. It promotes effective parenting skills including communication, positive reinforcement, problem solving, contingency management, assertive discipline and supervision. Research reveals significant improvements in reaction, behavior, and learning (Schinke, Brounstein, & Garner, 2002).

PATHS – Promoting Alternative Thinking Strategies (Greenberg & Kusche, 1997, 1998; Greenberg, Domitrovich, & Bumbarger, 1999) is an evidence based classroom program which focuses on cognitive skill-building to assist elementary school students with identifying and self-regulating their emotions. It has been used with a variety of children with special needs. It promotes social competency and reduces acting out and aggressive behavior.

A promising practice that reports application to American Indians is the *Life Skills Training Program*, which may significantly reduce substance use i.e. tobacco, alcohol, and marijuana (Botvin, Baker, Dusenbury, Tortu, & Botvin, 1990). This program teaches youth how to resist peer pressure and helps enhance self-esteem. Another promising program used with AI is *Preparing for the Drug Free Years*. This program focuses on enhancing bonding and reducing family-related risk factors (Hawkins, Catalano, & Kent, 1991). This program is highly researched and is based on defining and working with risk and protective factors.

The *Families and Schools Together (FAST) program* is a family-based practice that promotes protective factors and improves family functioning for children (aged 4-12) manifesting behavioral and academic problems (McDonald & Sayger, 1998). One of the primary strategies of this program is parent empowerment. It aims to achieve four main goals: enhance family functioning, prevent school failure, prevent substance abuse and reduce stress in the family.

Strengthening Multiethnic Families and Communities (SMFC) has been utilized by a number of American Indian communities with promising results. This program was designated a promising practice by the Center for Substance Abuse Prevention. Among American Indian parents, SMFC leads to improvement in the perceived quality of parent-child relationships including increased positive and decreased negative interactions, as well as perceived improvement in parental competence (Steele, 2002).

EVIDENCE BASED PRACTICES THAT MAY BE RELEVANT FOR AMERICAN INDIAN AND ALASKA NATIVE CHILDREN: EFFECTIVE MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS (SAMHSA)

The Cognitive Behavioral Therapy (CBT) for Child Traumatic Stress is a research based treatment model for children and adolescents ages 3 to 18, addressing trauma-related psychiatric symptoms seen in children following *9/11* (Schinke, Brounstein, & Garner, 2002). There are parallel sessions for children and parents, incorporating feeling identification, cognitive coping/processing, gradual exposure, stress management, and psycho education. Randomized control trials revealed significantly greater reductions in PTSD, depression, anxiety, problem behaviors, and parental emotional distress for children

receiving treatment. This model dealing with traumatic grief may be relevant to American Indians. Manson et al (1996) found a high incidence of trauma exposure among AI adolescents. Cognitive Behavioral Therapy for Child Sexual Abuse includes components such as psycho education, coping skills training, processing of traumatic memories, and training in personal safety skills (Schinke, Brounstein, & Garner, 2002). Parental involvement is included with joint sessions focused on communication about the abuse and associated issues. Parents also receive behavioral training to help reinforce healthy child behavior. Randomized control trials revealed significantly greater reductions in PTSD, depression, problem behaviors, and parental emotional distress as will as increased personal safety skills in children.

Stress Inoculation Training I targets stress reduction since the consequences of stress include anxiety, poor academic performance, delinquency, depression, and suicidal behavior. The practice focuses on enhancing coping skills and relaxation training for high school youth. Evaluation results indicate a significant reduction in anxiety compared with controls as well as increased self-esteem but showed no impact upon depression (Hains & Szyjakowski, 1990; Greenberg, Domitrovich, & Bumbarger, 1999). Because of the high trauma exposure among AI adolescents (Manson et al, 1996), stress is clearly a risk factor so this intervention would be beneficial for AI/AN youth.

CULTURALLY APPROPRIATE PRACTICES IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

Programs summarized in this section are grounded in indigenous culture and are being developed by and utilized in American Indian and Alaska Native communities. These programs show promise in our eyes, but have not yet officially been designated best or promising practices by national organizations.

A number of AI/AN substance abuse prevention models now incorporate traditional cultural activities. Spiritually oriented practices, such as purification lodges, smudging, talking circles, dream work and traditional help youth facilitate healing (Sanchez-Way & Johnson, 2000). Additional cultural activities also include learning traditional languages and crafts, cooking traditional foods, and subsistence activities such as hunting, fishing, and berry picking. In their review of the literature, Sanchez-Way and Johnson (2000) found that although the effect of culture upon substance abuse is indirect and acts through family and peers, some literature indicates that AI teens who identify with their culture are less likely to drink alcohol (Sanchez-Way & Johnson, 2000). Sanchez-Way and Johnson advocate that AI substance abuse prevention projects combine traditional cultural components with other demonstrated approaches.

Segal (2003) has led focus groups on Alaska Native practices. He defines best practices for Alaska Natives as utilizing traditional customs, indigenous healing practices along with appropriate non-Native healing approaches to address substance abuse and co-occurring intergenerational trauma including physical and/or sexual abuse.

Segal found that Alaska Native cultural identification issues were highly interrelated with drug abuse, which can in part be seen as a symptom of cultural identity (Segal, 2001, 2003).

Implicitly treatment can be informed by this understanding and thereby be a focus of intervention. Segal (1999) also found that cultural identification could successfully predict treatment completion and treatment outcome for Alaska Native women.

Segal (2003) reported that focus groups with AN consumers revealed that service providers needed to have familiarity and experience with AN clients and an understanding of community beliefs about healing. Further, practices must acknowledge cultural beliefs and incorporate them in the intervention. The respondents emphasized that spirituality is an important part of healing and that it should be an important component of effective intervention.

Segal (2003) advocates that historical trauma and multi-generational grief should also be a focus of the intervention. Staff training needs to include recognizing and treating trauma. Further, the incorporation of family members in treatment was advocated by AN focus group respondents, as was Native advisory boards, talking circles, and parenting education.

The AN focus groups identified some key best practice strategies that were consistently found to contribute to successful treatment with AI/ANs. These include spirituality, community support, ceremonies, elder involvement, Natives values, Native staff and Native peer support (Segal, 2003).

Years earlier, Silver and Wilson (1988) identified the therapeutic properties of AI purification lodge ceremonies including role modeling affect tolerance (the capacity for one to tolerate her/his emotions), promoting group collectivity, bonding, and ego-enhancement.

The following culturally oriented programs incorporate the key best practice strategies Segal (2003) highlighted. One project (HTUG), used by the authors, is described in detail to give the reader an idea of what a culturally appropriate program would look like.

In a Center for Substance Abuse Treatment-funded project of the Alaska Federation of Natives (AFN), a prototype model of care for substance abuse treatment for Alaska Natives was identified (Segal, 2003). The model incorporated traditional ways. Literature on traditional Native healing practices for mental health disorders as such is limited. However, other studies on Natives in treatment for substance abuse have demonstrated that cultural factors are important elements related to treatment outcome (Segal, 2001, 2003). Gutierres, S.E., Russo, N.F., and Urbanski, L. (1994) found that acculturation issues were related to treatment outcome and a higher treatment completion rate was found for women indicating that they practiced traditional Native activities while growing up and during the past year, with over 50% of these women viewing themselves as traditional.

Storytelling for Empowerment is a SAMHSA-designated promising practice for middle school rural/reservation American Indian youth and Latino urban youth (Schinke, Brounstein, & Garner, 2002). The focus is on risk factors such as confused cultural identity and the lack of positive parental role models. Goals are to decrease substance abuse, reduce risk factors, and increase resilience.

One of the few AI/AN programs designated as a promising practice is the *Zuni Life Skills Curriculum*. The model focuses on building social-emotional competence and reducing suicidal risk for Zuni Pueblo adolescents. Evaluation revealed that participants reported significantly less hopelessness and manifested higher suicide intervention skills. Another promising practice is the *Sacred Child Project*, serving several North Dakota tribes (Cross, Earle, Echo-hawk Solie, & Manness, 2000. It uses the Wraparound approach (Burns & Goldman, 1999) with children having diagnosable emotional disturbances or who are in danger of or transitioning back from placement outside of the home. The program integrates western treatment and traditional methods. "The whole idea about sacred child is to keep the child in the home or at the very least keep the child in the community".

The Historical Trauma & Unresolved Grief Intervention (HTUG):

A culturally appropriate practice that has not yet been included on the SAMHSA Model Programs is the *Historical Trauma and Unresolved Grief Intervention*. HTUG was recognized as an exemplary model by CMHS through the award of a Lakota (Teton Sioux) Regional Community Action Grant on Historical Trauma to the Takini Network, a Native non-profit community based organization. The authors are involved with this project and are presenting it in detail to give the reader an idea of what a culturally appropriate program might look like. The description includes background information on historical trauma and unresolved grief and how these experiences affect American Indians in this country. The program was developed for the Lakota, but it is applicable to other American Indians as well.

HTUG has been validated through formal evaluation and research, documented in peer reviewed journals as well as other publications (Brave Heart, 1995, 1998, 1999a, 1999b, 2000, 2001a, b; Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998). Literature on AI trauma (Manson et al.,1996; Robin, Chester, & Goldman, 1996) and general trauma literature (van der Kolk, McFarlane, & van der Hart, 1996) supports the theoretical constructs underpinning HTUG and the need for specific culturally based trauma theory and intervention.

Historical trauma (HT) is cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences. The historical trauma response (HTR) is the constellation of features in reaction to this trauma (Brave Heart, 1998, 1999a). The HTR often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions (Brave Heart, 1998, 1999). The HTR may include substance abuse, often an attempt to self-medicate to avoid painful feelings. The HTR is passed on across generations and intervening with parents can ameliorate the intergenerational transfer of substance abuse (Garbarino, Dubrow, Kostelny, & Pardo, 1990).

HTUG, a psycho educational group intervention, targets parents. Its goal is to reduce mental health risk factors and increase protective factors for children. It has several components: (a) education about traumatic Lakota history and its impact upon current lifespan trauma, (b) utilization of visual stimuli such as videotapes and slides to facilitate processing of that trauma through abreaction and catharsis, (c) fostering a re-connection to traditional Lakota cultural values that can serve as protective factors against mental health and substance abuse

issues, and (d) promoting group collectivity, bonding, and ego-enhancement as well as emotional containment by using traditional Native rituals such as the Lakota purification lodge which aids in that process (Brave Heart, 1998; Silver & Wilson, 1988).

Although HTUG was initially designed as a Lakota intervention, it can be modified for other tribal groups, and is being adapted by other communities such as the Eastern Band of Cherokee Indians. Historical trauma workshops have been delivered to AN communities as well as several other AI regions. HTUG is typically delivered ideally in a retreat setting, which affords a traditional milieu and emotional container. HTUG begins with a greeting circle, prayer, and burning of sage/sweetgrass to foster group collectivity and honesty (traditional belief). HTUG includes a review of traditional ground rules based traditional Native values. The first day focuses on the communal historical trauma (HT) such as massacres and boarding schools. Videos and slides are used with didactic presentation of facts about AI/AN massive group traumatic history. Opportunities for small and large group sharing as well as sharing in pairs are interspersed throughout the presentation of HT. Day Two focuses on completion of boarding school trauma and imparting traditional knowledge, which can serve as protective factors. Information about trauma response features and the physiological as well as emotional impact of trauma is imparted. Participants share life span trauma, after drawing a timeline of their trauma and loss experiences. Self-care plans are then developed and shared. There are also warm up and experiential exercises, using humor as an emotional container. Each day begins and ends with prayer and sometimes traditional singing. A key component is the facilitation of a consolidated positive Native identity through transcendent AI/AN cultural experiences such as the *oinikage* (purification ceremony), which permits cathartic self-disclosure, ego enhancement, collectivity, reformation of self, transfers expectations of healing, and further models affect tolerance (Brave Heart, 1998; Silver & Wilson, 1988).There is a *lowanpi* or *yuwipi* (healing ceremony) or an *inipi* or *oinikage* (purification lodge/ceremony) typically the 3rd night. The last day is more sharing re: self care, plans for the community to continue the process of healing, and a wiping of the tears ceremony or exercise.

The techniques and key operational components of HTUG are analogous to those utilized with other massive group trauma survivors such as group sharing, videotape stimulus material to facilitate retrieval of repressed memories, cognitive content about traumatic history as well as responses to that history, and traditional Native practices aimed at facilitating abreaction and catharsis (emotional processing and releasing) and transcendence (Brave Heart, 1995, 1998). The intervention facilitates disclosure, cohesiveness, bonding and mutual identification, and provides opportunities for role modeling affect tolerance, self-regulation, and trauma mastery comparable to other group intervention models with PTSD clients, massive group trauma survivors and their descendants (Brave Heart, 1998; Fogelman & Savran, 1979). HTUG is also equivalent to the Phase Oriented Treatment strategies for PTSD (van der Kolk, McFarlane, & van der Hart, 1996) utilizing (a) stabilization which includes education and identification of feelings, (b) reconditioning of traumatic responses and memories, (c) restructuring traumatic internal systems, (d) reestablishment of safe social connections and efficacy in relationships, and (e) amassing a collection of restorative emotional experiences (p. 426). HTUG results in symptom normalization (Koller, Marmar, &

Kansas, 1992) and a healthy sense of connection with deceased ancestors rather than fixation to the trauma (Fogelman, 1991).

The importance and impact of HTUG upon American Indian children can be understood through a description of the challenges for their parents. Many AI and some AN parents have most likely been the victims of punitive or "boarding school style discipline" which is perceived as negatively impacting parenting interaction with children and contributes poor mental health, substance abuse, violence, and other problems (Brave Heart, 1998, 1999a). Protective factors against psychosocial problems such as parental emotional availability and support, parental competence, and parental involvement with a child's schooling have all been negatively impacted by parental or generational boarding school experiences. Parents who have been traumatized as children are less likely to be emotionally present for their children. Parents raised in boarding schools lack role models of healthy parenting, thereby being at risk for parental incompetence. The lack of control over the school environment, choices about schooling, and negative boarding school experiences (see Brave Heart, 1995, 1999a) place AI parents at greater risk for a lack of involvement in the schooling of the current generation. Hence, there is a significant need for healing from this traumatic history among AI parents, which includes an emphasis on parental competence and parental support.

There is an increased risk of substance abuse and other emotional problems in children who experience: un-nurturing and ineffective parental disciplinary practices, absence of family rituals, alcohol-related violence, parental psychiatric problems such as depression, sibling alcohol use, and stressful life events such as verbal, physical, and sexual child abuse perpetrated by a family member (see Chassin, Pillow, Curan, Molina, & Barrera, 1993; Jacob & Leonard, 1994; Jennison & Johnson, 1998; Miller, Maguin, & Downs, 1997; Molina & Chassin, 1996; Orenstein & Ullman, 1996; Sher, 1997; Symth & Miller, 1998; Sher, Gershuny, Peterson, & Raskin, 1997).

A lack of effective AI/AN parenting role models and the lack of nurturing as well as abuse in boarding schools have resulted in punitive, authoritarian, uninvolved, and non-nurturing parents to varying degrees (see Brave Heart, 1995, 1999a, 2000; Morrisette, 1994). Poor spiritual foundations, weak Native identity, and poor family affiliation – consequences of the boarding school legacy and spiritual oppression (Brave Heart, 1999a) – are associated with Indian youth alcohol and other substance abuse (Oetting & Beauvais, 1989; Guyette, 1983).

An analysis of CSAP's High Risk Youth Cross-site study indicated that positive family relations with supervision, monitoring, and anti-drug family norms serve as protective factors against youth substance abuse (Nye, Zucker, & Fitzgerald, 1995). Protective family factors include positive discipline methods, high parental involvement, spiritual involvement, bonding with family and social groups that value non-use of alcohol and other substances, and external social support (see Alvy, 1991/1993). The literature on protective factors suggests that parents' encouragement of their children to dream and to establish goals and purpose in life is an important protective factor. The disempowerment and oppression of AI/AN as well as the prohibition against the open practice of Native spirituality historically has impaired Native ability, to varying degrees, of being able to dream about the future, to set life goals, and to find one's spiritual purpose in life.

Intergenerational Transfer of Trauma Research

Often associated with parental substance abuse, childhood trauma exposure influences the emotional and the sensory perceptual experiences of childhood events and these effects persist into adulthood (Segal, in press). Among Alaska Native females, substance abuse is related to emotional problems, parental neglect and abuse, and sexual victimization of offspring (Segal, in press).

An examination of risk factors for PTSD among descendents of Jewish Holocaust survivors is relevant to American Indians. Yehuda in Brave Heart (in press) found that, despite the lack of statistically significant differences in actual self- reported number of traumatic events or in the degree of trauma exposure, adult children of survivors had a higher degree of cumulative lifetime stress (Brave Heart, 2003, in press). Implicitly, there is a tendency among offspring to experience or perceive events as more stressful and traumatic. Children of Holocaust survivors were found to be more likely to develop PTSD in response to their own traumatic lifetime events when having a parent living with chronic PTSD. Rather than trauma exposure itself, the parental trauma symptoms are the critical risk factors for trauma responses among the children of survivors. For AI/AN, PTSD prevalence is 22% compared with 8% for the general population. For AI/AN veterans, PTSD rates are significantly higher than both African Americans and the general population, attributed at least in part to greater trauma exposure (Office of the Surgeon General, 2001). PTSD nomenclature inadequately represents AI/AN trauma (Robin, et al., 1996), specifically historical trauma (Brave Heart, 2003). Despite the pervasiveness of trauma exposure, AI youth often do not meet the criteria for PTSD because their culture may mask symptom presentation and assessment (Brave Heart, 1999, 2003, in press; Manson et al., 1996). The Takini Network is developing more accurate trauma assessment and evaluation efforts and studying the effectiveness of HT interventions.

First-degree relatives of trauma survivors with PTSD manifest a greater prevalence of mood and anxiety as well as substance use disorders (Brave Heart, 2003; Yehuda, 1999). Children of substance abusers attempt suicide at a higher rate (Segal, in press). Childhood sexual abuse reported by many AI/AN boarding school survivors is implicated in intergenerational trauma transfer and is a significant risk factor for depression, and/or anxiety disorders and substance abuse (Brave Heart, 1999a, 2003, in press; Robin, et al., 1996). Offspring of parents with anxiety or depressive disorders have an increased risk of developing a similar disorder (Beardslee & Wheelock, 1994). Depression and substance abuse are correlated with PTSD and are both common among AI/AN (Robin et al, 1996; Brave Heart, 1999b, 2003, in press); high trauma exposure is significant among AI/AN adolescents (Manson et al, 1996). All these factors of childhood and trans-generational trauma are considered in the HTUG program.

CONCLUSION AND RECOMMENDATIONS

The sparse literature regarding promising and evidence based practices with AI/AN children does not specify sample size, degree of cultural adaptation, if any, significance for treatment effect, and the outcome measures. Information regarding replication is not documented. There is a paucity of evidence based prevention and intervention practices *specifically* addressing the needs of Native children and youth and the issues that these young people

face. Existing evidence based models are often not culturally grounded, adapted, nor sufficiently tested with AI/AN populations.

Culturally based, culturally congruent, and culturally grounded practices that emerge from traditional AI/AN worldviews, philosophies, behavioral norms, relationships, attributes, and developed by Natives, need to be fostered, promoted, and evaluated. Federal agencies should promote and fund culturally congruent research and evaluation of Native-driven practices conducted by AI/AN evaluators primarily and incorporating a consideration for the AI/AN community. Native-developed and designed practice models should be encouraged and fostered, rather than simply applying practices developed with other populations. Federal agencies can facilitate the development of an AI/AN practice database, which the authors are currently exploring with CMHS staff. Finally, those evidence based and promising practices that have the potential to be of help to the AI/AN population should be adapted and then evaluated, utilizing focus groups of AI/AN community members, AI/AN key informants, and AI/AN consultants for such adaptation Culturally appropriate measurement instruments and research and evaluation designs need to be utilized.

References

Alvy, K.T. (1993). Parent training as a prevention strategy. Parent training is prevention: Preventing alcohol and other drug problems among youth in the family (pp. 11-26). Rockville, MD: Center for Substance Abuse Prevention (DHHS Publication No. (SMA) 93-2022) (original work published 1991).

Beardslee, WR & Wheelock, I. 1994. Children of parents with affective disorders: Empirical findings and clinical implications. In W. M. Reynolds & H.F. Johnson (Eds.).Handbook of depression in children and adolescents (pp. 463-479). New York: Plenum.

Botvin, G.J, Baker, E., Dusenbury, L., Tortu, S., & Botvin, E.M. (1990). Preventing adolescent drug abuse through a multimodal cognitive-behavioral approach: results of a 3-year study. Journal of Consulting and Clinical Psychology, 58, 437-446.

Brave Heart, M.Y.H. & DeBruyn, L.M. (in press). The Historical Trauma Response among Natives: The Lakota example in Brave Heart, DeBruyn, Segal, Taylor, & Daw (Eds) Historical Trauma within the American experience: Roots, effects, and healing. New York: Haworth Press.

Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. Journal of Psychoactive Drugs, 35(1), 7-13.

Brave Heart, M.Y.H. (2000) Wakiksuyapi: Carrying the historical trauma of the Lakota. Tulane Studies in Social Welfare, 21-21, 245-266.

Brave Heart, M.Y.H. (1999a) Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents, Journal of Human Behavior and the Social Environment, 2(1/2), 109-126.

Brave Heart, M.Y.H. (1999b) Gender differences in the historical trauma response among the Lakota. Journal of Health and Social Policy, 10(4), 1-21; and Health and the American Indian (eds: Priscilla A. Day & Hilary N. Weaver), New York: Haworth Press, 1-21.

Brave Heart, M.Y.H. (1998) The Return to the sacred path: Healing the historical trauma response among the Lakota Smith College Studies in Social Work, 68(3), 287-305.

Brave Heart, M.Y.H. (2001a) Clinical assessment with American Indians in R.Fong & S. Furuto (Eds). Cultural competent social work practice: Practice skills, interventions, and evaluation (pp. 163-177). Longman Publishers.

Brave Heart, M.Y.H. (2001b) Clinical interventions with American Indians in R. Fong & S. Furuto (Eds). Cultural competent social work practice: Practice skills, interventions, and evaluation (pp. 285-298). Longman Publishers.

Brave Heart, M.Y.H. & DeBruyn, L.M. (1998). The American Indian Holocaust: Healing historical unresolved grief. American Indian and Alaska Native Mental Health Research, 8(2), 56-78.

Brave Heart - Jordan, M.Y.H. (1995/1996). The Return to the Sacred Path: Healing from Historical Trauma and Historical Unresolved Grief Among the Lakota. (Doctoral dissertation, Smith College School for Social Work, 1995). Dissertation Abstracts International, A 56/09, p. 3742. (Copyright held by author. For copies, contact The Takini Network, 1818 West Fulton Street, # 101, Rapid City, SD 57702)

Burns, B.J., & Goldman, S.K. (Eds.). (1999). Promising practices in Wraparound for children with serious emotional disturbance and their families. Systems of Care: promising practices in children's mental health, 1988 Series, Volume IV. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Chassin, L., Pillow, D.R., Curran, P.J., Molina, B.S., et al., (1993). Relation of parental alcoholism to early adolescent substance use: A test of three mediating mechanisms. Journal of Abnormal Psychology, 102(4), 3-19.

Cross, T., Earle, k., Echo-hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a System of Care model in American Indian communities. Systems of Care: Promising practices in children's mental

Health, 2000 series, Volume I. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research, 47-53.

Duran, E., Duran, B., Brave Heart, M.Y.H. & Yellow Horse-Davis, S. (1998). Healing the American Indian Soul Wound. In Yael Danieli, (Ed.), International handbook of multigenerational legacies of trauma (pp. 341-354). New York: Plenum Publishing.

Fogelman, E. (1988). Therapeutic alternatives for Holocaust survivors and the second generation. In R.L. Braham (Ed.), the psychological perspectives of the Holocaust and of its aftermath (pp. 79-108). New York: Columbia University Press.

Fogelman, E. (1991). Mourning without graves. In A. Medvene (Ed.), Storms and Rainbows: The many faces of death (pp. 25-43). Washington, D.C: Lewis Press.

Fogelman, E. & Savran, B. (1979). Therapeutic groups for children of Holocaust survivors. International Journal of Group Psychotherapy, 29(2), 211-235.

Garbarino, J., Dubrow, N., Kostelny, K., & Pardo, C. (1990). Children in Danger: Coping with the Consequences of Community Violence.

Greenberg, Domitrovich, & Bumbarger (1999) Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Greenberg, M.T. & Kusche, C.A. (1997). Improving children's emotion regulation and social competence: The effects of the PATHS curriculum. Paper presented at meeting of Society for Research in Child Development, Washington, D.C.

Greenberg, M.T. & Kusche, C.A. (1998). Preventive intervention for school-aged deaf children: The PATHS curriculum. Journal of Deaf Studies and Deaf Education, 3, 49-63.

Gutierres, S.E., Russo, N.F., & Urbanski, L. (1994). Sociocultural and psychological factors in American Indian drug use: Implications for treatment. The International Journal of the Addictions, 29(14), 1761-1786.

Guyette, S. (1982). Selected characteristics of American Indian substance abusers. International Journal of the Addictions, 17 (6), 1000-1014.

Hains, A.A. & Szyjakowski (1990). A cognitive stress-reduction intervention program for adolescents. Journal of Counseling Psychology, 37, 79-84.

Hawkins, J.D., Catalano, R.F., & Kent, L.A. (1991). Combining broadcast media and parent education to prevent teenage drug abuse. In L. Donohew, H.E. Sypher, & W.J. Bukoski (Eds.), Persuasive communication and drug abuse prevention (pp. 283-294). Hillsdale, NJ: Erlbuam.

Holm, T. (1994). The national survey of Indian Vietnam veterans. American Indian and Alaska Native Mental Health Research, 6 (3), pp. 18-28.

Jacob, T., & Leonard, K. (1994). Family and peer influences in the development of adolescent alcohol abuse. pp 123-156 In R. Zucker, G. Boyd, & J. Howard (eds.). The development of alcohol problems: Exploring the biopsychosocial matrix of risk. National Institute of Alcohol Abuse and Alcoholism Research Monograph No.26 NIH Pub. No, 94-3495. Washington, DC: the Institute.

Jennison, K.M., & Johnson, K.A. (1998). Alcohol dependence in adult children of alcoholics: Longitudinal evidence of early risk. Journal of Drug Education, 28(1): 19-37.

Kestenberg, J.S. (1990). Survivor parents and their children. In M.S. Bergmann & M.E. Jucovy (Eds). Generations of the Holocaust (pp. 83-102). New York: Columbia University Press. (Original work published 1982)

Koller, P., Marmar, C.R., & Kansas, N. (1992). Psychodynamic group treatment of post-traumatic stress disorder in Vietnam veterans. International Journal of Group Psychotherapy, 42(2), 225-246.

Manson, S., Beals, J., O'Nell, T., Piasecki, J., Bechtold, D., Keane, E., & Jones, M. (1996). Wounded spirits, ailing hearts: PTSD and related disorders among American Indians. In Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds), Ethnocultural aspects of Posttraumatic Stress Disorder. Washington DC: American Psychological Association, pp. 255-283.

McDonald, L. & Sayger, T.V. (1998). Impact of a family and school based prevention program on protective factors for high-risk youth. Drugs &Society, 12, 61-85.

Miller, B.A., Maguin, E., & Downs, W.R. (1997). Alcohol, drugs, and violence in children's lives. In M. Galanter (Ed.), Recent developments in alcoholism: Vol. 13: Alcohol, drugs and violence (pp. 357-385). New York Plenum Press.

Molina, B.S.G., & Chassin, L. (1996). The parent-adolescent relationship at puberty: Hispanic ethnicity and parent alcoholism as moderators. Developmental Psychology, 32(4): 675-686.

Moran, J., & Yellow Horse, S. (2000). American Indian Core Measures Project. Final Report to Center for Substance Abuse Prevention.

Moran, J. (1999) Family Strengthening Project. Unpublished manuscript

Moran, J. (1999). Preventing alcohol use among urban American Indian youth: The Seventh Generation Program. The Journal of Human Behavior in the Social Environment, 2, 1–2, 1999.

Nye, C., Zucker,R., & Fitzgerald, H. (1995). Early intervention in the path to alcohol problems through conduct problems: Treatment involvement and child behavior change. Journal of Consulting and Clinical Psychology, 63, 831-840.

Oetting, E. R., & Beauvais, F. (1989). Epidemiology and correlates of alcohol use among Indian adolescents living on reservations. In: Alcohol Use Among U.S. Ethnic Minorities, NIAAA research monograph no. 18, Rockville, Maryland: U.S. Public Health Service.

Office of the Surgeon General (2001). Mental Health: Culture, Race, and Ethnicity Supplement to Mental Health: A Report of the Surgeon General (1999). Department of Health and Human Services under the direction of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, in partnership with the National Institute of Mental Health, National Institutes of Health.

Orenstein, A., & Ullman, A. (1996). Characteristics of alcoholic families and adolescent substance use. Journal of Alcohol and Drug Education, 41(3): 86-101

Patton, M.Q. (1990). Qualitative evaluation and research methods, Second Edition. Newbury, CA: Sage.

Randell, B.P., Eggert, L.L., & Pike, K.C. (1998). Immediate post-intervention effects of two brief youth suicide prevention interventions. Suicide and Life-Threatening Behavior.

Robin, R.W., Chester, B., & Goldman, D. (1996). Cumulative trauma and PTSD in American Indian communities (pp. 239-253). In Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds), Ethnocultural aspects of Post-traumatic Stress Disorder. Washington, DC: American Psychological Press.

Sanchez-Way, R. & Johnson, S. (2000). Cultural practices in American Indian Prevention Programs, Juvenile Justice Journal, 8(2), pp. 1-12.

Schinke, S., Brounstein, P., & Garner, S. (2002). Science-Based Prevention Programs and Principles, 2002. DHS Publication No. (SMA) 03-3764. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration

Segal, B. (2003). Summary Progress Report: Healing Practices. Anchorage, AK: Alaska Federation of Natives

Segal, B. (2001). Responding to victimized Alaska Native women in treatment for substance use. Substance Use and Abuse, 36 (6&7), 845-865.

Segal, B. (1999). Alaska Natives combating substance abuse and related violence through self-healing: A report to the people. Anchorage, AK: Alaska Federation of Natives.

Segal, B. (in press) Personal violence and historical trauma among Alaska Native pre-teen girls, and adolescent girls and women in treatment for substance abuse, in Brave Heart, DeBruyn, Segal, Taylor, & Daw (Eds) Historical Trauma within the American experience: Roots, effects, and healing. New York: Haworth Press.

Sher, K.J. (1997). Psychological characteristics of children of alcoholics. Alcohol Health and Research World, 21(3): 247-254.

Sher, K.J., Gershuny, B.S., Peterson, L., & Raskin, G. (1997). The role of childhood stressors in the intergenerational transmission of alcohol use disorders. Journal of Studies on Alcohol, 58: 414-427.

Silver, S.M. & Wilson, J.P. (1988). Native American healing and purification rituals for war stress. In John P. Wilson, Zec Harele, & Boaz Hahana (Eds.) Human adaptation to extreme stress: From the Holocaust to Viet Nam. (pp. 337-355). New York: Plenum Press.

Smyth, N.J., Miller, B.A. (1998) Parenting issues for substance abusing women. In S.L.A. Straussner & E. Zelvin (Eds.), Gender Issues in Addiction: Men and Women in Treatment. New York: Jason Aronson, Inc., 125-150

Steele, M. (2002) Strengthening Multiethnic Families and Communities Parent Training Program (1994-2001). Unpublished document

Swaim, R. C., Oetting, E. R., Edwards, R. W., & Beauvais, F. (1989). Links from emotional distress to adolescent drug use: A path model. Journal of Consulting and Clinical Psychology. 57(2), 227-231.

van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds) (1996). Traumatic stress: The effects of overwhelming experience on mind, body, and society. New York: Guilford Press.

van der Kolk, B.A., McFarlane, A.C., & van der Hart, O. (1996). In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds), Traumatic stress: The effects of overwhelming experience on mind, body, and society (pp. 417-440). New York: Guilford Press.

Yehuda, R. (1999) (Ed). Risk factors Posttraumatic Stress Disorder. Washington, DC: American Psychiatric Press.

Resource Guide

Cultural Enhancement Through Storytelling

A Best Practice

Description:

1. **Primary purpose:** "Cultural Enhancement Through Storytelling," 1997 winner of NCADD's Prevention and Education Meritorious Award, is a primary prevention program of NCADD's Tucson Affiliate. A community-based project located in Sells, AZ.

   The Programs philosophy is that stories teach respect for the self, school, teachers, community, family and tribe, and that the O'odham culture teaches through stories. Stories can strengthen and empower youth, "which include heroes and heroines who overcome adversity and win honor for themselves, family and community, help build a strong personal identity which can motivate youth toward future goals." All that the project represents can be found in the saying "O'odham Himdag `o wud t-gewkdag," which translates as "the O'odham way of life is our strength."

   The four objectives include: 1) seventh-grade students will show an increase in their ability to make good decisions and practice problem-solving skills; 2) students will learn the definition of a positive role model and be able to identify one within their community; 3) seventh-grade students will show an increase in their knowledge of alcohol and other drugs and a self-reported decrease in the use of these substances; and 4) students will feel a stronger connection to their culture and heritage.

   "Six major components comprise the project. Three of the components are seventh-grade school curricula for health studies, social studies and language arts. Each of the curricula is delivered over a six-week period by the classroom teacher, with assistance from the project staff. Pre- and post-tests are administered to measure specific skills learned by the students."

   "Tribal elders tell traditional stories during Winter Storytelling Nights in January, when community members are invited to join in song and dance. In addition, O'odham traditions and culture are being incorporated into the operations of the juvenile detention

center, the Tohono O'odham diabetes program and other services for children and adults."

2. Target populations: The Tohono O'odham Indian reservation, it targets children ages nine to fourteen.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available.

2. **Qualitative evaluation**: Information not available.

Evidence supporting practice:

This program received one of eight 1998 Exemplary Substance Abuse Prevention Program Awards, sponsored by the National Association of State Alcohol and Drug Abuse Directors, the National Prevention Network and the Center for Substance Abuse Prevention. The National Council on Alcoholism and Drug Dependence fights the stigma and the disease of alcoholism and other drug addictions.

Practice implementation:

1. **Staffing requirements:** Classroom teacher, with assistance from the project staff. Tribe members fluent in the O'odham language and knowledgeable in the traditions of their people are employed as site staff. Instrumental in its development, they have been affiliated with the project since the pilot phase began in 1991.
2. **Training requirements:** Six major components comprise the project. Three of the components are seventh-grade school curricula for health studies, social studies and Language arts. Each of the curricula is delivered over a six-week period by Pre-and post-tests are administered to measure specific skills learned by students.
3. **Cost of program:** none known.
   Prevention Material For Parents
   $1.25 - What Should I Tell My Child About Drinking? (Brochure)
   Comprehensive guide offers advice for various stages of a child's development and features a series of "teachable moments" that give parents a structured opportunity to sit down with their child and discuss alcohol.

   $59.99 - What Should I Tell My Child About Drinking? (Video)
   Hosted by Meryl Streep, this two-part video will help parents and other caregivers improve their communication skills about alcohol. Package includes companion brochure (see above) and facilitator's guide. VHS, 46 minutes, color.

   Prevention Materials For Youth
   $0.75 - Drinking Too Much Too Fast Can Kill You.
   How to recognize the signs of alcohol poisoning and what to do about it. Companion poster also available.

   $0.75 - Who's Got the Power? You . . . Or Drugs?

Straight talk--in their own words--for adolescent guys and girls, plus important health information, all in day-glo colors.

$0.75 - Girls! Straight Talk About Drinking and Drugs.
Gender-specific information for teen girls vividly conveyed in language they use and understand.

Posters
$2.00 - Don't Let Drinking Take Your Power Away.
Part of our "Prevention Series for Youth," this poster targets teen girls with a dramatic photograph. Printed both sides in English and Spanish. Four-color, 15 1/2" x 22 1/2."

$2.00 - Drinking Too Much Too Fast Can Kill You.
Simple, graphic message targets students on high school and college campuses, or anywhere binge drinking takes place. Also includes essential facts about alcohol for this audience. Two-color, 15 1/2" x 22 1/2".

Publications Kit
$10.00 - NCADD Sample Kit
Includes a sample of every NCADD publication EXCEPT the video. A $14.75 value. One per customer.

4. **Use of natural funding:** The Arizona Department of Health Services funds the project through the Community Partnership of Southern Arizona. The Indian Oasis Baboquivari School District, a major collaborator, provides additional funding.

Other considerations:

Contact information:

Compass Health Care
2475 N Jackrabbit Avenue
Tucson AZ 85745
520/620-6615

Relevant websites:

Email: tucson.az@ncadd.org

Strengthening Families Program

A Best Practice

Description:

1. **Primary purpose:** none known. The Strengthening Families Program (SFP) provides parenting and family skills development strategies to reduce problem behaviors in children, improve school performance, and reduce delinquency and alcohol and drug use in teenagers.

2. **Target populations**:

   Ages of Children:

   Preschool children (3-5 years of age): Use SFP parent and family training manuals, plus Dare to Be You children's manual, or Webster-Stratton's child and parenting series (find contact information for these programs on www.strengtheningfamilies.org

   Elementary school aged children (6-11 years): Use the original SFP. For detailed description of Strengthening Families Program (SFP)

   Junior high school students (12- 14 years): Use the 7-session Strengthening Families Program for 12-14 year olds (Molgaard and Kumpfer, 1994).

   High school students: Use the original SFP to teach high school students how to be better parents.

   Diverse Ethnic Populations

   African-American families: The Strengthening Families Program was modified twice for African-American children and parents. Each time new-revised manuals were developed on CSAP grants. The Strengthening Black Families Program was developed and found effective for rural African-American families in mental health and drug treatment in the South. The Safehaven Program is the SFP modification for inner city drug abusers developed by the Salvation Army Harborlight staff and the Detroit City Department of Health. The positive results of this research can be found in the International Journal of Addictions and the Journal of Substance Use and Abuse (Aktan, Kumpfer, and Turner). These two SFP curriculum sets can be ordered from the University of Utah.

   Asian and Pacific Islander Families: Also on a CSAP Grant, the Coalition for Drug-free Hawaii Developed the Strengthening Hawaii's Families Program. This program is substantially modified and includes 10 session of family values followed by 10 sessions of the original SFP modified to be more culturally appropriate. The outcome results, however, were somewhat better for the 14-session SFP than for the more culturally modified SFP (Kameoke). These curriculum manuals can be purchased through the Coalition for Drug-free Hawaii.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: none known.
   a. The standardized SFP Parent Interview Questionnaire (195-items) with client satisfaction and recommendations for SFP improvements added for the Follow-up Parent Interviews;
   b. The SFP Children's Interview Questionnaire (150-items);
   c. SFP Teacher/Trainer Interview Questionnaire (about 160-items), used in prior SFP studies modified by the local site evaluator recommendations and pilot tests of the instruments.

2. **Qualitative evaluation**: None known.

Evidence supporting practice:

1. **Peer-reviewed research:**

U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

www.strengtheningfamilies.org

Aktan, G. B. Kumpfer, K. L., & Turner, C. W. (1996). Effectiveness of a family skills training program for substance use prevention with inner city African-American families. Substance Use and Misuse.

Kumpfer, K. L. (1987). Special populations: etiology and prevention of vulnerability to chemical dependency in children of substance abusers. In Brown, B.S., & Mills, A.R. (Eds.) Youth at High Risk for Substance Abuse: 1-71. National Institute on Drug Abuse Monograph, DHHS Publication Number (ADM) 90-1537. Washington, DC: Supt. of Doc., U.S. Government Printing Office.

Kumpfer, K. L. (1989). Prevention of alcohol and drug abuse: A critical review of risk factors and prevention strategies. In Shaffer, D., Philips, I., & Euzer, N. (Eds.), Prevention of Mental Disorders, Alcohol and Other Drug Use in Children and Adolescents (pp. 309-371). OSAP Monograph No. 2. Rockville, MD.

Kumpfer, K. L. (1993). Strengthening America's families: Promising parenting and family strategies for delinquency prevention. A User's Guide, prepared for the U. S. Department of Justice under Grant No. 87-JS-CX-K495 from the Office of Juvenile Justice and Delinquency Prevention, Office of Juvenile Programs, U.S. Department of Justice.

Kumpfer, K. L. (1993). Safe Haven African American parenting project: Second year evaluation report. Submitted to City of Detroit Health Department, Health Behavior Laboratory, Department of Health Education, University of Utah, Salt Lake City, UT.

Kumpfer, K. L. (1995). Access to hard-to-reach women: Interventions as confounds or strategy. In C. Jones & M. De la Rosa (Eds.) NIDA technical review: Methodological issues: Etiology and consequences of drug abuse among women. Silver Spring, MD: National Institute of Drug Abuse ADAMHA.

Kumpfer, K. L. (1996). Principles of effective family-focused parent programs. Paper presented at the NIDA conference: "Drug Abuse Prevention Through Family Intervention", Gaithersburg, MD, January 1996

Kumpfer, K. L. (1996). Selective prevention approaches for drug abuse prevention: The Strengthening Families Program. Paper presented at the NIDA conference: "Drug Abuse Prevention Through Family Intervention", Gaithersburg, MD, January 1996.

Kumpfer, K. L. (1997). What works in the prevention of drug abuse: Individual, school and family approaches. DHHS, Center for Substance Abuse Prevention. Secretary's Youth Substance Abuse Prevention Initiative: Resource Paper: 69-105. March 1997.

Kumpfer, K. L. & Alvarado, R. (1995). Strengthening families to prevent drug use in multi-ethnic youth. In G. Botvin; S. Schinke ; & M. Orlandi (Eds.) Drug abuse prevention with multi-ethnic youth: 253-294. Newbury Park, CA: Sage Publications.

Kumpfer, K. L., & Bayes, J. (1995). Child abuse and alcohol, tobacco, and other drug abuse: Causality, coincidence, or controversy? In J.H. Jaffe (Ed.), The Encyclopedia of Drugs and Alcohol. New York: Macmillan.

Kumpfer, K. L., & Bluth, B. (in press). Parent/child transactional processes predictive of substance abuse resilience or vulnerability. In Johnson, J.L., & McDuff, D.K. (eds.) The Chronicity of Substance Abuse. Baltimore: Harcourt.

Kumpfer, K. L., & DeMarsh, J. P. (1985). Prevention of chemical dependency in children of alcohol and drug abusers. NIDA Notes 5: 2-3.

Kumpfer, K. L., & DeMarsh, J. P. (1986). Family environmental and genetic influences on children=s future chemical dependency. In S. Griswold-Ezekoye, K. L. Kumpfer, & W. Bukoski (Eds.), Childhood and Chemical Abuse: Prevention and Intervention (pp49-91). New York: Haworth.

Kumpfer, K. L.; DeMarsh, J. P.; & Child, W. (1989). Strengthening families program: Children's skills training curriculum manual, parent training manual, children's skill training manual, and family skills training manual (Prevention Services to Children of Substance-abusing Parents). Social Research Institute, Graduate School of Social Work, University of Utah.

Kumpfer, K. L.; Molgaard, V.; & Spoth, R. (1996). The Strengthening Families Program for prevention of delinquency and drug use in special populations. In R. Peters & R.J. McMahon, (Eds.) Childhood Disorders, Substance Abuse, and Delinquency: Prevention and Early Intervention Approaches. Newbury Park, CA: Sage Publications.

Kumpfer, K. L., Olds, D.; Alexander, J. F., Zucker, R. A., Gary, L. E. (In press). Family etiology of youth problems. In Ashery, R. & Kumpfer, K.L. (eds.) Family-Focused Preventions of Drug Abuse: Research and Interventions, NIDA Research Monograph. Submitted 9/17/96.

Kumpfer, K. L., Olds, D., Alexander, J. F., Zucker, R. A., Gary, L E. , & McDonald, L. (In press). Family-focused substance abuse prevention: What have we learned from other fields? In Asbery, R. and Kumpfer, K. (Eds.) Submitted 9/11/96.

Kumpfer, K. L., Sasagawa, M. & Harrison, S. L. (1995) Asian Association of Utah. Evaluation Report. Department of Health Education and Promotion, University of Utah, Salt Lake City, Utah 84112.

Kumpfer, K. L., & Turner, C. W. (1990-1991). The social ecology model of adolescent substance abuse: Implications for prevention. The International Journal of the Addictions, 25(4A), 435-463.

2. **Other supporting documents:** none known.

   $300 for purchasing a basic set of six newly revised SFP manuals including Spanish version (e.g., Family Skills Training, Children's Skills Training, Parent Skills Training, Children's Handbook, Parents' Handbook, and the Implementation Manual).

Practice implementation:

1. **Staffing requirements:** The program requires a part-time site coordinator and family recruiter and four trainers to deliver the program (two parent trainers and two children's trainers).
2. **Training requirements:** A minimum of two to three days is necessary for two co-trainers to train 10 to 40 participants. The training covers prevention theory, history, logistics, staffing, recruitment and retention, evaluation results, and extensive participant simulation/practice on each component (parent skills training, children's skills training, and family skills training).
3. **Cost of program:** A two day training is $2,700 plus travel expenses (hotel, airfare, and per diem.); a three day training is $3,700 plus travel expenses; $3,500 for up to 40 participants; $175 for 6 manuals
4. **Use of natural funding:** none known.

Other considerations:

Contact information:

Karol Kumpfer, PhD
Department of Health Promotion and Education
University of Utah
250 South, 1850 East, Room 215
Salt Lake City, UT 84112-0920
Phone: (801) 581-7718
Fax: (801) 581-5872

Relevant websites:

http://www.strengtheningfamiliesprogram.org/
E-mail: mailto:karol.kumpfer@health.utah.edu

Across Ages

A Best Practice

Description:

1. **Primary purpose:** The project is a school and community based drug prevention program for 9-13 year olds, which pairs older adult mentors (55 years and older) with youth. The program also employs community service, social competence training, and family activities to build youth sense of personal responsibility to self and community. The overall goal is to increase protective factors among high-risk youth to prevent, reduce, or delay alcohol, illegal substances, or tobacco use and the problems associated with such use. The aims are to (a) increase knowledge of health and substance abuse and foster healthy attitudes, intentions, and behaviors towards substance use, (b) improve academic performance and school bonding as well as attendance, behavior, and attitudes regarding school, (c) strengthen relationships with adults and peers, and (d) enhance problem solving and decision making skills.
2. **Target populations:** American Indian youth are included among the populations that have utilized this model. However, the original model was designed and tested on African Americans, European Americans, Asian Americans, and Latino 6th graders. The model is NOT appropriate for extremely rural populations, which would include most American Indian reservations, because of the lack of anonymity for the mentoring relationship. Targeted youth, defined as at risk youth, manifest risk factors such as residence in a community lacking positive free time activities or few positive role models, or being in kinship care because of the inability of birth parents to care for the youth often due to substance abuse.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available
2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

EBP resource:

Schinke, S. Brounstein, P. And Gardner, S. Science-Based Prevention Programs and Principles, 2002. DHHS Pub. No. (SMA) 03-3764. Rockville, ME: Center For Substance Abuse Prevention, Substance Abuse And Mental Health Services Administration, 2002.

1. **Peer reviewed research**:

Taylor, A. & Dryfoos, J. (1999). Creating safe passage: Elder mentors and vulnerable youth. Generations, Vol 22 (4), 43-48.

Taylor, A., LoSciuto l, Fox M. and Hilbert S. (1999). The mentoring factor: an evaluation of Across Ages. Intergenerational program research: Understanding what we have created. Family and Youth Series. Hayworth Press.

Rogers, A. and Taylor, A., Intergenerational mentoring: a viable strategy for meeting the needs of vulnerable youth. Journal of Gerontological Social Work. 28 (1& 2), 125-140.

2. **Other supporting documents**:
Catalano, R.F., Berglund, J.L., Ryan, J.A.M., Lanczak, H.S. & Hawkins, J.D. (1998). Positive youth development in the United States: Research findings on evaluations of positive youth development. U.S. Department of Health and Human Services.

Training Manuals:

- Across Ages Program Development and Training Manual $75
- Linking Lifetimes Program Development Manual $75
- Timeout Program Development Manual $50
- Grandma's Kids Coloring Book $5
- Elder Mentor Handbook $25
- Linking Lifetimes Summary Report $5
- Intergenerational Mentoring Planner $2
- Tip Sheets $10
- Open Doors, Open Hearts Manual and Video Set $75
- Linking Lifetimes: A global View of Intergenerational exchange $41

Practice implementation:

1. **Staffing requirements:** Part time clerical support, program coordinator-f/t, outreach coordinator-f/t or p/t
2. **Training requirements:** Recommendations to provide state-or agency-approved screening and training of mentors, who are 55 years or older, that includes 8 to 10 hours of preservice training and monthly in-service meetings. Recommended training and orientation to all participants.
3. **Cost of program:** none known.
   - Across ages program development training manual $75
   - Across ages handbook for parents, youth and teachers $25
   - Elder mentor handbook $25
   - Videos-Across ages: an intergenerational approach to prevention $25
   - Elders as mentors: A training program for older adults, includes facilitators guide $65
4. **Use of natural funding:** Pennsylvania Department of Education.

Other considerations:

Contact information:

Andrea Taylor, Ph.D., PI
(215) 204-6708
ataylor@temple.edu

Relevant websites:

www.temple.edu/cil/acrossageshome.htm

Creating Lasting Family Connections

A Best Practice

Description:

1. **Primary purpose:** CLFC curriculum focuses on family strengthening, substance abuse, and violence prevention. CLFC targets environmental risk factors by building skills for personal growth family enhancement, and interpersonal communication, including refusal skills for both youth and families.
2. **Target populations:** CLFC is designed for youth 9-17 years old. The youth evaluated in the project are from African American, White, or from mixed ethnic communities including Hispanics/Latinos, Asian Americans, and Native Americans. The developers also report that CLFC has been successfully implemented in schools, churches, recreation centers, community settings, juvenile justice facilities, and other settings.

Evaluating this practice:

The CLFC program was evaluated using random assignment procedures, valid and reliable outcome measures, and multivariate analysis methods to uncover direct and conditional relationships between the program and outcomes.

1. **Outcome measures used to evaluate practice:** Outcome measures not mentioned

2. **Qualitative evaluation**: Not mentioned

Evidence supporting practice:

EBP resource:

Schinke, S. Brounstein, P. and Gardner, S. Science-Based Prevention Programs and Principles, 2002. DHHS Pub. No. (SMA) O3-3764. Rockville, ME: Center For Substance Abuse Prevention, Substance Abuse And Mental Health Services Administration, 2002.

1. **Peer reviewed research**: (Johnson et al., 1996) That article appeared in the Journal of Adolescent Research (1996). The authors were Knowlton Johnson, Ted Strader, Michael Berbaum, Denise Bryant, Gregory Bucholtz, David Collins, and Tim Noe. In addition to this article, others appeared in the Journal of Volunteer Administration (Strader, Collins, Noe & Johnson, 1997); in Social Work (Johnson, Bryant, Collins, Noe, Strader & Berbaum, 1998); and an article in the Journal of Community Practice (Johnson, Noe, Collins, Strader & Bucholtz, 2000).

2. **Other supporting documents:**
    - Building Healthy Individuals, Families, and Communities: Creating Lasting Connections, Ted N. Strader with Tim Noe and David Collins, Published by Kluwer Academic/ Plenum Publishing Corporation, 124 pp., 2000.
    - "Mobilizing Church Communities to Prevent Alcohol and Other Drug Abuse: A Model Strategy and Its Evaluation", Journal of Community Practice with Knowlton Johnson, Tim Noe, David Collins, Ted N. Strader and Greg Bucholtz, Vol. 7 (2) 2000, pp. 1-27.
    - "Preventing and Reducing Alcohol and Other Drug Use among High-Risk Youths by Increasing Family Resilience," Social Work Journal of the National Association of Social Workers, Knowlton Johnson, Denise Bryant, David Collins, Tim Noe, Ted N. Strader, Michael Berbaum, Vol. 43, No. 4, pp 297-308.
    - "Mobilizing Church Communities for Alcohol and Other Drug Abuse Prevention Through the Use of Volunteer Church Advocate Teams, " The Journal of Volunteer Administration, Ted Strader, David Collins, Tim Noe and Knowlton Johnson, Vol. XV No. 2, Winter 1997, pp 16-29.
    - "Reducing Alcohol and Other Drug Use By Strengthening Community, Family, and Youth Resiliency: An Evaluation of the Creating Lasting Connections Program," Journal of Adolescent Research, Knowlton Johnson, Ted N. Strader, Michael Berbaum, Denise Bryant, Gregory Bucholtz, David Collins, and Tim Noe, Vol. II No. 1, January 1996, pp 36-67.
    - CLFC Training Modules: Includes all six training manuals, a set of 25 participant notebooks for all 6 trainings, and 6 poster sets.
        "Developing Positive Parental Influences" Training Kit $250.00 "Raising Resilient Youth" Training Kit $250
        "Getting Real" Adult Training Kit $250
        "Getting Real" Youth Training Kit $250 or Replacement set of 25 notebooks $99.95.
        "Developing Independence ad Responsibility" $250
        "Developing a Positive Response" $250

Practice implementation

1. **Staffing requirements:** Program developer, national training director and four facilitators p/t
2. **Training requirements:** Training is recommended for those interested in providing any of the Creating Lasting Family Connections (CLFC) program modules for youth and/or parents. Training from the developer, Ted N. Strader and his team of certified CLFC Master Trainers is available through Resilient Futures Network in a variety of formats. Training in the use of any individual module, or any of the parent and youth companion pairs of modules can be provided in a 2 to 3 day seminar.
3. **Cost of program:**
    a. Curriculum Materials (Complete Sets) $1224.50
    b. Supporting Material, Consultation, and Training:

c. "Creating Lasting Family Connections: Program Evaluation Kit (Includes one)each of Youth and Parent Survey, Construct Definitions and Psychometric Properties) $300.00
d. "Creating Lasting Family Connections" Program Training Assessment Survey $150.00
e. "Creating Lasting Family Connections" Program Training for 5-day course (per person) $750.00
f. "Creating Lasting Family Connections" Program Training for 10-day course (per person)$1500
g. "Building Healthy Individuals, Families and Communities" Book by Ted N. Strader, et al., (Kiuwer Academic/Peinum Publishers, New York, 2000) $25.00

4. **Use of natural funding:** Multiple contracts and grants

Other considerations:

Contact information:

Ted N. Strader or Teresa A. Boyd
COPES, Inc.
845 Barret Avenue
Louiville, KY. 40204
Phone: (502)583-6820
Fax: (502)583-6832

Relevant websites:

www.copes.org

Dare To Be You-Ute Indian Reservation

A Best Practice

Description:

1. **Primary purpose:** The primary purpose of this program was inspired by the need for family-based prevention efforts on the Ute reservation, which was experiencing high rates of substance abuse, unemployment, and teenage pregnancy. Thus, the program goals are to improve communication between parents and their children and to train teachers and community members to provide services to target families. Risk factors for parents include satisfaction with parenting roles, sense of personal worth, relationship with children, and use of harsh parenting.

2. **Target populations:** The target Audience for this program is Preschoolers and their families, which has been in operation from 1989-present. Since the program began in 1989, it has served approximately 180 families (the entire population of the reservation is 1,400), and remains popular among residents.

Evaluating this practice:

An experimental group method was used to evaluate this model.

1. **Outcome measures used to evaluate practice**: Information not available

2. **Qualitative evaluation**: information not available

Evidence supporting practice:

EBP resource:

Schinke, S. Brounstein, P. and Gardner, S. Science-Based Prevention Programs and Principles, 2002. DHHS Pub. No. (SMA) 03-3764. Rockville, ME: Center for Substance Abuse Prevention, Substance Abuse And Mental Health Services Administration, 2002.

1. **Peer reviewed research**:

Miller-Heyl, J., MacPhee, D., & Fritz, J. (2000). DARE to be You: A systems approach to the early prevention of problem behaviors. New York: Kluwer Academic/Plenum Publishers.

Fritz, J., MacPhee, D., & Miller-Heyl, J. (1999, April). Parent social cognitions and children's interpersonal problem solving. Poster presented at the Biennial Meeting of the Society for Research in Child Development, Albuquerque, NM.

Miller-Heyl, J., MacPhee, D., & Fritz, J. (1998). DARE to be You: A family-support, early prevention program. Journal of Primary Prevention, 18, 257-285.

MacPhee, D., Fritz, J., & Miller-Heyl, J. (1996). Ethnic variations in personal social networks and parenting. Child Development, 67, 3278-3295.

Fritz, J. J., Miller-Heyl, J., Kreutzer, J. C., & MacPhee, D. (1995). Fostering personal teaching efficacy through staff development and classroom activities. Journal of Educational Research, 88, 200-208.

DARE to be You Replication Manual for the DARE to be You Program for Families of Preschool Youth, Caregivers and Community. (2000). Colorado State University Cooperative Extension, Ft. Collins, CO.

DARE to be You Parent Training Guide Insert Packet. (1998). Colorado State University Cooperative Extension, Ft. Collins, CO.

DARE to be You Preschool Activity Guide. (1992). Colorado State University Cooperative Extension, Ft. Collins, CO.

DARE to be You Parent Training Guide. (1991). Colorado State University Cooperative Extension, Ft. Collins, CO.

DARE to be You K-12 Life Skills and Substance Abuse Prevention Curriculum (5-volume set). (1988). Colorado State University Cooperative Extension, Ft. Collins, CO.

DARE to be You Leaders' Manual, second Ed. (1985). Colorado State University Cooperative Extension, Ft. Collins, CO.

2. **Other supporting documents** :
   - Community leader manual
   - Set of K-12 school curriculum
   - Parent training guide
   - Pre-school activity guide
   - Parent and pre-school training set
   - Spanish/English edition parent training guide

Practice implementation:

1. Staffing requirements: Information not available

2. Training requirements: $3,000 for up to 40 participants (this includes materials) There are three components of the Dare to be You program. The family component provides training in communication, parenting skills, and social skills for children and parents. The school component trains and supports childcare providers and teachers, and the community component trains community members who will provide ongoing support to the target children and their families. There is a strong emphasis on hiring multicultural teen workers, since Ute youths typically have poor relationships with youths outside their community.

3. Cost of program:
   - $46 community leader manual
   - $150 set of K-12 school curriculum
   - $32 parent training guide
   - $32 pre-school activity guide
   - $60 parent and pre-school training set
   - $45 Spanish/English edition parent training guide
   - Other guides and supplemental materials are available

4. Use of natural funding:

Other considerations:

Contact information:

Jan Miller-Heyl, M.S.
Colorado State University
Cooperative Extension
215 N. Linden
Cortez, CO 81321
Phone: (970) 565-3606
Fax: (970) 565-4641

Relevant websites:

http://www.coopext.colostate.edu/DTBY/

With Eagle's Wings

A Best Practice

Description:

1. **Primary purpose**: "With Eagle's Wings is in its first year of the grant from the Center for Mental Health Services (CMHS) and is operated under the Northern Arapaho Nation. The program is the first tribally controlled mental health program on the reservation. The grant was written in dedication to Anthony Sitting Eagle, a principal chief of the Northern Arapaho people who died in 1997."

2. **Target populations**: "The program presently serves children and families who are referred or who are "walk-ins"; 504 children ages ten and under have been served at welcome house, the project's facility designed to protect children from abuse, neglect and domestically violent situations."

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Info not available

2. **Qualitative evaluation**: Info not available

Evidence supporting practice:

Resource:

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I. Washington, DC: Center for Effective Collaboration and Practice,

American Institutes for Research. http://www.mentalhealth.org/cmhs/ChildrensCampaign/PDFs/2000monographs/vol1.pdf

1. **Peer reviewed research**:

   Cross, T. L., et al (1989). Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed. Washington, D.C. Georgetown University: Child Development Center.

   Deserly, K. J., & cross, T. L. (1986). An assessment of tribal access to children's mental health funding. American Indian children's mental health services. Portland, or: national indian child welfare association.

2. **Other supporting documents**: Info not available

Practice implementation:

1. **Staffing requirements**: "The operational services teams (made up of staff that is responsible for the care of the consumers) are multidisciplinary and use program models that echo the traditions and beliefs of the American Indian cultures on the reservation."

2. **Training requirements**: "The strong cultural components will ensure culturally competent training for all service providers and staff, individual support through tribal elders and traditional healers, and access to spiritual healing practices."

3. **Cost of program**: Info not available

4. **Use of natural funding**: With Eagle's Wings is in its first year of the grant from the Center for Mental Health Services (CMHS) and is operated under the Northern Arapaho Nation.

Other considerations:

Contact information:

Substance Abuse & Mental Health Services (SAMHSA)

Relevant websites:

http://www.mentalhealth.org/cmhs/ChildrensCampaign/PDFs/2000monographs/vol1.pdf

Families That Care-
Guiding Good Choices

A Best Practice

Description:

1. **Primary purpose**:

2. **Target populations**: 4-12 and parents/families, Male and Female OF African American, American Indian/Alaska Native, Asian, American Hispanic/Latino, Native Hawaiian and Other Pacific Islander (NHOPI), AND White DESCENT ATTENDING Rural, Suburban, and Urban schools

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

EBP resource:

Schinke, S. Brounstein, P. and Gardner, S. Science-based prevention programs and principles, 2002. DHHS Pub. No. (SMA) 03-3764. Rockville, ME: Center For Substance Abuse Prevention, Substance Abuse And Mental Health Services Administration, 2002.

1. **Peer reviewed research:**

Hawkins J.D., Catalano R.F., & Kent L.A. (1991). Combining broadcast media and parent education to prevent teenage drug abuse. In L. Donohew & H. E. Sypher & W. J. Bukoski (Eds.), Persuasive communication and drug abuse prevention, (pp. 283-294). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Kosterman R., Hawkins J.D., Haggerty K.P., Spoth R., Redmond C. (2001). Preparing for the drug free years: session-specific effects of a universal parent-training intervention with rural families. Journal of Drug Education, 31(1),47-68.

Park J., Kosterman R., Hawkins J.D., Haggerty K.P., Duncan T.E., Duncan S.C., & Spoth R. (2000). Effects of the "preparing for the drug free years" curriculum on growth in alcohol use and risk for alcohol use in early adolescence. Prevention Science, 1(3), 125-138.

Redmond C., Spoth R., Shin C., & Lepper H.S. (1999). Modeling long-term parent outcomes of two universal family-focused preventive interventions: One-year follow-up results. Journal of Consulting and Clinical Psychology, 67(6), 975-984.

Spoth R., Redmond C., & Shin C. (1998). Direct and indirect latent-variable parenting outcomes of two universal family-focused preventive interventions: Extending a public health-oriented research base. Journal of Consulting and Clinical Psychology, 66(2), 385-399. Spoth R., Redmond C., & Shin C. (in review). Randomized trial of

brief family interventions for general populations: Adolescent substance use outcomes four years following baseline. Institute for Social and Behavioral Research. Iowa State University.

Spoth R., Reyes M.L., Redmond C., & Shin C. (1999). Assessing a public health approach to delay onset and progression of adolescent substance use: Latent transition and log-linear analyses of longitudinal family preventive intervention outcomes. Journal of Consulting and Clinical Psychology, 67(5), 619-630.

Hawkins J.D., Catalano R.F., & Kent L.A. (1991). Combining broadcast media and parent education to prevent teenage drug abuse. In L. Donohew & H. E. Sypher & W. J. Bukoski (Eds.), Persuasive communication and drug abuse prevention, (pp. 283-294). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Kosterman R., Hawkins J.D., Haggerty K.P., Spoth R., Redmond C. (2001). Preparing for the drug free years: session-specific effects of a universal parent-training intervention with rural families. Journal of Drug Education, 31(1),47-68.

Park J., Kosterman R., Hawkins J.D., Haggerty K.P., Duncan T.E., Duncan S.C., & Spoth R. (2000). Effects of the "preparing for the drug free years" curriculum on growth in alcohol use and risk for alcohol use in early adolescence. Prevention Science, 1(3), 125-138.

Redmond C., Spoth R., Shin C., & Lepper H.S. (1999). Modeling long-term parent outcomes of two universal family-focused preventive interventions: One-year follow-up results. Journal of Consulting and Clinical Psychology, 67(6), 975-984.

Spoth R., Redmond C., & Shin C. (1998). Direct and indirect latent-variable parenting outcomes of two universal family-focused preventive interventions: Extending a public health-oriented research base. Journal of Consulting and Clinical Psychology, 66(2), 385-399. Spoth R., Redmond C., & Shin C. (in review). Randomized trial of brief family interventions for general populations: Adolescent substance use outcomes four years following baseline. Institute for social and Behavioral Research. Iowa State University.

Spoth R., Reyes M.L., Redmond C., & Shin C. (1999). Assessing a public health approach to delay onset and progression of adolescent substance use: Latent transition and log-linear analyses of longitudinal family preventive intervention outcomes. Journal of Consulting and Clinical Psychology, 67(5), 619-630.

[Articles on PDFY have been published in the Journal of Drug Education, Prevention Science, Child and Adolescent Social Work Journal, Journal of Marriage and the Family, and the Journal of Community Psychology, to name a few.] [Articles on PDFY have been published in the Journal of Drug Education, Prevention Science, Child and Adolescent Social Work Journal, Journal of Marriage and the Family, and the Journal of Community Psychology, to name a few.]

Other supporting documents

- $729 for 1-9 Curriculum Kits
- $12 each for 1-9 Family Guides

Practice implementation

1. **Staffing requirements**: staffing SHOULD INCLUDE two co-leaders, parent and someone with group facilitation experience.

2. **Training requirements**: provide parenting workshops, understand the principles of adult learning, and be knowledgeable about risk and protective factors as they relate to prevention. It is highly recommended that workshop leaders attend a 3-day workshop leader's training event. Two co-leaders SHOULD SHARE responsibilities for instruction, modeling skills, and answering questions, lead workshops. It is most beneficial if workshop leaders are representative of the community.

3. **Cost of program**: *$4,750 (plus trainer expenses) for up to 12 people, plus $105 materials fee per person

4. **Use of natural funding**: information not available

Other considerations:

Contact information:

Channing Bete Company
One Community Place South
Deerfield, MA. 01373-0200
PrevSci@channing-bete.com

Relevant websites:

www.preventionscience.com

FAST - Families And Schools Together

A Best Practice

Description:

1. **Primary purpose**: Families and Schools Together (FAST) is a multifamily group intervention designed to build protective factors and reduce the risk factors associated with substance abuse and related problem behaviors for children 4 to 12 years old and their parents. FAST systematically applies research on family stress theory, family systems theory, social ecological theory, and community development strategies to achieve its four goals:

- Enhanced family functioning
- Prevention of school failure by the targeted child
- Prevention of substance abuse by the child and other family members
- Reduced stress from daily life situations for parents and children

One of the primary strategies of FAST is parent empowerment: parents receive support to be the primary prevention agents for their own children. Entire families participate in program activities that are designed to build parental respect in children, improve intra-family bonds, and enhance the family-school relationship. FAST activities were developed to build the social capital of parents and provide a safe place to practice parenting. Because of this program, the participating children increase their social skills and attention span, while reducing their anxiety and aggression. Research has shown that these childhood behavioral outcomes are correlated in adolescence to the prevention of substance abuse, delinquency, and school failure.

2. **Target populations**: Rural Wisconsin Indian Reservation (3 tribes), Grades K-2 Universal Invitation & recruitment;

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Teacher CBCL pretests used to match pairs prior to randomization.

2. **Qualitative evaluation**: No Information available

Evidence supporting practice:

EBP resource:

Schinke, S. Brounstein, P. and Gardner, S. Science-based prevention programs and principles, 2002. DHHS pub. No. (SMA) 03-3764. Rockville, ME: Center For Substance Abuse Prevention, Substance Abuse And Mental Health Services Administration, 2002.

1. **Peer reviewed research**:

Publications: McDonald Publication & Presentation List

Bierman, K. L., Greenberg, M. T., & the Conduct Problems Prevention Research Group. (1996). Social skill training in the FAST Track program. In Peters, R. DeV., & McMahon, R. J. (eds.) Prevention and early intervention: Childhood disorders, substance abuse and delinquency. Thousand Oaks, CA: Sage.

McDonald, L. (2002, October). Family Empowerment - FAST. Paper presented at the meeting of Wissenschaftliches Programm: Themen- und Terminplan, Siegen, Germany.

McDonald, L. & Moberg, P. Families and Schools Together: FAST Strategies for Increasing Involvement of All Parents in Schools and Preventing Drug Abuse. In *Increasing Prevention Effectiveness*.

McDonald, L. (2001, October). *Invited virtual presentation on FAST Families and Schools Together.* Paper presented at AIR-CECP Virtual Conference.

McDonald, L. (2001, August). *Families and Schools Together [Abstract]*. Paper presented at the 2nd National Conference on Drug Abuse Prevention Research, Washington, DC.

McDonald, L. (2001, April). Families and Schools Together (FAST). In M. Valkestijn and G. van de Burgwal (Eds.), *A Report on the European Conference. New opportunities for children and youth. Good practices and research regarding community schools.* EDE, The Netherlands.

McDonald, L. (2000). FAST: training & orientation manual. Madison, WI: FAST National Training and Evaluation Center.

McDonald, L. (2000, February). *Impact of Building Multiple Protective Factors in Family Systems of Children at Risk for Mental Health Problems [Abstract]*. Paper presented at the Chaos and Complex Systems Seminar, Madison, WI.

Moberg, D. P., McDonald, L. W., Burke, M., Brown, R. L., & McCubbin, H. I. (2000, September). Randomized Trial of Families and Schools Together (FAST): First Report on One-Year Outcomes. Paper presented at the meeting of Addictions 2000 Research Conference, Cape Code, MA.

Moberg, D. P., McDonald, L. W., Burke, M., Brown, R. L., & McCubbin, H. I.(2000, June). Randomized Trial of Families and Schools Together(FAST): Proximal Outcomes between Hispanic and African American Families. Paper presented at the meeting of Society for Prevention Research Conference, Montreal, Quebec.

McDonald, L. (1999). School safety: The efforts of states and school programs to make schools safe. Policy and Practice, 1(4), 9.

McDonald, L., & Frey, H. E. (1999). *Families and Schools Together: building relationships. OJJDP Bulletin.* Washington, DC: U. S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

McDonald, L. (1998, April). *A Multi-Family Approach: Families and Schools Together (FAST) Builds Protective Factors In Potentially Neglectful Families*. Proceedings of the conference Parenthood in America, Madison, Wisconsin.

McDonald, L. (1998). FAST team trainer manual: steps to certification (Rev. ed.). Madison, WI: FAST Training and Evaluation Center.

McDonald, L. (1998). Systematically building multiple protective factors to increase Head Start children's mental health: The evaluated and replicated multifamily FAST program. In F. Lamb-Parker, J. Hagen, R. Robinson, & C. Clark (Eds.), Children and families in an era of rapid change: creating a shared agenda for researchers, practitioners and policy makers (summary of conference proceedings) (pp. 274-275). Washington, DC: U. S. Department of Health and Human Services, Administration for Children, Youth and Families.

McDonald, L. (1998). Universal kindergarten FAST program manual. Madison, WI: FAST International.

McDonald, L., & Billingham, S. (1998). FAST orientation manual and elementary school FAST program workbook. (Rev. ed.). Madison, WI: FAST International.

McDonald, L., & Howard, D. (1998, December). Families and Schools Together. *Fact Sheet* (No. 88). Washington, DC: U. S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

McDonald, L., & Sayger, T. (1998). *Impact of a family and school based prevention program on protective factors for high-risk youth*. Drug and Society, 12, 61 -86.

Sayger, T. & McDonald, L. (1998). Evaluation report for Australian FAST schools. Madison, WI: FAST International.

McDonald, L. (1997). FAST early childhood program workbook and FAST middle school program workbook. Madison, WI: FAST International.

McDonald, L., Billingham, S., Conrad, P., Morgan, A., Nina. O., & Payton, E. (1997). *Families and Schools Together (FAST): Integrating community development with clinical strategy.* Families in Society, 78(2), 140-155.

McDonald, L. (1996). A prize-winning innovation: FAST (Families and Schools Together). In E.Wattenberg & Y.Pearson (Eds.), Defining excellence for limited services: A summary of proceedings (pp. 15-19). Minneapolis, MN: University of Minnesota.

McDonald, L. (1996). Families and schools together (FAST). In R.Talley & G.Walz (Eds.), Safe schools, safe students (pp. 59-63). Washington, DC: NECP, NAPSO, APA, ERIC.

McDonald, L. (1996). *FAST: Family and Schools Together*. Wisconsin Counties, 60 (4), 21-26.

McDonald, L., Pugh, C., & Alexander, J. (1996). Multitarget multiperspective indices of FAST program impact. Paper presented at the meeting of American Psychological Association, Toronto, Canada.

McDonald, L. (1995). FAST national evaluation report. Milwaukee, WI: Family Service America.

McDonald, L. (1994). FAST trainers training manual. Milwaukee, WI: Family Service America.

McDonald, L. (1993). Families and schools together: Final report for OHD/ADF/DHHS Grant #90-PD-165. Madison, WI: Family Service, Inc.

McDonald, L. (1992). Families and schools together(FAST): orientation manual and a program workbook. Madison, WI: Family Service, Inc.

McDonald, L., Coe-Braddish, D., Billingham, S., Dibble, N., & Rice, C. (1991). *Families and Schools Together: An innovative substance abuse prevention program*. Social Work in Education, 13, 118-128.

2. **Other supporting documents**: information not available

Practice implementation:

1. **Staffing requirements**: Trained Parents and a professional team

2. **Training requirements**: Information not available

3. **Cost of program**: Program implementation costs range totally on local resources. Communities have run the FAST program on a per family unit cost basis ranging from $300/ family to $1,800/ family. Alternatively, if you figure 10 families served per multi-family group cycle, cycles have cost the local collaborative from $3,000 to $18,000 per program cycle. FAST has been implemented in over 600 communities in 38 states and the creativity in budgeting and the access to local bartering for transportation, youth volunteers, VISTA workers, grocery stores for donated shopping vouchers, repositioned time by schoolteachers, social workers, etc. have been astonishing. The training start up costs (not including implementation of the multi-family group sessions) to bring a research based national program into your local community will include payment to the FAST National Training and Evaluation Center in a formal contract. These are standard fees and expected costs:
   - Technical assistance from FAST National
   - 4 days of training of local pilot team(s)
   - Travel of the team(s) to the training
   - Travel of the trainer to you (minimum three site visits)
   - Evaluation consultation, questionnaires, data analysis, and evaluation report for your local pilot FAST program
   - Manuals and supplies for the FAST training
   - Costs of the team members time to be trained

4. **Use of natural funding**: information not available

Other considerations:

Contact information:

Lynn McDonald, Program Developer
FAST National Training and Evaluation Center - Pat Davenport-CEO
2801 International Lane, Suite 105 P.O. Box 14500
Madison, Wisconsin 53704
Phone: (608) 663-2382

Relevant websites:

www.wcer.wisc.edu/fast

Parenting Wisely

A Best Practice

Description:

1. **Primary purpose**: The Parenting Wisely intervention is a self-administered, computer-based program that teaches parents and their 9- to 18-year-old children important skills for combating risk factors for substance use and abuse. The Parenting Wisely program uses a risk-focused approach to reduce family conflict and child behavior problems, including stealing, vandalism, defiance of authority, bullying, and poor hygiene. The highly interactive and nonjudgmental CD-ROM format accelerates learning, and parents use new skills immediately. The Parenting Wisely program:
   - Reduces children's aggressive and disruptive behaviors
   - Improves parenting skills
   - Enhances family communication
   - Develops mutual support
   - Increases parental supervision and appropriate discipline of their children

   A highly versatile program, Parenting Wisely can be used alone, in a group, or with a practitioner at a variety of locations such as public agencies, schools, libraries, or at home. Semiliterate parents can use the Parenting Wisely program, as it provides the option to have the computer read all text aloud. Printed program portions are written at the fifth-grade level, and the entire program is available in Spanish.

2. **Target populations**: 9-18 delinquents, at-risk adolescents, and parents; Male and Female, living in Urban, Suburban, and Rural settings.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

Schinke, S. Brounstein, P. and Gardner, S. Science-based prevention programs and principles, 2002. DHHS Pub. No. (SMA) 03-3764. Rockville, ME: center for substance abuse prevention, substance abuse and mental health services administration, 2002.

1. **Peer reviewed research**:

Gordon, D.A. (2000). Parent training via CD-ROM: Using technology to disseminate effective prevention practices. The Journal of Primary Prevention, 21(2), 227-251. Kacir, C. & Gordon, D.A. (1997).

Interactive videodisk parent training for parents of difficult pre-teens. Child and Family Behavior Therapy, 21(4), 1-22

Lagges, A. & Gordon, D.A. (1997). Interactive videodisk parent training for teen mothers. Child and Family Behavior Therapy, 21(1), 19-37.

Segal, D., Chen, P., Gordon, D.A., Kacir, C., & Gylys, J. (1999). Parenting Adolescents Wisely: Comparing interactive computer-laserdisc and linear video methods of intervention in a parent-training program. In press, International Journal of Human Computer Interaction.

2. **Other supporting documents**: The Parenting Wisely program is a interactive intervention program contained on a CD-ROM that is formatted for a personal computer PC). The PC must have a CD-ROM player and the ability to play video on the computer screen and play sound.

   Complete program materials include:

   - One interactive CD
   - One program manual
   - Five parent workbooks
   - Parent completion certificates, program description brochures
   - Program poster and referral cards
   - Evaluation instruments (on a floppy disk, for duplication

   Materials:

   - Three part video series costs $299
   - CD Kit costs $599 and includes:1 display poster, 5 workbooks, 1 service provider manual, 5 program completion certificates, 10 referral cards, 1 floppy disk with pre/post evaluation instrument, 20 brochures, and 2 parent registration forms.

Practice implementation:

1. **Staffing requirements**: practitioners, counselors and program trainers can be used for groups or families.

2. **Training requirements**: Staff training is not required to implement the program, as it stands alone and is self-administered. A service provider's guide supplies all the information necessary to fully implement the program. No formal training available

3. **Cost of program**: information not available

4. **Use of natural funding**: information not available

Other considerations:

Contact information:

Donald Gordon, Program Developer
FamilyWorks, Inc.
340 W. State Street
Room 135B, Unit 19
Athens, OH 45701-3751
Phone: (740) 593-9505
(541) 488-0729
Toll Free: 1(866) 234-WISE
Fax: (541) 482-2829
Email: familyworks@familyworksinc.com

Relevant websites:

http://www.parentingwisely.com/

Preparing For Drug Free Years

A Best Practice

Description:

1. **Primary purpose**: "Preparing for the Drug Free Years project teaches parents, 1) skills to increase their children's opportunities for family involvement, 2) teaches skills needed by children and adolescents, and 3) teaches parents skills to provide reinforcement for desired behavior and appropriate consequences for undesired behavior. The program covers the following topics: (1) understanding the risk factors of drug abuse, (2) understanding the nature and extent of the problem, (3) reducing risks by strengthening family bonds, (4) conducting family meetings and fostering family communication, (5) establishing a family position on drugs, (6) identifying and establishing positive reinforcements and appropriate negative consequences, (7) reinforcing a child's use of refusal skills, (8) expressing and controlling anger, (9) increasing children's participation in the family, and (10) creating a parent support network."

   Target Risk Factors: "family management problems; family conflict; favorable attitudes toward drug use; parental attitudes and involvement; anti-social behavior in early adolescence; alienation/rebelliousness; friends who use."

   Protective Factors: "family bonding; opportunities, skills and recognition; healthy beliefs and clear standards."

2. **Target populations**: "Parents of children 8-14 years old; urban, multiethnic communities; African American; Native American; Hispanic/Latino; Asian/Pacific Islander."

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: information not available.

2. **Qualitative evaluation**: information not available

Evidence supporting practice:

Best/Promising Resource: *http://www.health.state.nm.us/bhsd/prevention/xbluepart2.htm*

Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993 from the National Criminal Justice Reference Service, (800) 851-3420.

1. **Peer reviewed research**: info not available

2. **Other supporting documents**: info not available

Practice implementation:

1. **Staffing requirements**: Staffing includes the hiring of two volunteer workshop leaders, with one leader being a parent.

2. **Training requirements**: The program Prefers training for leaders in-group facilitation skills. The program also prefers training in presenting the curriculum, which involves attending a 3-day workshop directed by certified DRP trainers. A Curriculum Kit for workshop leaders includes everything needed to present the workshops.

3. **Cost of program**: Not specified

4. **Use of natural funding**: Not specified

Other considerations:

Contact information:

Developmental Research and Programs,
130 Nickerson, Suite 107,
Seattle, WA 98109,
(800) 736-2630,

Relevant websites:

mailto:moreinfo@drp.org

Project Alert

A Best Practice

Description:

1. **Primary purpose**: Project ALERT offers a drug prevention curriculum for to reduce both the onset of substance abuse and regular use. The 2-year, 14-lesson program focuses on the substances that adolescents are most likely to use: alcohol, tobacco, marijuana, and inhalants.

   Project ALERT has 3 main goals that focus on individual, peers, family and schools:
   - To motivate adolescents against drug use
   - To teach adolescents the skills and strategies needed to resist pro-drug pressures
   - To establish nondrug-using norms Protective Factors To Increase

2. **Target populations**: The target population for Project ALERT is 11 to 14 years old, from widely diverse backgrounds and communities. "The program has proved successful with high- and low-risk White, African American, Hispanic/Latino, Asian American, and Native American youth from urban, rural, and suburban communities and a variety of socioeconomic backgrounds. The original program was tested in schools in different geographic areas with different population densities, and among students with a range of racial/ethnic and economic backgrounds."

Evaluating this practice:

"Project ALERT used a rigorous pre-post design with random assignment of 30 schools to one control and two treatment conditions (i.e., an adult teacher group and an adult teacher plus teen leader group). The participating schools had diverse student bodies. Nine schools had a minority population of 50 percent or more." The data collected included Self-reported drug use surveys.

1. **Outcome measures used to evaluate practice**: Information not available

   Individual
   - Current use of alcohol, tobacco, or illegal drugs
   - Intention to use in the future
   - Belief that drug use is not harmful or has positive effects
   - Belief that drug use is normal
   - Low self-esteem
   - Inadequate resistance skills

   Peer
   - Peer drug use
   - Peer approval of drugs

   School
   - High levels of drug use

- Low norms against use

Family

- Lack of clear norms against use
- Poor communication

2. **Qualitative evaluation**: information not available

Evidence supporting practice:

Schinke, s. Brounstein, p. And Gardner, s. Science-based prevention programs and principles, 2002. DHHS Pub. No. (SMA) 03-3764. Rockville, ME: center for substance abuse prevention, substance abuse and mental health services administration, 2002.

1. **Peer reviewed research**:

Research A. High: A Multi-Site Longitudinal Test," Science, 247:1299-1305, 1990; also RAND, R-3919-CHF, March 1990.

B. Ellickson, Phyllis L. and Robert M. Bell, Prospects for Preventing Drug Use Among Young Adolescents, The RAND Corporation, R-3896-CHF, April 1990.

C. Ellickson, Phyllis L., Robert M. Bell, and Ellen R. Harrison, "Changing Adolescent Propensities to Use Drugs: Results from Project ALERT" Health Education Quarterly, 20(2): 227-242, 1993.

D. Ellickson, Phyllis L., Robert M. Bell and Kimberly McGuigan, "Preventing Adolescent Drug Use: Long Term Results of a Junior High Program," American Journal of Public Health, 83(6): 856-861, 1993; also RAND, RP-208, 1993.

E. Bell, Robert M., Phyllis L. Ellickson, and Ellen R. Harrison, "Do Drug Prevention Effects Persist into High School? How Project ALERT Did with Ninth Graders," Preventive Medicine, 22:463-483, 1993; also RAND RP-237, 1993.

Additionally, Project ALERT has been published in the following journals:

Published in Science (1990), Journal of Research in Crime and Delinquency (1992), American Journal of Public Health (1993), Health Education Quarterly (1993) and Preventive Medicine (1993).

Project ALERT Replication Study:

Penn State Cooperative Extension and School collaborations TENA L. ST. PIERRE, PH.D. The Pennsylvania State University

Additionally, Project ALERT has been published in the following journals

Published in Science (1990), Journal of Research in Crime and Delinquency (1992), American Journal of Public Health (1993), Health Education Quarterly (1993) and Preventive Medicine (1993).

2. **Other supporting documents**:

Teacher manual (includes core and booster lessons), 8 student videos, 12 classroom posters, overview video for colleagues & community, optional teen leader manual

- Trained Project ALERT teachers continue to receive:
- Free video & print curriculum updates
- Free subscription to ALERT Educator teacher support newsletter
- Toll-free phone support & TA
- Access to an on-line faculty advisor
- NOTE: An overview/promotional video is available on request
- Parental/take-home materials also available in Spanish.

Practice implementation:

1. **Staffing requirements**: information not available
2. **Training requirements**: Project ALERT training is intended for middle grade core teachers, health teachers, physical education instructors and guidance counselors. Educators participating in training gain understanding of the content, process and goals of Project ALERT and acquire the skills needed to deliver the lessons effectively. They learn how to implement the program with fidelity and develop confidence in their ability to teach the curriculum successfully. It is important to train all educators who will be involved in delivering both years of the program. Consideration should be given to training administrators who have oversight responsibility, school nurses and school resource officers.
3. **Cost of program**: $150 (includes training workshop, all program materials, and on-going TA); Workshop and online training are available. Also, onsite training costs $4200 for 25 participants and an additional $150 for each additional person.
4. **Use of natural funding**

Other considerations:

Contact information:

Dr. Phyllis Ellickson and colleagues at RAND developed and evaluated Project ALERT.
Health Services Administration, U.S.
Project ALERT
725 South Figueroa Street
Suite 970
Los Angeles, CA 90017-5416
Phone: (800) 253-7810
Fax: (213) 623-0585
Email: info@projectalert.best.org

Relevant websites:

http://www.projectalert.best.org/

Project Venture: The National Indian Youth Leadership Project

A Best Practice

Description:

1. **Primary purpose**: The Project Venture Program is a youth development program designed to prevent substance abuse by implementing an outdoor adventure/service-Leadership approach. It is recognized by the Center for Substance Abuse Prevention as a "Promising Program" for Native youth and communities, it is currently being replicated in at least twenty other locations across the United States. In 2003, Project Venture is under going the process to become officially recognized as a Model Program by NREPP and CSAP.

   Project ventures focus strategies include building skills in self-confidence, teamwork, cooperation, and trust through summer skill-building leadership camps and outdoor adventure activities. "Project Venture is currently being replicated or adapted in more than a dozen communities around the Nation because of its appeal as a culturally appropriate prevention program. Among its many accomplishments, the program has shown significant reductions in delaying the onset of lifetime use of alcohol and marijuana."

2. **Target populations**: High-risk Native American youth in tribal, alternative, and public schools. Initially tried with Navajo youth in grades 6-9.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:
   - Overall risk profile for alcohol, tobacco, and other drug use
   - Delayed onset/lifetime use of alcohol and marijuana use
   - Past 30-day use of alcohol and marijuana
   - Frequency of cigarette, inhalant, and alcohol use
   - Depression and aggressive behavior

2. **Qualitative evaluation**: information not available

Evidence supporting practice:

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention

Web Resource: http://www.modelprograms.samhsa.gov/textonly.cfm?page=background

1. **Peer reviewed research**: information not available

2. **Other supporting documents**:
   - Project Venture recognized as Exemplary Program by Center for Substance Abuse Prevention, SAMHSA/HHS
   - Project Venture ranked in top four prevention programs nationally, CSAP cross-site evaluation study
   - Project Venture ranked most effective prevention program serving Native youth, CSAP cross-site evaluation study
   - 25 national Project Venture replication sites funded
   - 2003
   - Project Venture has met the criteria to become a national Model Program, first Native American program to be designated Model Program
   - NIYLP selected Milestone Program by Kellogg Foundation for 75th anniversary celebration
   - NIYLP Turtle Island Project spotlighted in Kellogg Foundation annual report, 2003
   - Articles
   - Project Venture: An Outdoor Adventure/Service-Leadership Approach to Prevention

Practice implementation:

1. **Staffing requirements**: Info not available

2. **Training requirements**: Info not available

3. **Cost of program**: Info not available

4. **Use of natural funding**: Dependence on government and private grants.

Other considerations:

Contact information:

McClellan Hall, Program Director
NIYLP
P.O. Box 2140
Gallup, NM 87301-4711
Voice: (505) 722-9176
Fax: (505) 722-9794
Email: *atallant@niylp.org*

Relevant websites:

http://www.niylp.org/main/index.htm
http://www.modelprograms.samhsa.gov/textonly.cfm?page=background

Promoting Alternative Thinking Strategies (PATHS)

A Best Practice

Description:

1. **Primary purpose**: PATHS (Promoting Alternative Thinking Strategies) is a comprehensive program for promoting emotional and social competencies and reducing aggression and acting-out behaviors in elementary-school-aged children, while simultaneously enhancing the educational process in the classroom.

   Protective Factors: Individual
   Emotional understanding, Self-control, Empathy development, Emotion regulation, Problem-solving skills, Communication skills, Cognitive and academic skills, Family communication skills, Positive peer relations, Positive classroom atmosphere, Teacher management, AND Teacher-student relations

   Risk Factors: individual
   Impulsivity, Aggression, Internalizing problems (depression & anxiety), Poor peer relations, Disruptive classroom behavior, AND Chaotic classroom environment.

2. **Target populations**: This innovative curriculum for kindergarten through sixth grade (ages 5 to 12) is used by educators and counselors as a multiyear, prevention model. The PATHS curriculum was developed for classroom use with all elementary school children. PATHS has been field-tested and researched in general education classrooms, with a variety of special-needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted), and among African American, Hispanic/Latino, Asian American, Pacific Islander, Native American, and White children. Ideally, it should be initiated at the start of schooling and continue through grade six.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Info not available

2. **Qualitative evaluation**: Info not available

Evidence supporting practice:

EBP resource:
Schinke, S. Brounstein, P. and Gardner, S. Science-based prevention programs and principles, 2002. DHHS Pub. No. (SMA) 03-3764. Rockville, ME: Center For Substance Abuse Prevention, Substance Abuse And Mental Health Services Administration, 2002.

1. **Peer reviewed research**:

Kusche, C. A. & Greenberg, M. T. (1994) The PATHS Curriculum. Seattle: Developmental Research and Programs.

Greenberg, M. T., & Kusche, C. A. (1993). Promoting social and emotional development in deaf children: The PATHS Project. Seattle: University of Washington Press.

Greenberg, M. T., Kusche, C. A., Cook, E. T., & Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS Curriculum. Development and Psychopathology, 7, 117-136.

Bierman, K., Greenberg, M. T., & Conduct Problems Prevention Research Group (1966). Social skills in the FAST Track Program. In. R. DeV. Peters & R. J. McMahon (Eds.). Prevention and early intervention: Childhood disorders, substance abuse, and delinquency (pp. 65-89). Newbury Park, CA: Sage.

Greenberg, M. T., & Snell, J. (1997). The neurological basis of emotional development. In P. Salovey (Ed.) Emotional development and emotional literacy (pp. 92-119) . New York: Basic Books.

Greenberg, M. T. (in press). Educational interventions. In P. Hindley and N. Kitson (Eds.). Mental Health and Deafness. London.

Greenberg, M. T. (1997). Promoting social and emotional competence: The PATHS Curriculum and the CASEL Network. Reaching Today's Youth, 49-52.

Elias, M. J., Zins, J. E., Weissberg, K. S., Greenberg, M. T., Haynes, N. M., Kessler, R., Schwab-Stone, M. E., & Shriver, T. P. (1997). Promoting social and emotional learning: guidelines for educators. Alexandria, VA: Association For Supervision And Curriculum Development.

Greenberg, M. T., & Kusche, C. A. (1998). Preventive intervention for school-aged deaf children: The PATHS Curriculum. Journal of Deaf Studies and Deaf Education, 3, 49-63.

Greenberg, M. T. & Kusche, C. A. (1998) Promoting Alternative Thinking Strategies. Institute of Behavioral Sciences, University of Colorado.

Kusche, C. A, & Greenberg, M. T. (1998) Integrating emotions and thinking in the classroom. THINK, 9, 32-34.

Kusche, C. A., Riggs, R. S., & Greenberg, M. T. (in press). Paths: using applied psychoanalysis to teach emotional literacy to preoedipal, oedipal and latency-aged children. The American Psychoanalyst

Kusche, C. A., & Greenberg, M. T. (in press). PATHS in your classroom: Promoting emotional literacy and alleviating emotional distress. In J. Cohen (Ed.) Social emotional learning and the elementary school child: A guide for educators. New York: Teachers College Press.

Conduct Problems Prevention Research Group. (in press). Initial impact of the Fast Track prevention trial for conduct problems: II. Classroom effects. Journal of Consulting and Clinical Psychology.

2. **Other supporting documents**: The curriculum consists of an Instructional Manual, six volumes of lessons, pictures and photographs, and additional materials. A research book is also available.
   - The Turtle Technique (Schneider & Robin, 1978)

- Control Signals Poster (CSP). The CSP is modeled on the notion of a traffic signal and is a revised version of the Stop Light used in the Yale-New Haven Middle School Social Problem Solving Program (Weissberg, Caplan, & Bennetto, 1988).
- Following the conceptual model developed by D'Zurilla and Goldfried (1971), Shure and Spivak (1978), and Weissberg et al. (1981),

Practice implementation:

1. **Staffing requirements**: teachers, counselors,

2. **Training requirements**: The PATHS curriculum provides teachers with a systematic and developmental procedure for reducing adverse factors, which can negatively affect a child's adaptive behavior and ability to profit from his/her educational experiences. The PATHS curriculum provides teachers with systematic and developmentally based lessons, materials, and instructions for teaching their students:

3. **Cost of program**: $3,000 plus expenses (does not include materials)

   Materials:
   - $640 for a complete 7-volume set
   - $300-$350 for each individual grade level
   - Implementation Costs:
   - Using existing staff approximately $15 per child per year over 3 years
   - Using full-time salaried on-site PATHS coordinator approximately $40-$50 per child per year

4. **Use of natural funding**:

Other considerations:

Contact information:

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Mark T. Greenberg, Ph.D.
Prevention Research Center
Henderson Building S-109
Pennsylvania State University
University Park, PA 16802
Phone: (814) 863-0112
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Email: mxg47@psu.edu

Relevant websites:

http://www.prevention.psu.edu/PATHS/

Blue Bay Healing Center

Description:

1. **Primary purpose**: Development of the blue bay healing center and its relationship to suicide prevention efforts on the flathead reservation and to prevent Substance abuse among youth on the reservation by breaking the generational cycle associated with this program.

2. **Target populations**: Developing a culturally relevant treatment modality that engages the entire reservation population in the healing process.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Info not available

2. **Qualitative evaluation**: The program is well known on the flathead reservation and is most effective treatment.

Evidence supporting practice:

1. **Peer reviewed research**: A survey was conducted to discover how knowledgeable of the services of the program and to assess the satisfaction of the services they received.

2. **Other supporting documents**: Info not available

Practice implementation:

1. **Staffing requirements**: Many staff members are hired for their experience with alcohol and other drug abuse. While the program has an extensive training program that provides excellent exposure to current thinking in the field and to high-level practitioners, it cannot produce an immediate professional style in newly hired counselors who are largely without a formal educational background. In such an environment, there will always be a few counselors who project an image to other agencies and to the community at large that raises questions of ethics and property. Within the agency, there are likely to be instances when gossip and an informal friendship network replace responsible communication and professional-level consultation.

2. **Training requirements**: A holistic approach is used in prevention including medical detoxification with hospitals, screening for inpatient treatment, and satellite offices in four reservations areas.

3. **Cost of program**: Info not available

4. **Use of natural funding**: Info not available

Other considerations:

Contact information:

Flat head reservation

Relevant websites:

Http://www.uchsc.edu/ai/ncaianmhr/journal/Mono4.pdf

Boys & Girls Club Northern Cheyenne Smart Moves Program

Description:

1. **Primary purpose**: In 1993, the Northern Cheyenne Nation established one of the first Boys & Girls Clubs located on Indian lands that was managed and operated by Indian people.

   The Club has over ten programs and content areas directed at addressing the multiple issues of alcohol, tobacco, and other drug use. When the survey of Indian students in the Northern Cheyenne community revealed youth were at risk for substance abuse, the Club implemented a series of SMART MOVES (Skills Mastery and Resistance Training) prevention programs. As a member of the national Boys & Girls Club of America, the Northern Cheyenne Club has access to the resources such as SMART MOVES, which the national Club developed and makes available to their affiliates throughout the country.

2. **Target populations**: Ninety-nine percent of Club participants are Northern Cheyenne youth and parents. The majority of participants are referrals; however, membership in the Club is voluntary. The referral system is comprised of links with four school districts, tribal courts, social services, health providers and individual referrals from educators, counselors, family, friends, peers and community members.

   The objective is to decrease the risk factors for substance abuse by increasing protective factors in the following areas:

   - Bonding through attachments and commitments with family, friends, school and community to achieve the positive values held by each group.
   - Development of healthy beliefs and clear positive standards for behavior by youth and adults, especially parents and tribal leaders.
   - Development and strengthening of social skills to resist use.

- Promoting belief in moral order as defined by Northern Cheyenne tradition and contemporary standards.
- Developing assertiveness and social skills.
- Increasing peer resistance and refusal skills.
- Strengthening problem solving and decision-making skills.
- Increasing conservative group norms regarding substance use.
- Increasing knowledge of the health consequences and prevalence of use.
- Analyzing media and peer influence of use by Youth and adults.

The Boys and Girls Club of Northern Cheyenne is an independent, non-profit organization located on tribal lands. It has a 12 member governing board comprised of representatives from the tribal government,

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available
2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

1. **Peer reviewed research**: Information not available
2. **Other supporting documents**: None available

Practice implementation:

1. **Staffing requirements**: Seven administrative staff and seven line staff

2. **Training requirements**: Trained and certified substance abuse prevention staff. The SMART components are all curriculum-based programs that use educational lectures, role-play, group activities, and discussion to promote the children and youth. When structured prevention program sessions are not taking place, Club youth participate in activities designed to stress non-drug use norms in order to keep the youth and their families, especially parents, involved in the prevention programs.

3. **Cost of program**: Operating budget of $750,000.00

4. **Use of natural funding**: State and private sources, The Bureau of Justice assistance. Northern Cheyenne Tribe, St. Labre Indian School Education Association, and First Interstate Banc system.

Other considerations:

Contact information:

Boys And Girls Club Of Northern Cheyenne Nation
P.O. Box 309
Lame Deer, Mt. 59043
Phone: (406) 477-6654
Fax: (406) 477-8646

Relevant websites:

Http://www.bgca.org/

Domestic Violence Pilot Projects

Description:

1. **Primary purpose**:

   The domestic violence pilot projects include:

   - Ketchikan Indian Corporation, Ketchikan, AK. The federally recognized Tribe administers health care and other services for its members. The pilot site will develop a domestic violence-screening tool and promote a culturally sensitive health care awareness campaign addressing domestic violence. It also will provide medical staff training and technical assistance to local and regional clinics.
   - Feather River Tribal Health, Inc., Oroville, CA. The non-profit Tribal organization serves patients from Butte, Sutter and Yuba Counties. The pilot site will work to establish a violence-screening program in its medical and dental departments. It also will implement screening services for its female patients and develop a case management system for handling cases involving domestic violence.
   - Houlton Band of Maliseet Indians, Houlton, ME. The ambulatory care clinic provides services to the Tribe's members and those of other federally recognized Tribes who reside in the area. The clinic already has services for victims of domestic violence and collaborates with the state coalition against domestic violence. The pilot site will train its staff and implement a mandatory screening policy for all female patients over the age of 12.
   - Mississippi Band of Choctaw Indians, Choctaw Health Center, Choctaw, MS. The health center is wholly Choctaw-managed, and its health care programs meet the specific needs of Tribe members. The Center already has domestic violence procedures in place, but the pilot program will work to develop culturally sensitive screening tools. The site also will develop more education and training for its health care providers.

- Rosebud Indian Health Service, Rosebud, SD. This clinic on the Rosebud Indian Reservation provides ambulatory and inpatient care to members of the Rosebud Sioux Tribe. The clinic currently collaborates with the White Buffalo Calf Woman Society to raise awareness about domestic violence on the Reservation. The pilot site will train its staff on domestic violence and implement screening and other prevention programs.
- Gerald L. Ignace Indian Health Center, Milwaukee, WI. This clinic is the only physical and mental health provider for the Native population in Southern Wisconsin. The pilot site will create culturally relevant screening tools to identify the needs of victims of domestic violence, train its staff on domestic violence and form collaborative partnerships with area service providers to improve its victim referral process.

2. **Target populations**: Information not available

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available
2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

Http://endabuse.org/programs/display.php3?Docid=35

Http://endabuse.org/programs/display.php3?Docid=183

1. **Peer reviewed research:** Information not available
2. **Other supporting documents:** Information not available

Practice implementation:

1. **Staffing requirements**: Information not available
2. **Training requirements**: Information not available
3. **Cost of program:** Six are fully funded with budgets ranging from $50,000 to $65,000
4. **Use of natural funding**

Other considerations:

Contact information:

Family Violence Prevention Fund
383 Rhode Island St. Suite #304
San Francisco, CA 94103-5133
Phone: (415) 252-8900
Fax: (415) 252-8991
TTY: (800) 595-4889

Relevant websites:

Http://endabuse.org/programs/display.php3?Docid=35
Http://endabuse.org/programs/display.php3?Docid=183

K' E' Project

Description:

1. **Primary purpose**: The K'E Project provides services to the Navajo Nation, the largest American Indian reservation in the United States. The K'E Project uses Navajo concepts of health and well-being in its delivery of services to children and families. The provider is sensitive to the family's cultural needs, which enhance family values to participate in their children's healing.

   The project Uses K'E teachings and practices as the central philosophy for healing, and they provide an array of home-based services. These Services include:

   - Both in-home and outpatient counseling and therapy that is strengths-based and family centered
   - Traditional/cultural counseling and healing that includes K'E teachings and practices in efforts to strengthen family and clan relationships as well as assistance obtaining support services for traditional healing
   - Behavior management services to maintain children in the home via positive skill development
   - Aftercare and follow-up counseling and support services upon completion of treatment
   - Prevention and community education, including outreach, referral, collaboration, networking and community education
   - Case management and advocacy for adequate and appropriate resources to support and empower individuals and families

2. **Target populations**: Not specified

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available
2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

EBP resource:
http://www.mentalhealth.org/cmhs/childrenscampaign/pdfs/2000monographs/vol1.pdf

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a System of care model in American Indian communities. Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research. P. 43-44.

1. **Peer reviewed research**:

Cross, T. L. (1986). Drawing on cultural tradition in Indian welfare practice. Social Casework, 67, 283-289.

Cross, T. L. & Rylander, L. (1986). Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children. Portland, OR: Regional Research Institute, Portland State University and Northwest Child Welfare Institute.

Cross, T. L., et al (1989). Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington, D.C. Georgetown University: Child Development Center.

Cross, T. L. (1995). Understanding family resiliency from a relational worldview. In H.L. McCubbin, E.A. Thompson, A. I. Thompson, & J. E. Fromer, (Eds.). Resiliency in Ethnic Minority Families. Vol I: Native and Immigrant American Families. Madison, WI: University of Wisconsin System.

Culturally Relevant Ethnic Minority. (1989). Seattle Indian Health Board's culturally oriented mental health program. Multi-Ethnic Mental Health Services (pp. 163-190). Mount Vernon, WA.

Deserly, K. J., & Cross, T. L. (1986). An assessment of tribal access to children's mental health funding. American Indian Children's Mental Health Services. Portland, OR: National Indian Child Welfare Association.

2. **Other supporting documents**: Information not available

Practice implementation:

1. **Staffing requirements**: Information not available
2. **Training requirements**: Information not available
3. **Cost of program**: Information not available

4. **Use of natural funding**: In 1994, the Center for Mental Health Services (CMHS) funded the first of five American Indian children's mental health projects. This monograph examines five American Indian children's mental health projects funded by the Center for Mental Health Services (CMHS).

Other considerations:

Contact information:

Information not available

Relevant websites:

Http://www.mentalhealth.org/CMHS/CHILDRENSCAMPAIGN/PDFS/2000MONOGRAPHS/VOL1.PDF

The Kmihqitahasultipon Program

Description:

1. **Primary purpose:** "The Kmihqitahasultipon Program serves children and families of the Passamaquoddy Tribe of Indian Township, Maine. The Kmihqitahasultipon Program, the name of which means "we remember" in Passamaquoddy, works with a major goal of "restoring Passamaquoddy culture and traditions to the daily life of Indian Township families and children for the purpose of improving overall community well-being." Because a large number of families in the Passamaquoddy community have experienced some kind of trauma (from time spent in boarding schools, separation from the community, or abuse), the Kmihqitahasultipon Program in many ways considers the entire community when designing and delivering services. If a family has more than one very young child, the program often works with all the children in that family." (p. 81). "The Kmiqhitahasultipon Program has four primary philosophical commitments: (1) a focus on the strengths, roles, and responsibilities of staff, as well as their working relationships; (2) frequent, relationship-based interventions and supports for children; (3) cultural competence; and (4) a strong connection to the community." (p. 82-83)

   "Full-time parent advocates at the Kmiqhihatasultipon Program offer valuable resources to parents of very young children. This includes developing a supportive and trusting relationship with the family member. When this relationship is in place, the parent advocate is able to provide many supports to the family member, including, 1) help with parenting skills, 2) respite, 3) willingness to listen to family members on a regular and ongoing basis, 3) facilitation of communication between parents and teachers; and 4) information for family members regarding various community supports." (P.84-85).

2. **Target populations:** Information not available

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available
2. **Qualitative evaluation:**

Evidence supporting practice:

The Kmiqhitahasultipon Program, Indian Township, Maine. In: Promising Practices in Early Childhood Mental Health Promising Practices in Children's Mental Health Systems of Care - 2001 Series, Volume III, pp. 81-86.

Web Resource:
http://www.mentalhealth.org/cmhs/childrenscampaign/pdfs/2000monographs/vol1.pdf

1. **Peer reviewed research:** Information not available
2. **Other supporting documents:** Information not available

Practice implementation:

1. **Staffing requirements**: "All staff, except one, is Passamaquoddy. Several speak Passamaquoddy and thus can offer services in both English and Passamaquoddy. The Kmihqitahasultipon Program also benefit from a twice-monthly consultation with psychologists from Harvard University. Video conferencing is used to discuss a particular case the Kmihqitahasultipon Program staff present."

2. **Training requirements**: "An initial intensive five-day-a-week, four-week-long orientation and training program offered the staff a unique opportunity to learn one another's strengths and areas of contribution, as well as to focus on their collective vision and goals for the program itself." (p. 86).

3. **Cost of program:** Information not available

4. **Use of natural funding**: Program was initially funded by Wings of Maine and began receiving funds independently of Wings of Maine in 1997.

Other considerations:

Contact information:

Information not available

Relevant websites:

Http://www.mentalhealth.org/cmhs/childrenscampaign/pdfs/2000monographs/vol1.pdf

Life Givers

Description:

1. **Primary purpose:** The Life Givers Program provides an on site services to deliver case management, including medical screening and monitoring; individual, group, and family counseling; alcohol and drug education; gender and survivor groups; social/life skills training; mental health crisis intervention and screening; in-home schooling and developmental child care to meet the needs of Native female teens. The program serves communities across the state from Ketchikan to Barrow. The program has been commended for cultural integrity of the program, integrating culture throughout the treatment continuum. An early Head Start center provides developmentally appropriate care to infants and toddlers with classrooms organized into interest centers. Each child is assessed and receives a develop individual learning plan, guided socialization sessions between teen parents and their children and parenting training.

2. **Target populations:** Ages of girls in program are between ages 13-18. Ages of children in daycare are between ages 0-3.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

Fairbanks Native Association

Web resource:
http://www.fairbanksnative.org/lifegivers.html
National Child Welfare Resource Center for Family-Centered Practice

1. **Peer reviewed research**:

2. **Other supporting documents**: Information not available

Practice implementation:

1. **Staffing requirements**: Mental Health Clinicians

2. **Training requirements**: The program implements a bio-psycho-social-spiritual model of addiction. “This model encompasses six systems: the biological system and physical recovery, the psychological system, the recovery environment (both family and peer relations), and promoting recovery at the community level.”

3. **Cost of program**: Information not available

4. **Use of natural funding**: Information not available

Other considerations:

- Award for Dedication and Commitment to Serving Women and Children Affected by Substance Abuse from U.S. Department of Health and Human Services.
- Cited as promising practice by the Office of Juvenile Justice and Delinquency Prevention

Contact information:

Fairbanks Native Association
Clinical Director: Montean Jackson
Telephone: 452-1274 Fax: 452-1282
Location: 605 Hughes Avenue, Fairbanks, AK 99701
Fax: 202.742.5394
Email: fnalife2@mosquitonet.com

Relevant websites:

Http://www.fairbanksnative.org/lifegivers.html

Minneapolis American Indian Center, Ginew/Golden Eagle Program

Description:

1. **Primary purpose:**: This program provides intensive services to prevent child abuse, family violence, chemical abuse, delinquency, teen pregnancy, prostitution, suicidal behavior, truancy and running away from home for American Indian youth. "The Ginew/Golden Eagle Program offers at least three months of one-on-one sessions with the Youth Advocate, meetings with the family and home visits. If needed, the Youth Advocate will provide court advocacy, probation monitoring, and referrals to other services and/or treatment. It is anticipated that three-fourths of the youth will also take part in daily activity groups at least twice a month." (p. 18). "Service Area: Youth Minneapolis Youth Intervention Programs strive to eliminate involvement (or further involvement) of at-risk youth in Minnesota's juvenile justice system by offering comprehensive prevention, early intervention, and diversion services to youth and their families." (p. 3).

2. **Target populations**: American Indian youth between the ages of 9 and 18. The program targets youth who are at risk of child abuse, family violence, chemical abuse,

delinquency, teen pregnancy, prostitution, suicidal behavior, truancy and running away from home.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

Minnesota Department of Economic Security
Office of Youth Development, December 1996, p. 18.

1. **Peer reviewed research**: Information not available

2. **Other supporting documents**: Information not available

Practice implementation:

1. **Staffing requirements**: Program directors, counselors,

2. **Training requirements**: Information not available

3. **Cost of program**: The average state investment per client is estimated at $67.

4. **Use of natural funding**: "The Minnesota Legislature funded Youth Intervention Programs at a level of $650,000 for 1996 and an additional $650,000 for 1997. Funding was provided under Chapter 312, Section 23, and Grants in Aid to Youth Intervention Programs, established under §268.30, Subdivisions 1 and 2. An additional $240,000 appropriation was made by the 1996 Legislature to fund six new programs which will begin on January 1, 1997" (p. 4). Applicants for state funding must provide two dollars in local funds for every one dollar the state invests. Many programs provide local matching funds in amounts, which far exceed the required 2 to 1 match.

Other considerations:

Contact information:

Contact: Shirlee Stone
612-879-1766

John Olson
Youth Programs Analyst
Office of Youth Development
MN Dept. of Economic Security
390 North Robert St.
St. Paul, MN 55101
(612) 282-2732

(800) 456-8519
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Office of Youth Development
MN Dept. of Economic Security
390 North Robert St.
St. Paul, MN 55101
(612) 296-6064
(800) 456-8519
Mailto:ktracy@ngwmail.des.state.mn.us

Relevant websites:

Http://www.maicnet.org/Ginew/

Mno Bmaadzid Endaad "Be in Good Health at His House"

Description:

1. **Primary purpose:** The Sault Ste. Marie Tribe of Chippewa Indians is in partnership with the Bay Mills Tribe of Chippewa Indians and Hiawatha Behavioral Health on this services project. Mno Bmaadzid Endaad, "Be in Good Health at His House," is a program that integrates tribal tradition and values with western modalities. The program collaborates with community, tribal and nontribal programs of human services, and other agencies while maintaining cultural integrity into the program. Thus, Mno Bmaadzid Endaad is integrated into the Indian communities it serves. The program is a model for multidiscipline collaboration, which becomes the focal point for their system of care. The following is their mission statement, as well as objectives of the program:

   "To develop an integrated, seamless and multidisciplinary service delivery system that provides culturally sensitive services. It shall be designed for the prevention and early identification of child abuse and neglect. Services shall be client oriented, easily accessible, and focused toward measured positive outcomes…"

   - "Objective 1: The development of a seamless health and human service delivery system inclusive of multiple systems that will emphasize prevention, early intervention, and coordinated services to improve access of services to Native American children and their families.

- "Objective 2: To provide non-native service providers with information and training regarding the cultural norms and practices; specifically, parenting, family values, and norms.
- "Objective 3: To educate the community to the needs of children with serious emotional disturbance and their families and availability of services to ensure that all children are provided a safe and nurturing environment in which to grow."

2. **Target populations:** Information not available

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Cross, T.L. et. al. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. Washington, D.C.: Georgetown University: Child Development Center.

American Indian Practices Converge in a "System of Care" for Children. SAMHSA NEWS, Vol. IX, No. 1, Winter 2001.

1. **Peer reviewed research**: Information not available

2. **Other supporting documents**:

- Use of extended family and the extended family concept (context)
- Use of traditional teachings that describe wellness, balance, and harmony or provide a mental framework for wellness and use these as objectives for the families (mind)
- Use of specific cultural approaches such as storytelling, talking circles, ceremonies, sweat lodges, feasts, etc. (mind, spirit, body)
- Use of cultural adaptations to mainstream system of care practices such as wraparound, respite, crisis intervention, collaboration (mind, context)

Practice implementation:

1. **Staffing requirements**: Staff includes professionals and paraprofessionals, natives and non-natives. The staff use spiritual healing methods, and employ grassroots mentors, elders, and community members who, reflect the deeply rooted traditions of community. Mno Bmaadzid Endaad staff demonstrates commitment by modeling this same generosity of self.

2. **Training requirements**: The program provides training to non-native service providers regarding cultural norms and practices; specifically, parenting, family values, and norms.

3. **Cost of program:** Information not available

4. **Use of natural funding**: "A variety of tribal programs, such as tribal schools and substance-abuse treatment programs, are additional resources and part of the system of care with which Mno Bmaadzid Endaad collaborates."

Other considerations:

Contact information:

Hardy Stone Director of Communications
CMHS Child, Adolescent, and Family Branch
Room 11C-16
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-1333.
mailto:hstone@samhsa.gov.com

Relevant websites:

Http://www.mentalhealth.org/cmhs/childrenscampaign/pdfs/2000monographs/vol1.pdf

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Natural Helpers Programs

Description:

1. **Primary purpose:** The Tribal Youth Program I is implemented in the Lower Elwha Klallam Tribe in the State of Washington. This programs is a Juvenile Justice Program that has four Goals: 1) Reduce, Control, and Prevent Indian Juvenile Crime, 2) Provides Intervention for Court-Involved Youth, 3) Improvement to Tribal Juvenile Justice Systems, and 4) Prevention Programs Focusing on Alcohol and Drugs.

   "The Lower Elwha Juvenile Justice Program is a prevention project that incorporates strategies from all of the objectives of the Tribal Youth Program. Services are offered to all native children from elementary through age 18. Elementary children are offered a curriculum that addresses the issues of residing in a home affected by substance abuse. Other program components include intensive advocacy services for adolescents involved with the criminal justice system and enhancement of the tribal court to enable services to be provided for family-related issues. Additionally, the tribe assesses all native youth in

grades 6–12 within the Port Angeles School District to determine developmental profiles. In addition, the "natural helpers," provide training and partnership, and Comprehensive Substance Abuse Primary Prevention Services that are Coalition Driven."

- Goal 1: To empower youth to plan, implement, and evaluate prevention activities to reduce ATOD abuse and other related problems in northern Rio Arriba County.
- Objective 1: provide on-going support, leadership training, and prevention activities to 100% of Chama Valley Middle School students.

2. **Target populations:** Native children from elementary through age 18.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

1. **Peer reviewed research**:

   MMWR Weekly April 10, 1998 / 47(13):257-261

   Suicide Prevention Evaluation in a Western Athabaskan American Indian Tribe -- New Mexico, 1988-1997 http://www.cdc.gov/mmwr/preview/mmwrhtml/00051966.htm

2. **Other supporting documents** : Information not available

Practice implementation:

1. **Staffing requirements:** Information not available
2. **Training requirements:**
   - Conduct a training of trainers on conflict management. Train approximately 15 youth in conflict management skills and techniques to be Natural Helpers. Implement conflict management once a week in group settings.
   - Train a minimum of 15 new middle school Natural Helpers in leadership and peer counseling techniques.
   - Involve approximately 40 Natural Helpers, and other students, in developing activities such as fundraising, to be implemented quarterly.
   - Implement one activity per quarter throughout the school year.
   - Trained Natural Helpers will identify and refer other students to school and community resources, including identifying students in need of mentoring, tutoring, or other services.
3. **Cost of program**: $95,500
4. **Use of natural funding:** Information not available

Other considerations:

Contact information:

Relevant websites:

Pride: Substance Abuse Education/ Intervention Program

Description:

1. **Primary purpose:** The PRIDE program is prevention based. It also incorporates strong intervention practices and policies, as well as treatment referral and after-care provision. The pride program is a comprehensive plan that addresses all aspects of the substance abuse issue.

2. **Target populations:** The PRIDE program has been implemented at the tribe's elementary, middle, and high schools.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** The pride program has resulted in positive results that have been determined through formal as well as informal measures. A renewed commitment of the Puyallup tribal council and administrative program initiatives, principal among them the pride program, have resulted in significant improvement in student outcomes.

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

1. **Peer reviewed research**: The pride program researched studies with students, by taking questionnaires about alcohol & drug use, as well as suicidal attempts.

2. **Other supporting documents**: Karachi tribal mental health agency

Practice implementation:

1. **Staffing requirements:** Staff is encouraged to communicate among the three school campuses; opportunities for dialogue and observation regularly occur at an interschool and intraschool level.

- Building principals. One full-time employee per school provides program oversight within school, ensures building-level communications flow, reviews infusion and pull-out class lesson plans, and coordinates referral process for intervention.
- Behavior development specialists. One full-time employee per school acts as a case manager for the intervention component; provides direct support for the security component; provides crisis intervention, referral, and direct support, particularly for behavioral needs; implements individual student behavior contracts; assists with after-care programs; provides ongoing counseling; and assists with implementation of interagency agreements, particularly for student referral and interagency communication.
- Chemical dependency counselors (CDCS). The principal of the high school is completing certification requirements for CDC 1, and an additional CDC 1 position is available on an itinerant basis Additional consultant, outpatient, and inpatient CDC counseling is available through interagency agreement with the Puyallup tribal treatment center.
- Pride teachers. At each school, an instructor is responsible for teaching pride curriculum units on a regular basis. These individuals also act as consultants for other teachers' daily lesson plan infusion activities.

2. **Training requirements:** Information not available

3. **Cost of program:** The pride program has been implemented without any outside funding. Base school budgets, including title v funds, special education monies, and basic Indian student equalization program (ISEP) funding, support the program.

4. **Use of natural funding:** Funded through a P.L. 638 self-determination contract with the bureau of Indian affairs.

Other considerations:

Contact information:

Information not available

Relevant websites:

Http://www.uchsc.edu/ai/ncaianmhr/journal/Mono4.pdf

Pueblo Of Zuni Recovery Center

Description:

1. **Primary purpose:** The Zuni Recovery Center (ZRC): This center provides holistic services to the many different segments of the community that are affected by substance abuse. The Center has three primary programs: 1) a comprehensive day treatment program, 2) a DWI school, and 3) an underage drinking initiative. Although these programs focus on different populations, they share the same core mission of reducing the prevalence and incidence of chemical dependency by helping clients to address the issues underlying their dependency and to embrace healthier lifestyles. The Comprehensive Day Treatment Program: This component of the ZRC provides differentiated services for adults, youth and children that include individual, group and family counseling and other wellness treatments such as nutrition and physical fitness training. Specialized treatment programs accommodate clients who are chemically dependent and who need dual treatment for both substance abuse and mental health problems, or who are adult children of alcoholics. The DWI Program: This program treats DWI offenders through a combination of education, group therapy, mandatory community service, and therapeutic fitness training at Zuni's Wellness Center.

2. **Target populations:** Information not available

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available
2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

1. **Peer reviewed research**: Information not available
2. **Other supporting documents:** Information not available

Practice implementation:

1. **Staffing**: Information not available
2. **Training requirements:** Information not available
3. **Cost of program**: $487,800 annually
4. **Use of natural funding**: ZRC receives financial support from federal, state, and tribal sources, as well as private foundations.

Other considerations:

Contact information: Relevant websites:

Danny Ukestine, Director
Zuni Recovery Center
P.O. Box 339
Zuni, NM 87327
Phone: 505 782-4717
Fax: 505782-4181

Sacred Child Project

Description:

1. **Primary purpose:** This five-year-old program was to create mental health service for Native American children living on North Dakota's reservations. The program is overseen by Debra Painte at the United Tribes Technical College, which serves five sites: Spirit Lake Nation, Standing Rock Nation, Three Affiliated Tribes, Turtle Mountain Band of Chippewa and Trenton Indian Service Area. This program integrates western services and traditional healing methods such as traditional healers, clans, extended family, churches and ceremonies. Other Sacred Child Project services include: 1) Wraparound care coordination and training, 2) Parent advocacy, 3) Parent and community education, 4) Tutoring, 5) Mentoring, 6) Traditional healing, 7) Recreational activities, 8) Cultural activities, 9) Psychological assessments,10) Transportation,11) Limited family, emergency financial assistance, and 12) Youth social development activities.

2. **Target populations:** American Indian youth between ages 1 to 22 who are agency or private placement referrals. To qualify, parent coordinators must have a child with emotional or behavioral challenges or must have an extended family member with similar issues.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. Systems of Care: Promising Practices in Children's Mental

Health, 2000 Series, Volume I. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research. P. 47-53.

Jodi Rave Lee covers Native issues for The Lincoln (Neb.) Journal Star and Lee Newspapers. She can be reached at (402) 473-7240 or jravejournalstar.com. Tuesday, November 27, 2001

1. **Peer reviewed research**:

Bronfenbrenner, U. (1979). The ecology of human development : Experiments by nature and design. Cambridge, MA: Harvard University Press.

Bruns, E. J., Burchard, J. D., Ermold, J., & Dakan, E. (2000, March). Development of the Wraparound Fidelity Index: Results from an initial pilot test. Paper presented at the 13th Annual Research Conference of the University of South Florida's Research and Training Center for Children's Mental Health, Clearwater Beach, FL.

Burns, B. J., & Goldman, S. K. (Eds.). (1999). Promising practices in Wraparound for children with serious emotional disturbance and their families. Systems of Care: promising practices in children's mental health, 1998 Series, Volume IV. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

2. **Other supporting documents**: Information not available

Practice implementation:

1. **Staffing requirements**: Parent Coordinators, intake team, care coordinators, and support team. All staff is Native American or from the community they are serving. The 12 life domains of the plan of care include cultural and spiritual domains.

2. **Training requirements**: On-going training provided for case-by-case situations

3. **Cost of program**: Limited funding is provided to families needing wraparound services, which is determined by a support team. Cost of care includes resources used to implement intervention, and outcomes of care plan.

4. **Use of natural funding**: Information not available

Other considerations:

Contact information:

Sacred Child Project, North Dakota
Contact Person At Location:
Susan Paulson
701-854-3861

Jan Two Shields
701-255-3285, Ext 385

John VanDenBerg
The Community Partnership Group
9715 Bellcrest Road
Pittsburgh, PA 15237
412-366-6428

Relevant websites:

Vdb@Nauticom.Net

Southeast Alaska Regional Health Consortium

Description:

1. **Primary purpose**: "The Southeast Alaska Regional Health Consortium is part of the Seven Circles Coalition, which serves the youth in nine communities in southeastern Alaska -- Wrangell, Petersburg, Yakutat, Haines, Saxman, Klawock, Juneau, Sitka, and Ketchikan." Each community has a large Native American population. The Coalition has traditionally been involved with Native elder organizations, a women's safe shelter, and a senior citizens' center. Interventions focus on youth assets, rather than focusing on deficiencies. Youth are involved in all aspects of project planning and implementation. Project activities include establishing a website and hosting substance abuse prevention teleconferences." SEARHC provides culturally relevant residential treatment services to clients. The Raven's Way Program is a six-week residential program for adolescents between the ages of 13 and 18 who have problems with alcohol and/or drug abuse. "The goal is to help youth troubled by dependency problems to find their own path towards spiritual healing, by blending conventional and adventure based therapy." One component is a three-week program wilderness exchange program that helps youth experience healthy lifestyles, teamwork skills, and self-confidence. A second component focuses on youth development of family living skills where youth spend two weeks in a group home and 12 days at a remote camp.

2. **Target populations:** The Raven's Way Program is a six-week residential program for adolescents between the ages of 13 and 18 who have problems with alcohol and/or drug abuse.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

Southeast Alaska Regional Health Consortium. In: Promising practices and strategies to reduce alcohol and substance abuse among OJP American Indians and Alaska Natives. U.S. Department of Justice: Office of Justice Programs. August 2000, pg. 29-34.

1. **Peer reviewed research**: Information not available

2. **Other supporting documents:** Information not available

Practice implementation:

1. **Staffing requirements**: Program staff provides comprehensive treatment services along with part time support from the SEARHC Edgecumbe Hospital.

2. **Training requirements**: Staff development is ongoing and consists of two weeks of formal training for each program component annually, in-house training is provided to acquire an Alaska Counseling Certification, and staff attends off-island conferences and workshops on behavioral health.

3. **Cost of program**: Total: $2,120,000; Ravens Way: $930,000; BBHC: $830,000; Deilee Hit: $360,000

4. **Use of natural funding**: State of Alaska Division of Alcohol and Drug Abuse, Medicaid and third party funding.

Other considerations:

Contact information:

Southeast Alaska Regional Health Consortium
222 Tongass Drive
Sitka, AK. 99835
Phone (907) 966-2411
Fax: (907) 966-8656

Relevant websites:

Storytelling for Empowerment

Description:

1. **Primary purpose:** Storytelling for Empowerment is a school-based secondary prevention program designed for club and classroom settings. The project has been tried with American Indian and Latino-Latina middle school youth, which addressed the risk factors of confusion of cultural identity, the lack of congruence of multicultural learning styles and instruction, and the lack of consistent, positive parental role models. Program goals include "decreasing the incidence of alcohol, tobacco, and illegal drug use among high-risk youth by identifying and reducing factors in the individual, family, school, peer group, neighborhood/community, and society/media." The Program also focuses on increasing factors that strengthen youth resiliency to protect youth from using substances.

2. **Target populations:** The targeted population for the Project is American Indian middle school-aged youth living on a rural Indian Nation, as well as Latino-Latina middle school-aged youth living in urban settings. Grades 5-8.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

The Center for Injury and Violence Prevention, Virginia Department of Health The VCU Center for the Study and Prevention of Youth Violence in collaboration with The Virginia Department of Education:

Http://modelprograms.samhsa.gov/print.cfm?Pkprogramid=172

1. **Peer reviewed research:** Information not available

2. **Other supporting documents:** Storytelling for Empowerment Project includes a Storytelling PowerBook (27-lesson activity book), and a Facilitator's Guide. The sections in the PowerBook include: Knowledge Power (knowledge of brain physiology, definition of additions, physical effects of drug, charts, games); Skills Power (decision making strategies with role plays); Personal Power (five multicultural stories, symbol making, plays); Character Power (four multicultural stories of historical figures, character trait mandalas); Culture Power (definitions of culture, biculture, sub culture, cultural symbol); and Future Power (stories of multicultural role models, choosing a role model, drawings, goal setting). As 20-30 sessions are necessary to decrease alcohol and marijuana use, the intervention can be implemented within 3 months during the school year.

Practice implementation:

1. **Staffing requirements:** Information not available

2. **Training requirements:** Storytelling powerbook (English and Spanish) Storytelling for Prevention (English and Spanish) Facilitator's Guide for Storytelling powerbook Available on www.wheelcouncil.org

3. **Cost of program:** Information not available

4. **Use of natural funding:** Information not available

Other considerations:

Contact information:

Annabelle Nelson, Ph.D., Program Developer
The Wheel Council
P.O. Box 22517
Flagstaff, AZ 86002-2516
Phone: (928) 214-0120
Fax: (928) 214-7379
annabelle@wheelcouncil.org

Relevant websites:

www.wheelcouncil.org

The Dream Catcher Meditation

Description:

1. **Primary purpose**: The dream catcher meditation is a short-term treatment insight-oriented model designed for American Indian adolescents. Its overall goal is to "help clients' express unconscious conflicts and to facilitate differentiation and healthy mutuality. (p. 51). Risk factors include high levels of truancy, delinquency, drug use, and suicide rates. Some protective factors include rituals and symbolism of Native American Church peyote meetings, stomp dances, sun dances, and many other ceremonies, including rites of passage and ceremonies for religious renewal to effect balance.

2. **Target populations:** American Indian youth-age not specified

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Information not available

2. **Qualitative evaluation**: Case Study evaluation of each session.

Evidence supporting practice:

Resource:
Robbins, R. (1994). The Dream Catcher Meditation: A Therapeutic Technique Used With American Indian Adolescents American Indian And Alaska Native Mental Health Research, Vol. 10, 1: P. 51-65.
Web resource:
http://www.uchsc.edu/ai/ncaianmhr/journal/10(1).pdf

1. **Peer reviewed research:** The Dream Catcher Meditation 65

2. **Other supporting documents:** The program consist of twelve sessions that include: 1) Self-Reflection, 2) Respect for Ancestors, 3) Differentiation, 4) Respect for Place, 5) Appreciation of Others, 6, 7, 8)Psychological Traumas, 9) Integration, 10) Outside Influences, 11) Life Goals, and 12) Evaluation and Termination.

Practice implementation:

1. **Staffing requirements:** Information not available

2. **Training requirements:** Information not available

3. **Cost of program:** Information not available

4. **Use of natural funding:** Information not available

Other considerations:

Contact information:

Rockey Robbins, Ph.D.
Department of Applied Health & Education Psychology
Oklahoma State University
1406 Amherst
Norman, OK 73071

Relevant websites:

Http://www.uchsc.edu/ai/ncaianmhr/journal/10(1).pdf

The Zuni Life Skills

Description:

1. **Primary purpose:** The Zuni life skills development curriculum takes a skills training approach to reduce the risk factors for suicide among Zuni adolescents.

2. **Target populations:** Zuni high school adolescents

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** The project focused on changes in students in the three experimental conditions. Measures consisted of a student survey administered at the beginning and end of the semester and one mid-semester measure of suicide potential. The student survey included the following variables: Suicide behavior, suicide risk factors, personal & social skills.

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

1. **Peer reviewed research**: This model has been implemented numerous times (Hollin & Trower, 1986) and studied over 20 years that has shown effectiveness with diverse groups, skills training developed by counselors and educators to help these populations make changes in their lives and environment (see the work of Engels, 1984; Jansen & Meyers-Abel, 1981 and Schinke, Holden, & Moncher, 1989). Such programs focus on enhancing cognitive and behavioral skills necessary for coping effectively with affective arousal, stress, and negative states (Feiner & Fetner, 1989).

2. **Other supporting documents**:

Ashby, M. R., Gilchrist, L. D. & Miramontez, A. (1987), Group Treatment For Sexuality-Abused American Indian Adolescents, Social Work With Groups, 10, 21-32.

Bach, P. J., & Bornstein, P.H. (1981). A Social Learning Rationale And Suggestions For Behavioral Treatment With American Indian Alcohol Abusers, Addictive Behaviors, 6, 75-81.

Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, NJ: Prentice Hall.

Practice implementation:

1. **Staffing requirements:** Teachers, school personnel, and community people involved in the curriculum implementation

2. **Training requirements:** Three training sessions were provided to teachers, school personnel, and community people involved in the curriculum implementation. Each training program was planned around a model for implementing health education

innovations including (a) background on theoretical foundations for the curriculum and the research; (b) demonstration of new skills to be mastered by teachers, preferably using content from the curriculum; (c) practice of skills; (d) observation and feedback on teachers' performance of the new skills; and (e) coaching of the teachers in the application of new concepts and skills within the classroom environment.

3. **Cost of program:** Information not available

4. **Use of natural funding:** Information not available

Other considerations:

Contact information:

Zuni Pueblo High Schools

Relevant websites:

Http://www.uchsc.edu/ai/ncaianmhr/journal/mono4.pdf

United American Indian Involvement, Inc. Ah-No-Ven (Healing) Home – Youth Regional Treatment Center

Description:

1. **Primary purpose:** United American Indian Involvement, Inc. (UAII) is a non-profit 501(c)(3) organization that provides services to the Los Angeles American Indian Community. The Youth Regional Treatment Center (YRTC) is currently being developed in collaboration with Indian Health Service. UAII will establish a residential facility to address the unique needs of American Indian youth who have been separated from their families or have significant substance abuse issues.

2. **Target populations:** Target population, i.e. age, gender, language, etc. not listed for current service programs. However, in mid-to-late 2003, the program plans on opening a 24-hour, seven day a week treatment home for up to ten (10) American Indian girls between the ages of 14 to 18.

Evaluating this practice:

1. Outcome measures used to evaluate practice: Information not available

2. Qualitative evaluation: Information not available

Evidence supporting practice:

Web Resource:
http://www.laindianhealth.com/

1. **Peer reviewed research:** Information not available

2. **Other supporting documents:** Information not available

Practice implementation:

1. **Staffing requirements:** Information not available

2. **Training requirements:** Information not available

3. **Cost of program:** Information not available

4. **Use of natural funding:** Program funding includes: Indian Health Service, California Rural Indian Health Board – Community Challenge Grant, California Employment Development Department, California Office of Criminal Justice Programs, City of Los Angeles Community Development Department, CAN-Fit, First 5 Los Angeles (Prop 10), Los Angeles County Alcohol Programs – General Relief, Office of Alcohol Programs-Prop 36, Los Angeles County Department of Mental Health, Los Angeles County Department of Public and Social Services, Los Angeles County Community Development – CSBG, CSAIBG, Los Angeles County Dept. Of Health Services, Office of AIDS Programs and Policy, substance Abuse and Mental Health Services Administration (SAMSHA) – CMHS, and Private Donations.

Other considerations:

Contact information:

1125 West 6th Street, Suite 400
Los Angeles
213-202-3970

Relevant websites:

Http://www.laindianhealth.com/

Wraparound Milwaukee

Description:

1. **Primary purpose:** Wraparound Milwaukee provides services based on the wraparound approach, which is implemented as a Medicaid managed care behavioral health carve-out for specific populations, e.g. children and adolescents with serious emotional disturbance who are under court order in the child welfare or juvenile justice system.
2. **Target populations:** The population that has been served by Wraparound Milwaukee is approximately 47% African American, 38% Caucasian, 8% Hispanic, and 3% Native American.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Child and Adolescent Functioning Assessment Scales (CAFAS); Child Behavior Checklist (CBCL-C)
2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

Burns, B.J., and Goldman, S.K. (Eds.) (1999). Promising practices in wraparound for children with serious emotional disturbance and their families. Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Vol IV. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

EBP resource: http://cecp.air.org/promisingpractices/1998monographs/vol4.pdf

1. **Peer reviewed research**:

Bruns, E., Burchard, J., & Yoe, J.T. (1995). Evaluating the Vermont System of Care: Outcomes Associated with Community-Based Wraparound Services. Journal of Child and Family Studies, 4 (3), 321-39.

Clark, H., Lee, B., Prange, M., & Mcdonald, B. (1996). Children Lost Within The Foster Care System: Can Wraparound Service Strategies Improve Placement Outcomes? Journal Of Child And Family Studies, 5 (1), 39-54.

Clark, H., Prange, M., Lee, B., Stewart, E., Mcdonald, B., & Boyd, L. (1998). An Individualized Wraparound Process for Children in Foster Care with Emotional/Behavioral Disturbances: Follow-up Findings and Implications from a Controlled Study. In Outcomes for Children and Youth with Behavioral and Emotional Disorders and Their Families: Programs and Evaluation Best Practices. Pro-Ed Publishing.

Clarke, R., Schaefer, M., Burchard, J., & Welkowitz, J. (1992). Wrapping Community-Based Mental Health Services around Children with a Severe Behavioral Disorder:

An Evaluation of Project Wraparound. Journal of Child and Family Studies, 1 (3), 241-61.

Cumblad, C. (1996). The Pathways Children and Families Follow Prior to, During, and After Contact with an Intensive, Family-Based, Social Service Intervention in Urban Settings. Ph.D. Dissertation, Department of Educational Psychology, Counseling, and Special Education, Northern Illinois University.

Dennis, K., Vandenberg, J., & Burchard, D. (1992). The Wraparound Process. Presented at the First National Wraparound Conference, Pittsburgh, PA.

Donnelly, J. (1994). A Comparison of Youth Involvement and a Sense of Unconditional Care with Wraparound versus Traditional Services. Master's thesis, University of Vermont.

Duchnowski, A., Kutash, K., & Rudo, Z. (1997). School, Family, and Community Team Manual. Tampa, FL: Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute.

Eber, L. (1994). The Wraparound Approach. Illinois School Research and Development Journal, 30 (3), 17-21.

Eber, L. (1996). Wraparound Can Enhance the Development, Application, and Evaluation of Effective Behavior Interventions. Counterpoint, 17 (2), 16-18.

Hyde, K., Burchard, J., & Woodworth, K. (1996). Wrapping Services in an Urban Setting. Journal of Child and Family Studies, 5 (1), 67-82.

Hyde, K., Woodworth, K., Jordan, K., & Burchard, J. (1995). Wrapping Services in an Urban Setting: Outcomes of Service Reform in Baltimore. In The 7th Annual Research Conference Proceedings. A System of Care for Children's Mental Health: Expanding the Research Base. Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Illback, R., Neill, T., Call, J., & Andis, P. (1993). Description and Formative Evaluation of the Kentucky IMPACT Program for Children with Serious Emotional Disturbance. Special Services in the Schools, 7 (2), 87-109.

Kamradt, B. (1996). The 25 Kid Project: How Milwaukee Utilized a Pilot Project to Achieve Buy-in among Stakeholders in Changing the System of Care for Children with Severe Emotional Problems. Paper presented to the Washington Business Group on Health.

Malysiak, R. (1998). Deciphering the Tower of Babel: Examining the Theory Base for Wraparound Fidelity. Journal of Child and Family Studies, 7 (1), 11-25.

Malysiak, R. (1997). Exploring the Theory and Paradigm Base for Wraparound. Journal of Child and Family Studies, 6 (4), 399-408.

Mcdonald, B., Boyd, L., Clark, H., & Stewart, E. (1995). Recommended Individualized Wraparound Strategies for Foster Children with Emotional/Behavioral Disturbances and Their Families. Community Alternatives, 7 (2), 63-82.

Rosen, L., Heckman, M., Carro, M., & Burchard, J. (1994). Satisfaction, Involvement, and Unconditional Care: The Perceptions of Children and Adolescents Receiving Wraparound Services. Journal of Child and Family Studies, 3, 55-67.

Rosenblatt, A. (1996). Bows and Ribbons, Tape and Twine: Wrapping the Wraparound Process for Children with Multisystem Needs. Journal of Child and Family Studies, 5 (1), 101-17.

Vandenberg, J. & Grealish, M. (1996). Individualized Services and Supports Through the Wraparound Process: Philosophy and Procedures. Journal of Child and Family Studies, 5 (1), 7-21.

Vandenberg, J., & Grealish, M. (1998). The Wraparound Process Training Manual. Pittsburgh, PA: The Community Partnerships Group.

Yoe, J., Bruns, E., & Burchard, J. (1995). Evaluating Individualized Services in Vermont: Behavioral and Service Outcomes. In The 7th Annual Research Conference Proceedings. A System of Care for Children's Mental Health: Expanding the Research Base. Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Yoe, J., Santarcangelo, S., Atkins, M., & Burchard, J. (1996). Wraparound Care in Vermont: Program Development, Implementation, and Evaluation of a Statewide System of Individualized Services. Journal of Child and Family Studies, 5 (1), 23-39.

2. **Other supporting documents**: Information not provided.

Practice implementation:

1. **Staffing requirements**: Project director and project management staff.
2. **Training requirements**: Information not available
3. **Cost of program**: Information not available
4. **Use of natural funding**: Wraparound Milwaukee is funded through a blending of child welfare and juvenile justice funds, a monthly capitation for each Medicaid child enrolled in the project, and federal grant dollars from the Center for Mental Health Services.

Other considerations:

Contact information:

Contact: Bruce Kamradt, Project Director,
Wraparound Milwaukee
(414) 257-7639

Relevant websites:

Http://cecp.air.org/promisingpractices/1998monographs/vol4.pdf

Daughters of Tradition

Promising Alternative

Description:

1. **Primary purpose:** The Daughters of Tradition (DOT) is an educational program designed for Native American girls that is implemented over one year. It is best when facilitated by caring adults who will share their wisdom, as well as involving local community members, grandparents and Elders. The program can be delivered in schools, churches, boys and girls clubs, or at someone's home. Daughters of tradition continues to go through an extensive review process in 87 different American Indian communities, through a grant provided CSAP--centers for substance abuse prevention. The review process includes using focus group evaluation to illicit responses concerning the cultural appropriateness of the intervention. The risk factors include drug & alcohol, low self-esteem, and abuse.

2. **Target populations:** This prevention program is for 8-12 year old Native American girls living in rural and urban areas.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

1. **Peer reviewed research:** Information not available

2. **Other supporting documents:** Daughters of Tradition Kits - Set of 14 Posters, My Journal, Daughters Booklet, and T-Shirt; Facilitator's Kit - Set of 14 Posters, My Journal, Daughters Booklet, T-Shirt, set of instructional videos, and facilitator's manual

Practice implementation:

1. **Staffing requirements:** Whether training is for individuals, teams, organizations, families, communities, the goal is to Foster Wellbriety. Thus, training focuses on achieving a healthier environment so that positive energy, creativity, success and values can be obtained.

2. **Training requirements:** White Bison Training includes curriculum training, technical assistance and consulting services for Native American communities, corporations, nonprofit organizations, professional associations, educational institutions and government agencies. All of the trainings and related services are designed around the teachings of traditions and natural laws passed down through generations of Native American Elders. All White Bison, Inc. Trainings are adapted to appropriately meet the cultural needs of Native American communities and corporate communities.

3. **Cost of program:** Information not available

4. **Use of natural funding:** Information not available

Other considerations:

Contact information:

White Bison, Inc.
6145 Lehman Drive Suite 200
Colorado Springs, CO 80918
Phone: 719-548-1000
Fax: 719-548-9407
Website: www.whitebison.org
info@whitebison.org

Relevant websites:

Http://www.whitebison.org/youth/dot.html

The Healing Lodge of the Seven Nations

Promising Alternative

Description:

1. **Primary purpose:** The philosophy of treatment of the healing lodge is the belief that addiction is "progressive and chronic and is not a symptom of some other problem." These risk factors include physical problems, which affect emotional, interpersonal, psychological, economic and personal well-being.

2. **Target populations:** The target population is American Indians and Alaska Native youth who are identified as having a substance abuse problem. The Seven Nations include Kalispel, Colville Confederated Tribes and Spokane Tribe of Indians in Washington; Kootenai, Coeur d'Alene and Nez Perce tribes of Idaho and the Confederated Tribes of the Umatilla Reservation in Oregon.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

Resource: http://www.healinglodge.org/About/aboutdefault.htm

1. **Peer reviewed research:** Information not available

2. **Other supporting documents:** The Program's educational focus includes American Indian History, Current Events, Poetry and Fiction Writing, and Mathematics. Also included is the spiritual and cultural belief related to the medicine wheel, the talking circle, smudging and the sweat lodge.

Practice implementation:

1. **Staffing requirements:** The Healing Lodge is a diverse staff that includes an Administrative Director, Treatment Technicians, Treatment Coordinator, Clinical Coordinator, Chemical Dependency Professionals, Mental Health Counselors, and Family Counselors.

2. **Training requirements:** The program provides training to staff, as well as educate and involve the young people in ceremonies, dream catchers, and sweats lodge ceremonies. In addition, the program brings in guest speakers, elders, guest drums and people from the community. The program's intention is to provide education and awareness of options so that the youth can develop their own spirituality.

3. **Cost of program:** Information not available

4. **Use of natural funding:** Partial funding for the Healing Lodge comes from State funds from Washington State's Department of Alcohol and Substance Abuse (DASA).

Other considerations:

Contact information:

President
Tina Nemena, Kalispel Tribe
Usk, WA.

The Healing Lodge Of The Seven Nations
5600 E. 8th Ave.
Spokane, WA. 99212

Relevant websites:

Http:/www.healinglodge.org/

Native Visions-Wind River

Promising Alternative

Description:

1. **Primary purpose:** Native vision is committed to helping youth attain a healthy start to life, fitness, and school completion through "the traditional '"hoop of life"' model that is central too much of American Indian belief. The hoop, or the person, is made up of four elements: the emotional, the mental, the physical and the spiritual." The program helps children complete their hoop by focusing on:
   - The emotion - by increasing youth self esteem
   - The mental – by improving educational attainment and life skills;
   - The physically, by improving fitness and nutrition while decreasing drug and alcohol use;
   - The spiritual – by increasing cultural attachment and personal identity through increased interaction with parents, mentors and elders.

2. **Target populations:** Information not available

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

1. **Peer reviewed research:** Information not available

2. **Other supporting documents:** Information not available

Practice implementation:

1. **Staffing requirements:** "Clint wagon, a native vision program coordinator, and colleagues from several youth organizations create and implement a curriculum to improve the health of children on the wind river reservation of Wyoming."

2. **Training requirements:** In partnership with Harvard University's Project on American Indian Economic Development, the Native Vision will take on the 'Nation Building for Native Youth', a pilot curriculum in self-governance, self-determination and leadership skills. The program's goal is to emphasize the notion of contribution: "What kind of Legacy will you leave for your people?"

3. **Cost of program:** Info not available

4. **Use of natural funding:** The Center for American Indian and Alaskan Native Health, The NFL Players Association, The Nick Lowery Foundation

Other considerations:

Contact information:

Native Vision National Office
621 N Washington St.
Baltimore, MD 21205
phone (410) 955-6931
fax (410) 955-2010

Native Vision Wind River Office
PO Box 629
Fort Washakie, WY 82514
phone (307) 335-9301
fax (307) 335-9298

Relevant websites:

http://www.nativevision.org/

Project Eagle

Promising Alternative

Description:

1. **Primary purpose:** "Project Eagle was originated as a three-year leadership program funded by the Office of Indian Education. After those first three years in the early 1990's, several of the Project Eagle facilitators chose to continue to conduct Eagle programs in response to requests made by tribes and schools across the United States." (p. 57).

   "The project eagle program offers gifted American Indian adolescents and their parents a safe environment to express their feelings and thoughts. It utilizes culturally relevant and appropriate psycho-educational group techniques to promote cultural identity, self-disclosure, processing, altruism, positive parent/child interaction, and leadership skills. The identified risk factors include developmental disabilities, depression, suicide, anxiety, alcohol and substance abuse, low self-esteem and alienation, running away, and school dropout as high priority areas." (p. 56)

2. **Target populations:** American Indian students, age 13 to 19, with "leadership potential."

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Quantitative (using a five-point scale-five being the highest score and one the lowest) questions and the total mean responses showed the following results:

    - I would rate my interaction with my parent/guardian during Project Eagle…
    - I would rate the Eagle activities as…
    - I felt I was respected as an individual…
    - I felt accepted in Project Eagle…
    - I became a more effective leader:
    - I felt the Eagle activities were related to American Indian culture…
    - Overall, I rate the Eagle sessions…

2. **Qualitative evaluation:** Open-ended questions were used to illicit information related to what respondents appreciated most about the eagle session. The overall emerging themes identified included the following:

    - Bonded me with my parent.
    - Allowed me to share my feelings.
    - Helped me to feel proud of being American Indian.
    - Improved my self-esteem.
    - Helped me to become a better leader.

Evidence supporting practice:

Resource:

Robbins, R., Tonemah, S., Robbins, S. (2002). Project Eagle: techniques for multi-family psycho-educational group therapy with gifted American Indian adolescents and their parents. American Indian and Alaska Native Mental Health Research, Vol 10, Number 3, 2002, 56-74.

1. **Peer reviewed research:** Robbins, R. (1993). Project Eagle Psycho-educational Training Manual. Norman, OK: American Indian Research and Development.

2. **Other supporting documents:** Project Eagle manual

Practice implementation:

1. **Staffing requirements:** Eagle group facilitators are hired to help youth participants take Responsibility for their actions and learning.

2. **Training requirements:** Eagle facilitators learn skills that encourage youth sharing, risk-taking, and interpersonal validation, refrain from asserting their "expert" knowledge, experience, or personal values in words or tone, and to build trust among participants.

3. **Cost of program:** Information not available

4. **Use of natural funding:** Office of Indian Education

Other considerations:

Contact information:

Rockey Robbins
Counseling Psychology
University of Oklahoma
1406 Amhurst
Norman, OK 73071

Relevant websites:

Http://www.uchsc.edu/ai/ncaianmhr/journal/10(3).pdf

Project Making Medicine

Promising Alternative

Description:

1. **Primary purpose:** Project making medicine. Project making medicine (pmm) is a national training program for mental health professionals from tribal and Indian Health Service agencies in the prevention and treatment of child abuse. Since 1994, PROJECT MAKING MEDICINE has trained over 150 professionals working with Native children on reservations around the country.

2. **Target populations:** Participants who work with American Indian children and families

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

Web resource: http://w3.uokhsc.edu/ccan/page11.html

1. **Peer reviewed research:** Bigfoot, D. S. (1999, April). Project making medicine: Traditional teaching and healing methods. Paper presented at the National Indian Child Welfare Association Conference, Minneapolis, MN.

2. **Other supporting documents:** "When Your Baby Cries" video on the prevention of Shaken Baby Syndrome. To order contact: Department of Pediatrics - Emergency Medical Services Project (405) 271-3307 or P.O. Box 26901, Oklahoma City, OK 73190. $15.00 plus shipping

Practice implementation:

1. **Staffing requirements:** Mental health and substance abuse personnel who work with tribal members.

2. **Training requirements:** Project making medicine (pmm) offers a 2-week training program on the treatment of child physical and sexual abuse with an emphasis on Native American practices, for providers working with American Indian children and families. Once participants complete the 2 week training, PMM will schedule an on-site visit to help providers conduct a community wide training in the prevention and awareness of child abuse and neglect.

   Week one training topics:
   - Historical Overview of Child Abuse and Neglect (CAN)
   - Impact of Abuse on Brain Development
   - Effects of Violence on Native Children
   - Treatment of Children with Sexual Behavior Problems
   - Abuse Focused Therapy for Children
   - Parent-Child Interaction Therapy
   - Working with Non-Offending Parents
   - Native American Perspective of Human Development
   - Value Systems and Learning Styles
   - Traditional Approaches and Methods to Healing
   - Treatment for Drug Exposed Infants
   - Alcohol Related Neurological Disorders
   - Treatment of Secondary Disabilities

   Week Two Training Topics
   - Storytelling and American Indian Consultation
   - Introduction to Clinical Supervision
   - Adolescent Sex Offender Treatment
   - Interagency Collaboration
   - Child Protection Teams
   - Teachings of the Medicine Wheel
   - Child Advocacy Centers in Indian Country
   - Guidelines for Expert Testimony
   - Preparing for your On-site

3. **Cost of program:** Info not available

4. **Use of natural funding:** Info not available. PMM is funded by a grant from the Indian Health Service and the Office of Child Abuse and Neglect in HHS.

Other considerations:

Contact information:

Program Developer:
Delores Subia-Big Foote
Center On Child Abuse And Neglect
University of Oklahoma Health Sciences Center
P.O. Box 26901 CHO 3B 3406
Oklahoma City, OK 73190
Phone: (405) 271-8858 Fax: (405) 271-2931

Relevant websites:

http://w3.ouhsc.edu/ccan
Http://w3.uokhsc.edu/ccan/page12.html

Sons of Tradition

Promising Alternative

Description:

1. **Primary purpose:** The Sons of Tradition provides a character-building framework that encourages youth to create healthy identities for themselves as young Native American men. The program also focuses preventing alcohol and drug for youth living in rural and urban communities through traditional methods.

   Because of participating in this year long program boys will:
   - Become aware of and be able to discuss their feelings
   - Learn to apply the teachings and principles of healthy living to their own lives
   - Recognize healthy behavior and learn how to avoid unsafe situations
   - Understand the meaning of anger, guilt, shame, and fear
   - Understand and apply spiritual values to their lives and experience healthy lifestyles, strong character and a sense of harmony as a result
   - Learn how to engage in talking circles that encourage sharing experiences, exploring new concepts and learning how to help each other

2. **Target populations:** A Prevention Education Program for 13-17 year old Native American males.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

1. **Peer reviewed research:** Info not available

2. **Other supporting documents:**

The Son's Booklet addresses the following issues and activities:

- Read a "letter from Grandpa."
- Tell a story about alcohol and opportunity to identify what it does to individuals, families, the community and the nation
- Learn the facts to reduce alcohol, marijuana, cocaine, inhalants, depression, FAS/FAE, suicide, etc.
- Learn the facts to prevent sexual abuse, domestic violence
- Values--Building Character and Making Choices
- Teachings of the Elders
- The Seven Philosophies
- "Culture as Prevention" (notes about elders as mentors, Native American Naming ceremonies, etc)
- "Word Find" game based on prevention words and traditions
- Recording of telephone numbers of emergency services
- Learn facts related to alcohol, suicide, substance abuse, and depression

Three Mind mapping posters that deliver messages related values (respect, honesty, loyalty, commitment and tolerance), Seven Philosophies, and Grandpa Says, which is based upon the teachings of the Elders.

Seven Philosophies Booklet: Developed to address the philosophy of women, children, family, community, the Earth, the Creator, and "myself."

Grandpa Says Video: This video goes with the Grandpa Says Mind Mapping posters. It contains video clips of Elders and youth speaking about the importance of values and meaning in one's life. It also provides a basis for understanding the role and identity of young Native American men.

Cycle of Life Video: This video explains the Cycle of Life teachings and presents the eight thought patterns and eight feelings.

Talking Circle Video: This video describes three different ways to conduct talking circles and how to engage the boys in the learning process of the talking circles.

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:** "White Bison, Inc. Develops and delivers training, technical assistance and consulting services for Native American communities, corporations, nonprofit organizations, professional associations, educational institutions and government agencies. All of the trainings and related services are designed around the teachings, traditions, and natural laws passed down through the generations by Native American Elders. All White Bison, Inc. Trainings are adapted to appropriately meet the cultural needs of Native American communities and of corporate communities."

"**Fostering Wellbriety: Organizational and Individual Wellness** The goal is to achieve a healthier environment in which positive energy, creativity, success and value added performance is the outcomes whether for the individual, the team, organization, the family, or the community. Organizational and individual wellness is the goals. Thus, there is an emphasis upon addressing the truth, being honest with one's self and others, creating a vision of what is desired, and replacing negative (fear based) thoughts and values with those that promote cooperation, unity and success."

3. **Cost of program:** Info not available

4. **Use of natural funding:** Info not available

Other considerations:

Contact information:

White Bison, Inc.
6145 Lehman Drive Suite 200
Colorado Springs, CO 80918
Phone: 719-548-1000
Fax: 719-548-9407
E-mail us: info@whitebison.org

Relevant websites:

Website: www.whitebison.org
Http://www.whitebison.org/youth/sot.html

Southern Ute Peaceful Spirit Youth Services Program

Promising Alternative

Description:

1. **Primary purpose:** The Program provides three prevention and intervention components managed by the Peaceful Spirit Youth Services Division. The components include Highway Safety, Underage Drinking Prevention and Youth Counseling. The primary goal uniting the three components is to reduce substance abuse by providing primary and secondary prevention, intervention and treatment services to adolescents and their families. Another goal is to restore and strengthen protective factors by stimulating healthy community growth that reduces adolescent substance abuse. Peaceful Spirit also

recognizes that prevention should be community wide, involve the Tribe's neighbors, have visible public support and strong participation from law enforcement, as well as incorporate culturally relevant services.

2. **Target populations:** The target populations are Southern Ute and Ignacio area youth from age 12 through age 18. However, different components involve all age groups, from infants to elders. No fees or income.

   Youth counseling: the goal of this component is to provide alcohol and drug education and treatment to substance using or abusing youth and their families, targeting youth ages 12 to 18. Client referrals come from local schools, tribal and county courts, the clinic, social services, group homes, family members. Although Indian youth receive priority, all youth regardless of ethnicity may be served. Clients must be affected by, or at risk of substance abuse to receive services.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

1. **Peer reviewed research:** Information not available

2. **Other supporting documents:** Media, newspaper articles and public service announcements publicizing community prevention efforts used to raise community awareness to decrease tolerance of alcohol abuse problems.

Practice implementation:

1. **Staffing requirements:** Staffing includes four youth staff members, two master level counselors, and one paraprofessional staff. Additionally, Southern Ute community actions programs, inc. Provides administrative, personnel, Peaceful spirit's alcohol recovery center provides clinical supervision and assistance with case management.

2. **Training requirements:** Youth counselors receive State of Colorado alcohol and drug abuse counselor training or certification. Along with officers training, all four staff members attend relevant training in their area of expertise

3. **Cost of program:** No fee or income guidelines prohibit service access. $139,000 annually (combined).

4. **Use of natural funding:** State of Colorado, southern Ute tribe, and in-kind donations.

Other considerations:

Contact information:

Kathryn Bowers, Youth Services Coordinator
Peaceful Spirit Youth Services
P.O. Box 800
Ignacio, Co. 81137
Phone: (970)563-0041
(970) 563-9030

Relevant websites:

Www.Ojp.Usdoj.Gov/Americannative/Promise.Pdf

Turtle Mountain Safe Communities Program

Promising Alternative

Description:

1. **Primary purpose:** Victims, concerned citizens developed the Safe Communities program, and family, friends and relatives of a teenage boy lost to a motor vehicle crash. The Safe Communities Program to address the individual and community risk factors associated with alcohol and substance abuse. The Safe Communities Program goal is to increase protective factors through strategies to alter individual and shared community and social environments by:

    - Creating healthy beliefs, attitudes and lifestyles,
    - Increasing skills for alcohol or substance abuse resistance and abstinence,
    - Cultivating community mobilization through awareness and education activities, and
    - Increasing community ownership and responsibility for societal, cultural and legal changes.
    - The three components of the Turtle Mountain Safe Communities Program are:
    - Mothers Against Drunk Driving (MADD), the Safe Communities Coalition, and Highway Safety.
    - By 2003, the Safe Communities Program seeks to:
    - Reduce DWI by approximately 50%, especially among chronic offenders,

2. **Target populations:** Adolescent youth, and adult groups

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation:** Information not available

Evidence supporting practice:

Web Resource: http://www.madd.org/news/0,1056,1285,00.html

1. **Peer reviewed research:** Information not available

2. **Other supporting documents**: Information not available

Practice implementation:

1. **Staffing requirements:** Information not available

2. **Training requirements:** The program provides increased training, and technical assistance resources for staff development.

3. **Cost of program:** $92,453 Annually

4. **Use of natural funding:** The program receives funding from the North Dakota Department of Transportation (DOT), the BIA Indian Highway Safety Program and the Community Service Block Grant program.

Other considerations:

Contact information:

Sharon A. Parisien, Director
Turtle Mountain Safe Communities Program
P.O.Box 900
Belcourt, ND 58316
Phone (701) 477-6459
Fax (701) 477-5134

Mothers Against Drunk Driving National Office
511 E. John Carpenter Fwy, Suite 700
Irving, TX. 75062
Phone: (800) 438-6233
Fax: (972) 869-2206

BIA Highway Safety Program
505 Margqueet, NW Suite 1425

Relevant websites:

Http://Www.Madd.Org/

Twelve Feathers Program

Promising Alternative

Description:

1. **Primary purpose:** This program provides experiential group counseling, focuses on a zero tolerance policy for alcohol and drugs on campus, and implements a life skills training with traditional American Indian cultural activities. The program's goal is to reduce the number of students who withdraw from college due to alcohol and drug violations. Southwestern Indian polytechnic institute (SIPI) is a two-year institution where all students are tribal members from more than 100 different native American communities across the nation. Twelve feathers program at SIPI helps students develop an awareness and understanding of their traditions and culture.

2. **Target populations:** The program targets american Indian students in attaining degrees in higher education. It also targets high-risk students.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Information not available

2. **Qualitative evaluation**: Information not available

Evidence supporting practice:

EDP resource: http://kafka.SIPI.tec.nm.us/subabuseedu.htm

1. **Peer reviewed research**: Information not available

2. **Other supporting documents**: Classrooms courses

Practice implementation:

1. **Staffing requirements**: Information not available

2. **Training requirements**: Information not available

3. **Cost of program**: Information not available

4. **Use of natural funding**: Information not available

Other considerations:

Contact information:

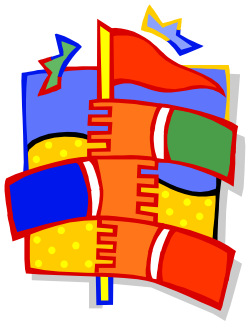
Southwestern Indian Polytechnic Institute - Albuquerque, Nm
Project Director: Johnnie J. Wardlow

The Higher Education Center For Alcohol And Other Drug Prevention
Education Development Center, Inc.
55 Chapel Street
Newton, Massachusetts 02458-1060
Phone: (800) 676-1730
Fax: (617) 928-1537

Relevant websites:

Http://Www.Edc.Org/Hec/Pubs/Model.Html - Sipi
Http://Www.Edc.Org/Hec/Ed/Models/0109-Winners.Html - Sipi
Http://Kafka.Sipi.Tec.Nm.Us/Subabuseedu.Htm
Higheredctr@Edc.Org
Web: Http://Www.Edc.Org/Hec/

Adult Ethnic Minority



Contributors:

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University of Washington

A Review of the Literature

Research consistently documents that health and mental health disparities exist for communities of color, such as African-American, Asian-Pacific Islanders, First Nation, and Latino populations (DHHS, 2001). Unfortunately, evidence based mental health programs to address the needs of the adults of these communities are woefully scarce. A thorough review of the literature revealed there is abundant discussion of best practice standards and recommendations, for example, the Schizophrenia Patient Outcomes Research team (PORT) (Lehman & Steinwachs, 1998). The review also found recurring acknowledgement of the need for evidence-based practice with ethnic minority populations. However, an extensive search of the websites of well-established agencies and associations such as NIMH, NIDA, SAMSHA, APA, NASW, CSAP, and OJJDP, and a review of the literature identified only a handful of programs currently meet the specified criteria for persons of color. Of these best practice or promising programs, many of them either target substance abuse or focus on children and adolescents while incorporating a parent component. As a result, little systematic research on ethnic differences in the use of appropriate treatments for unipolar and bipolar affective disorders has been conducted (Miranda et al., 2002).

These findings are congruent with the document, *Mental Health: Culture, Race, and Ethnicity: A supplement to Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 2001). This report found little empirical evidence regarding outcomes of mental health care for ethnic minorities. It examined controlled clinical trials used by professional associations and government agencies to established treatment guidelines for four major mental health conditions: bipolar disorder, schizophrenia, depression, and ADHD. Since 1986, nearly 10,000 participants have been included in randomized clinical trials evaluating the efficacy of interventions for the aforementioned disorders. For nearly half of the participants, no information on race or ethnicity was reported in the published findings. For another 7 percent, studies reported the designation, "non-white", without specifying the minority group. In total, across all study categories, only 561 African Americans, 99 Latinos, 11 Asian Americans/Pacific Islanders and 0 American Indians/Alaskan Natives are available for analysis (Miranda, 2002).

Lack of inclusion of ethnic minorities is similarly found among studies forming the evidence base for the American Psychiatric Association guidelines for depression care. Among the studies' 3860 participants, there were only 27 identified African Americans and no Latinos. This dearth of representation of persons of color contributes to the fact that there are scant published studies examining the efficacy of specific treatments or service delivery interventions for ethnic minorities with affective disorder (Miranda et al., 2003).

The woeful lack of inclusion of adult ethnic minorities in clinical trials and research significantly contributes to the fact that many evidence-based programs (EDP) are developed generically, that is to say, without a specific ethnic minority population in mind. For example, a number of practices are considered the state of the art. For instance, the Assertive Community Treatment (ACT) model has a long history of demonstrated effectiveness. Now

in its 26th year, the ACT model evolved out of work led by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D. Targeting individuals in their late teens to their elderly years who have a severe and persistent mental illness causing symptoms and impairments that produce distress and major disability in adult functioning (e.g., employment, self-care, and social and interpersonal relationships), ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT provides highly individualized services directly to consumers who receive the multidisciplinary services within their home and community.

Other best practices include supported employment, family psycho education, illness management and recovery, medication management and treatment for co-occurring disorders. However, none of these EDP's was designed to be culturally relevant to ethnic minority populations. In examining the efficacy of these six practices in comparison across ethnic groups, appreciable differences due to culture and ethnicity are often found. A notable exception is the only study examining family psycho education involving Latino families in the United States, which found mixed results (Telles et al., 1995). In such instances, mental health practitioners are forced to try to make appropriate adaptations to make the intervention relevant to the communities of color they serve.

These findings are sobering but not wholly unexpected. Three principal factors contribute to the deafening scarcity of evidence-based practice programs or models that are relevant to ethnic and cultural minorities. One, the predominant reliance upon a Western medical model of practice exerts a powerful but constraining influence upon evidence-based practice and intervention programs as well as funding patterns for research of exemplary practice. The Western model dictates the rules of what constitutes evidence-based practice. In addition, this individualistic and dualistic model of health often conflicts with the family-centered values and holistic notions of health espoused by ethnic minority communities. Two, the lack of ethnic minority investigators currently leading research perpetuates the development of programs that do not necessarily ask the most relevant and most crucial questions to promote meaningful change in communities of color. The significant under representation of minority investigators is a critical disparity. Three, the reliance upon standardized measures often do not capture cultural differences and nuances within ethnic minority groups and across such groups as most of these measures were not normed for such populations.

Despite the dearth of evidence-based mental health programs for ethnic minority adults, there is a wealth of practice wisdom within the African-American, Asian-Pacific Islander, Native American, Latino and immigrant communities. Unfortunately, much of this wisdom and experience has not been widely published which hampers replication and dissemination efforts to meet the rigorous criteria for evidence-based practice. Translating practice wisdom into scholarly research remains a significant hurdle.

Another barrier to the development of evidence-based practices that are responsive to the uniqueness of ethnic minority adults is translating research into practice. Mere adaptation of programs and strategies developed for middle to high income European Americans for use with ethnic minority groups is inadequate. It is imperative that programs also be developed

from the “ground up” and with consumer/patient input to be culturally responsive and relevant. Indeed, such culturally grounded interventions can have far-reaching beneficial effects and draw upon the strengths within the client system itself (Hurdle, 2002).

The experience of Latinos is one example of the present state of mental health services for adult ethnic minorities in the United States. Much of the findings regarding Latinos are also applicable to African Americans, Asian/Pacific Islanders, and Native Americans. According to the Census Bureau, Latinos constitute the largest minority group in the United States (2000), The National Comorbidity Survey (NCS; Kessler et al., 1994) identified Latinos as having a significantly higher prevalence of current affective disorders compared with non-Latino Whites and African-Americans. In addition, Latinos (5.6%) were significantly less likely to have received specialty mental health care compared with non-Latino White persons (11.9%). Current research suggests that adult Latinos may be at high risk for disorders such as depression and anxiety (Organista, 2000). The recent Supplement to the Report of the Surgeon General on Mental Health (DHHS, 2001) finds that Latinos with diagnosable mental disorders also experience a greater disability burden than do whites, mostly attributable to the fact that they get less care and poorer quality of care.

Little is known about the clinical and functional outcomes of Latinos who do access care. Only three small efficacy studies of depression treatments have focused on Latinos (Alonso et al., 1997; Comas-Diaz, 1981; Rossello & Bernal, 1999). Although results were favorable, their sample sizes are too small to establish the efficacy of known treatments for Latinos. One primary care study did find that group cognitive behavioral therapy (CBT) was effective for patients with minor depression, of whom 24% were Latino (Miranda & Muñoz, 1994). More recently, Miranda and colleagues conducted a randomized controlled trial to treat depression in predominantly low-income young African American and Latina women. Cognitive-behavioral Therapy was found to be more effective than community care at 6 months for reducing depressive symptoms.

The significance of these findings is more alarming because Latinos underutilize mental health services and may have less access to mental health care in comparison with the majority of the US population. Latinos are especially less likely to seek care from mental health care specialists, with fewer than 1 in 11 of Latinos with mental disorders seeking care from mental health care specialists and fewer than 1 in 5 seeking care from general health care providers (Hough et al., 1987). These rates are worse for Latino immigrants with disorders--only 1 in 20 sees a mental health specialist and 1 in 10 sees a general health care provider (Vega et al., 1999).

Multiple factors contribute to this underutilization among Latinos and other ethnic minority populations. One, low income Latinos as well as low income minority families may not view mental health services as a priority or as beneficial given their other significant daily needs. Two, the values systems and views of normative behavior by ethnic populations differ from the mainstream and may lead to an under recognition of certain mental health problems. Three, African Americans and other minorities appear to experience a higher proportion of misdiagnosis and inappropriate service, which may lead them to perceive treatment as ineffective. Fourth, the lack of insurance coverage also contributes to underutilization of

services. U.S Census data (2000) highlight that Latinos comprised 35.3% of uninsured people compared with 11.9% of non-Latino White persons. Nearly 25% of African-Americans are uninsured, a figure that is 1.5 times higher than for Whites. Similarly, 21% of Asians and 25% of American Indians/Alaskan Natives do not have health insurance. Fifth, immigrants to the United States such as West Africans, Asians, Latinos and Russians, often receive little assistance in understanding how to navigate the complex public and private mental health and health systems of care. Thus, potential users of public mental health services may "drop out" because of the difficulties and frustration of navigating a complex and unfamiliar system while seeking to access services.

Other commonly cited factors for underutilization of mental health care systems by ethnic minority populations in the United States include:

- the stigma of mental illness from within society but also within families
- the varying ways that members of different ethnic minority groups define mental health and mental illness
- lack of culturally appropriate services
- consumer fears of experiencing discrimination in treatment settings
- mental health providers' lack of awareness or knowledge regarding culturally appropriate policies and practices
- language barriers
- systemic barriers, such as funding sources that place strict limits on reimbursable services

(Brown et al., 2000; Hanson, 2001; Kaiser Commission, 2000).

Language and cultural differences between providers and patients may impede detection and effective treatment (DHHS, 2001). General health providers may lack sufficient knowledge about effective treatments, for example, depression, and may find referrals to specialty care unduly complicated and burdensome (Meredith et al., 1999). Additional barriers to depression care among ethnic minorities are internal, such as a lack of knowledge about depression and its treatment, little perceived need for depression care, fear of medications, and stigma (DHHS, 1999; Greenblatt & Norman, 1982; Woodward et al., 1992). In addition, due to the lack of familiarity and education regarding depression treatment in the communities of depressed minorities, there is little opportunity for encountering a social network that would encourage and be supportive of depression care (Dwight-Johnson et al., under review).

Even when Latinos and other ethnic minorities do enter mental health care, they are less likely than whites to receive treatment that is concordant with evidence-based guidelines (DHHS, 2001). For example, one study of a representative national sample found that many persons with depression and anxiety do not receive appropriate care, with only 24% of Latinos receiving appropriate care compared to 34% of Whites (Young et al., 2001). Among individuals with visits to a general medical provider assessed in the National Ambulatory

Medical Care Surveys of 1992-1993 and 1994-1995, Latinos were less than half as likely as Whites to have received a diagnosis or antidepressant medication (Skaer et al., 1999).

According to the Surgeon General Report (DHHS, 2001) the primary care setting is a critical target for improvements in mental health treatment for ethnic and racial minorities. This focus is due in part to the fact that low income, ethnic minority, and immigrant populations under utilize specialty mental health care and are more likely to seek help in primary care than in specialty care (Cooper-Patrick et al., 1999; Miranda et al., 1998; Vera et al., 1998). Although recent studies demonstrate the feasibility and effectiveness of practice-based intervention programs to improve care for depression in primary care settings, only one included a substantial Latino sample and none has demonstrated sustainability. Partners in Care (PIC) is the only large, multi-site study of a primary care based, quality improvement intervention for depression that included a substantial number of Latino subjects; 778 white, 398 Latino, and 93 African-American patients were enrolled (Wells, 1999; Wells et al., 2000). Over the course of one year, rates of appropriate depression care for patients in intervention clinics improved within each ethnic group by 8-21% (Miranda et al., 2003). Latinos were particularly responsive to improvements in care such that rates of continued depression at one year decreased 27%. Notably, although Latinos experienced improvements in rates of appropriate care and depression outcomes following the PIC intervention, they continued to lag behind Whites in absolute rates of care and remission from depression. For example, six months after patient enrollment, only 30% of Latinos in the intervention clinics were receiving appropriate care, compared to 48% of whites; 47% of Latinos in the intervention clinics still met criteria for probable depression, compared to 37% of Whites.

The lack of study of the mental health needs and the prevalence of mental health disorders of Latinos is not unique. It dominates the literature for all ethnic minority populations. The prevalence of anxiety disorders among African Americans has not been well studied to date. Survey data from the Epidemiologic Catchment Area Study (ECA) (Robins & Reiger, 1991) suggested a higher lifetime prevalence of simple phobia among African Americans compared to White community residents. Two major studies, the ECA and the National Comorbidity Study (NCS) (Kessler et al., 1994) examined the prevalence of mood disorders among African Americans in the community. Both studies found that African Americans are slightly less likely to be depressed than are Whites. However, these findings should be considered in light of the fact that persons who are homeless or incarcerated were not includes in these community studies and African Americans are highly overrepresented in both of these populations (Miranda et al., 2002). Issues in the psychiatric assessment and treatment of African-American include historical diagnostic bias that has resulted in over diagnosis of schizophrenia. In addition, it is important to recognize and assess the contextual experience of many African-Americans who experience the chronic stressors of poverty and high-crime in their neighborhoods.

Few studies have examined the rates of mood disorders among Asian Americans. In the only large study, Chinese Americans living in Los Angeles were found to have relatively low rates of depression and dysthemia (Takeuchi et al., 1998). However, 7% of the participants had experienced a culturally related diagnosis with overlapping symptoms with depression.

One national sample, according to the Surgeon General's Report, revealed that Asian Americans were only one-quarter as likely as Whites were, and one-half as likely as African Americans and Latinos, to have sought outpatient treatment for mental health concerns. Asian Americans are also less likely than Whites to be psychiatric inpatients. Yet several studies also found that Asian Americans exhibit more severe and chronic psychiatric disturbances compared with non-Asians (Lin, Inui, & Kleinman, 1982). This finding suggests that Asian Americans are likely to endure psychiatric distress for longer periods before coming to the attention of the mental health system. Studies also demonstrate that Asian Americans are more likely to drop out after initial contact with mental health providers or to terminate prematurely (Uba, 1994)

Existing services typically are not responsive to the needs of Asian American and Pacific Islanders. Western diagnostic criteria may overlook culturally specific symptom expression and culture-bound syndromes. The existence of culture bound syndromes points to a lack of precise correspondence between indigenous experience and labels and established diagnostic criteria, which promotes the risk of misdiagnosis and contributes to low utilization and high dropout rates (Lin & Cheung, 1999).

Divergent conceptualizations of self, the relationship between the self and social groups, and the relationship between the mind and the body exist for Asians and Westerners. For example, many Asian cultures do not have the same concrete definition of mental illness as used in mainstream American culture. They do not distinguish psychological symptoms from physical ones and tend to regard both kinds of symptoms as signs of physiological disharmony and sickness (Kim, 1993). Such differences are likely to have profound and pervasive influences on the recognition and reporting of psychiatric symptoms, the help-seeking process, the use of mental health care systems, and the response to various treatment modalities (Lin & Cheung, 1999).

No large-scale studies presently exist to provide rates of mood and mental disorders among Native Americans and Alaska Native adults. According to the Supplement to the Surgeon General's Report (2001), the historical traumas of oppression, discrimination, and removal from traditional lands have contributed to American Indian's current lack of educational and economic opportunities and their significant representation among populations with high need for mental health care. There is a high incidence of co-occurring disorders among this population, especially concerning alcohol use (Beals, Novins, Mitchell, Shore, & Manson, 2001). Although Alaska Natives and First Nation peoples comprise less than 1% of the general population, they constitute 8% of the homeless population in the United States (Census, 2000). The homeless, in general, are at significant risk of mental disorder.

Despite these documented risk factors, little is known about service utilization for psychopathology for American Indian adults. To date, almost all of the literature has focused on substance-related disorders. In a recent study, King (1999) reported that 44% of the American Indian adults surveyed in his study who had experienced a mental health problem did not seek out any kind of help, and of those that did seek help, only 28% contacted a mental health agency.

There are no recent, scientifically rigorous studies available to shed light on the need for mental health care among Alaska Natives. However, as with other ethnic minority communities, cultural differences in the expression and reporting of distress are well established among Alaska Natives and American Indians. Words such as "depressed" and "anxious" are absent from some American Indian and Alaska Native languages (Manson, Walker & Kivkhor, 1987). Also highlighting the need for assessment that attends closely to culture is the finding that certain DSM diagnoses, such as major depressive disorder, do not correspond directly to the categories of illness recognized by some American Indians.

The prevalence of mental disorders among communities of color and the need for culturally competent services for ethnic communities should consider that people with severe mental illness have a markedly elevated risk of exposure to trauma. Nearly 90% of persons with severe mental illness have been exposed to trauma and most have had multiple exposures (Mueser, Goodman, Trumbetta et al., 1998). Up to 53 percent of individuals with severe mental illness report childhood sexual or physical abuse and up to 81% report having experienced some type of victimization during their life (Rosenberg, Mueser, Friedman, Gorman, Drake, et al., 2001). Recent evidence suggests that a significant percentage of American Indians are at high risk for exposure to trauma and its mental health sequealae (Beals, Holmes, Ashcraft, Fairbank, Friedman et al., in press).

To address some of the barriers in the delivery of mental health services to people of color, patient and client attitudes and preferences should be sought out as they also affect acceptance of treatment. Patients' attitudes about the value of mental health care may be affected by treatment experience, with patients who have a positive treatment outcome valuing treatment more than those who have not been treated or who have had a poor treatment outcome (Dwight-Johnson et al., 2000; Sherbourne et al., 2001).

This patient-centered approach may be especially important for socially disadvantaged populations that have historically underutilized mental health services, perhaps in part because programs have not been tailored to their needs. Indeed, little is understood about the nature of depression treatment preferences of low-income minority populations, who are unlikely to have had any exposure to quality depression care and who may not feel empowered in advocating for their health care preferences.

Identification of patient preferences is crucial towards improving the quality and delivery of mental health services for ethnic minority populations. For example, African-Americans, women, and those with more knowledge about counseling are more likely to prefer counseling over medication (Cooper-Patrick et al., 1997; Dwight-Johnson et al., 2000), while those who do not get time off from work for medical appointments are more likely to prefer antidepressant medication (Dwight-Johnson et al., 2000).

In addition to direct practice considerations, such as described above, there are organizational and administrative considerations in implementing evidence-based practice in adult mental health for ethnically diverse populations. Research and experience show the relevance of agency context to the ability to implement culturally relevant programs and interventions. The agency environment can facilitate and circumscribe program possibilities. The need for

relative autonomy, balanced with the need for interdependence, is among some of the considerations.

Given the epidemiological and demographic statistics of morbidity and mortality related to mental illness in the U.S., the stark lack of evidence based practice in adult mental health culturally relevant to ethnic minority communities is a major gap. Ethnic minorities are a rapidly growing population within the United States. Failure to gain the knowledge necessary to provide appropriate mental health care for this population is a real and critical problem that should be a major priority for research and practice.

In summary, few programs and strategies exist that meet the criteria for evidence-based practice for ethnic minority populations. Only a limited understanding prevails of how to respectfully engage diverse minority populations in research or how to adapt or tailor intervention approaches for these populations. In addition, limitations in the treatment-effectiveness research base that defines evidence-based practices persist. Sue and colleagues maintain that the paucity of treatment outcome studies involving ethnic minorities makes it difficult to draw conclusions about the effectiveness of psychiatric treatments for these populations (1995). Rigorously designed studies to establish outcomes of treatment strategies for specific psychiatric disorders are critically needed. In addition, systematic research is needed to determine whether these practices are effective in all ethnic subpopulations, among persons who have multiple disorders, and in all practice settings (Goldman, Ganju, Drake, Gorman, Hogan et al., 2001).

References

Alonso, C.C., Fuentes, T.B., Carrero, P.C., & Faci, T.V. (1997). Regional cerebral blood flow on depression in dementia vascular: A case report. *Psiquis., 18,* 48-52. Alpe Editores SA, Spain.

Beals, J., Holmes, T., Ashcraft, M., Fairbank, J., Friedman, M., Jones, M., Schlenger, W., Shore, J., & Manson, S.M. (in press). A comparison of the prevalence of the post-traumatic stress disorder across five racially and ethnically distinct samples of Vietnam theater veterans. *Journal of Traumatic Stress*.

Beals, J., Novins, D.K., Mitchell, C., Shore, J.H., & Manson, S.M. (2001). Comorbidity between alcohol abuse/dependence and psychiatric disorders: Prevalence, treatment implications, and new directions among American Indian populations. In P. Mail (Ed.), National Institute on Alcohol Abuse and Alcoholism Monograph. Washington, DC: U.S. Government Printing Office.

Brown, E.R., Ojeda, V.D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care*. Los Angeles, CA: UCLA Center for Health Policy Research and the Henry J. Kaiser Family Foundation.

Comas-Diaz, Lillian. (1981). Puerto Rican espiritismo and psychotherapy. *American Journal of Orthopsychiatry, 51,* 636-645.

Cooper LA, Gonzales JJ, Gallo JJ, et al: (2003). The acceptability of treatment for depression among African-American, Hispanic, and white primary care patients. *Medical Care, 41*, 479-89.

Drake, R.E., Goldman, H.H. Leff, H.S., et al., (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services, 52*, 179-182

Dwight-Johnson, M., Lagomasino, I., Aisenberg, E., & Fink, A. (in review). Listening to Depressed Hispanics: The Use of Focus Groups to Inform the Design of Relevant and Ethical Treatment Interventions in Primary Care. *Hispanic Journal of Behavioral Sciences.*

Dwight-Johnson M, Sherbourne CD, Liao D, et al: (2000). Treatment preferences among depressed primary care patients. *Journal of General Internal Medicine, 15*, 527-34.

Goldman, H.H., Ganju, V., Drake, R.E., Gorman, P., Hogan, M., Hyde, P.S., & Morgan, O. (2001). Policy Implications for Implementing Evidence-Based Practices, *Psychiatric Services 52*, 1591-1597.

Greenblatt M. & Norman M (1982). Hispanic mental health and use of mental health services: A critical review of the literature. *American Journal of Social Psychiatry 2*, 25-31.

Hanson, K.L. (2001). Patterns of insurance coverage within families with children. *Health Affairs, 20*, 240-6.

Hough, R.L., Landsverk, J.A., Karno, M., Burnam, M.A., et al. (1987). Utilization of health and mental health services by Los Angeles Mexican Americans and non-Hispanic Whites. *Archives of General Psychiatry, 44,* 1987, 702-709.

Hurdle, D.E. (2002). Native Hawaiian traditional healing: Culturally based interventions for social work practice. *Social Work, 42,* 183-192.

Kaiser Commission on Medicaid and the Uninsured: Health Insurance Coverage and Access to Care Among Latinos. (2000). Key Facts Report. The Henry J. Kaiser Family Foundation, Washington, DC.

Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K.S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*, *51*, 8-19.

Kim, L. (1993). Psychiatric care of Korean Americans. In A.C. Gaw (Ed.), *Culture, Ethnicity, and Mental Illness*. Washington, DC: American Psychiatric Press.

King, J. (1999). Denver American Indian Mental Health needs survey. In D.K. Novins (Ed.), American Indian and Alaska Native mental health research. *The Journal of the National Center, 8*, 1-12.

Lehman, A.F. & Steinwachs, D.M. (1998). At issues: translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin, 24*, 1-9.

Lin, K.M., Inui, T., & Kleinman, A. (1982). Sociocultural determinants of help-seeking behavior of patients with mental illness. *Journal of Nervous and Mental Disease, 170*, 78-85.

Manson, S.M., Walker, R.D., & Kivkhor, D.R. (1987). Psychiatric assessment and treatment of American Indians and Alaska Natives. *Hospital and Community Psychiatry, 38*, 165-173.

Meredith, L.S., Sturm, R., & Wells, K.B. (1999). A naturalistic study of psychotherapy: The medical outcomes study approach. In N.E. Miller & K.M. Magruder (Eds.), *Cost-effectiveness of psychotherapy: A guide for practitioners, researchers, and policymakers. (pp. 52-62).*

Miranda, J., Azocar, F., Komaromy, M., et al. (1998). Unmet mental health needs of women in public-sector gynecologic clinics. *American Journal of Obstetrics and Gynecology, 178,* 212-227.

Miranda, J., Chung, J.Y., Green, B.L., Krupnick, J., Siddique, J., Reviciki, D.A., & Belin, T. (2003). Treating depression in predominantly low-income young minority women: a randomized controlled trial. *Journal of the American Medical Association, 290,* 57-65.

Miranda, J. & Munoz, R.F. (1994). Intervention for minor depression in primary care patients. *Psychosomatic Medicine, 56,* 136-141.

Mueser, K.T., Goodman, L.A., Trumbetta, S.L., et al., (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66*, 493-499.

National Technical Assistance Center. (2001). *Creating Cultural Competent Mental Health Systems for Latinos. Perspectives from an Expert Panel*. Cultural Diversity Series. Prepared by Viccora, E.

Organista, K. (2000). Latinos. In J.R. White & A.S. Freeman (Eds.), *Cognitive-behavioral Group Therapy* (pp. 281-303). American Psychological Association, Washington, DC.

Rosenberg, S.D., Mueser, K.T., Friedman, M.J., Gorman, P.G., Drake, R.E., Vidaver, R.M., Torrey, W.C., & Jankowski, M.K. (2001). Developing Effective Treatment for Posttraumatic Disorders Among People with Severe Mental Illness. *Psychiatric Services, 52*, 1453-1461.

Rossello, J. & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting & Clinical Psychology, 67,* 734-745.

Sherbourne, C.D., Wells, K.B., Duan, N., Miranda, J., Unuetzer, J., Jaycox, L., Schoenbaum, M., Meredith, L.S., & Rubenstein, L.V. (2001). Long-term effectiveness of disseminating quality improvement for depression in primary care. *Archives of General Psychiatry, 58,* 696-703.

Skaer, T.L., Sclar, D.A., Robinson, L.M., & Galin, R.S. (2000). Trends in the rate of depressive illness and use of antidepressant pharmacotherapy by ethnicity/race: An assessment of office-based visits in the United States, 1991-1997. *Clinical Therapeutics, 22,* 1575- 1589.

Sue, S., Chun, C., & Gee, K. (1995). Ethnic minority intervention and treatment research. In J.F. Aponte, R. Young-Rivers, & J.B. Wohl (Eds.), *Psychological Interventions and Cultural Diversity*. New York: Allyn & Bacon.

Telles, C., Karno, M., Mintz, J. et al. (1995). Immigrant families coping with schizophrenia: behavioral family intervention verses case management with a low-income Spanish-speaking population. *British Journal of Pyschiatry, 167*, 473-479.

Torrey, W.C., Drake, R.E., Dixon, L., Burns, B.J., Flynn, L., Rush, A.J., Clark, R.E. & Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services, 52*, 45-50.

Uba, L. (1994). *Asian Americans: Personality patterns, identity, and mental health*. New York: Guilford Press.

U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General. (20001). U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Rockville, MD,

U.S. Department of Health and Human Services: Mental Health: A Report of the Surgeon General. (1999). Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Rockville, MD, U.S.

Vera, M., Alegria, M. Freeman, D.H., Robles, R., Pescosolido, B., & Pena, M. (1998). Help seeking for mental health care among poor Puerto Ricans: Problem recognition, service use, and type of provider. *Medical Care, 36,* 1047-1056.

Vega, W.A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry, 156,* 928-934.

Wells, K.B. (1999). The design of Partners in Care: Evaluating the cost-effectiveness of improving care for depression in primary care. *Social Psychiatry & Psychiatric Epidemiology*, *34*, 20-29.

Wells, K.B., Sherbourne, C., Schoenbaum, M., et al. (2000). Impact of disseminating quality improvement programs for depression in managed primary care: A randomized controlled trial. *Journal of the American Medical Association, 283*, 212-220.

Woodward A.M., Dwinell A.D., & Arons B.S. (1992). Barriers to mental health care for Hispanic Americans: a literature review and discussion. *Journal of Mental Health Administration*, *19*, 224-36.

Young, A.S., Klap, R., Sherbourne, C.D., Wells, K.B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry, 58,* 55-61.

Resource Guide

Creating Lasting Family Connections

A Best Practice

Description:

1. **Primary purpose:** Creating Lasting Family Connections (CLFC) is a comprehensive family strengthening, substance abuse, and violence prevention curriculum that has scientifically demonstrated that youth and families in high-risk environments can be assisted to become strong, healthy, and supportive people. CLFC is designed for youth 9 to 17 and their families. The populations that participated in the evaluations were primarily African American, Caucasian, or of mixed ethnicity; were 11 to 15 years of age; and lived in rural, suburban, or urban settings. The program has been implemented in 40 States with a variety of populations including Hispanic, Asian American, and Native American. CLFC has been successfully implemented in schools, churches, recreation centers, community settings, juvenile justice facilities, and other settings.

   Program results, documented with children 11 to 15 years, have shown significant increases in children's resistance to the onset of substance use and reduction in use of alcohol and other drugs. CLFC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth.

   Risk Factors Addressed

   - Early first use of substances
   - Family conflict
   - Family management problems
   - Parental attitudes and involvement

   Protective Factors Addressed

   Individual

   - Appropriate substance use knowledge and beliefs
   - Attitudes unfavorable to substance use
   - Bonding with mother and father
   - Honest communication

- Social skills and competence

Family

- Appropriate parental substance use knowledge and beliefs
- Appropriate parental substance using behavior
- Family management skills (including family meetings)
- Bonding with youth
- Help-seeking for family and personal problems
- Family stability, harmony, cohesiveness, and positive communication

School

- School bonding by youth
- School attendance

Community

- Youth and parent perceptions of community support
- Access to health and social service
- Community empowerment
- Responsiveness and flexibility of social service provision
- Community service

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: None is specified. However, the program description indicates that program was evaluated rigorously using random assignment procedures, valid and reliable outcome measures, and multivariate analysis methods to uncover direct and conditional relationships between the program and outcomes. Ten experimental sites assessed over a five year period and data indicates that as the intervention improved family functioning, parental and youth substance use decreased.

2. **Qualitative evaluation**: None known.

Evidence supporting practice:

Peer-reviewed research: The CLFC program evaluation found positive effects on family and youth resiliency and on substance use among youth 11 through 15 years of age. The program also increased community resiliency by empowering community volunteers to identify, recruit, and retain families.

Statistically significant overall program effects on family resiliency included:

- Improved parental knowledge of and beliefs about substance use
- Increased youth involvement in setting rules related to substance use
- Increased use of community services

Positive effects on youth resiliency included:

- Increased use of community services when personal or family problems arose
- Increased bonding with mother, father, and siblings
- Increased community involvement under specific conditions

In addition, the program improved family modeling of alcohol use in African-American communities and moderated overall family alcohol use. Most important, the evaluation

found that reductions in substance use among youth who participated in the program were conditionally related to changes in family-level and youth-level resiliency factors targeted by the program.

Practice implementation:

1. **Staffing requirements:** two P/T facilitators for each parent and youth modules. They will also be responsible for case management or referrals to community services.
2. **Training requirements:** 5-10 days by developer of program.
3. **Cost of program:** $750 per participant or $200 to $1,200 per day.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** Program start-up takes 1 to 3 months, and includes 5 to 10 days of training by the developer; community mobilization activities; and identification and recruitment of parents and youth. After the recruitment phase, these four part-time facilitators can work with up to 30 families, 1 day per week, 4 hours a day, for the duration of the 20-week program. Facilitators should provide 2.5 hour parent and youth training sessions weekly, over a 20-week period. The modules may also be offered in 5-week increments throughout the year if families are unable to commit to a 20-week program.

Other considerations:

This best practice comes with an evaluation tool. This tool costs $300 and includes self-administered surveys for both youth and parents, parent consent forms, survey administration and scoring guidelines, and contact information for technical assistance. Most agencies find one-week training sufficient.

Contact information:

Ted N. Strader, M.S., Program Developer
Council on Prevention and Education: Substances, Inc. (COPES)
845 Barret Avenue
Louisville, KY 40204
Phone: (502) 583-6820
Fax: (502) 583-6832
Email: *tstrader@sprynet.com*

Relevant websites:

www.copes.org/include/clfc.htm
www.modelprograms.samsha.gov

References:

Assertive Community Treatment

A Best Practice

Description:

1. **Primary Purpose:** Assertive community treatment has been distinguished from other models of case management of severe mental illness or co-occurring disorders in several dimensions. These include lower case loads, team rather than individual case management, an emphasis on outreach, and an orientation to the teams providing as many services as possible rather than referring clients to other providers.

   PACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, PACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. PACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, PACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The PACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year.

   Now in its 26th year, the PACT model evolved out of work led by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., on an inpatient research unit of Mendota State Hospital, Madison, Wisconsin, in the late 1960s. PACT strives to lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness, to meet basic needs and enhance quality of life, to improve functioning in adult social and employment roles, to enhance an individual's ability to live independently in his or her own community, and to lessen the family's burden of providing care.

   Treatment:
   - psychopharmacologic treatment, including new atypical antipsychotic and antidepressant medications
   - individual supportive therapy
   - mobile crisis intervention
   - hospitalization
   - substance abuse treatment, including group therapy (for clients with a dual diagnosis of substance abuse and mental illness)

   Rehabilitation:
   - behaviorally oriented skill teaching (supportive and cognitive-behavioral therapy), including structuring time and handling activities of daily living

- supported employment, both paid and volunteer work
- support for resuming education

Support services:

- support, education, and skill-teaching to family members
- collaboration with families and assistance to clients with children
- direct support to help clients obtain legal and advocacy services, financial support, supported housing, money-management services, and transportation

2. **Target population:** The PACT model is indicated for individuals in their late teens to their elderly years that have a severe and persistent mental illness causing symptoms and impairments that produce distress and major disability in adult functioning (e.g., employment, self-care, and social and interpersonal relationships). PACT participants usually are people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder (manic-depressive illness); those who experience significant disability from other mental illnesses and are not helped by traditional outpatient models; those who have difficulty getting to appointments on their own as in the traditional model of case management; those who have had bad experiences in the traditional system; or those who have limited understanding of their need for help.

   Risk factor(s) addressed

   - Mental health issues
   - Self-care issues
   - Lack of access to mental health and health services
   - Homelessness

   Protective factor(s) addressed

   - Family support

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: None known.
2. **Qualitative evaluation**:

Evidence supporting practice:

PACT clients spend significantly less time in hospitals and more time in independent living situations, have less time unemployed, earn more income from competitive employment, experience more positive social relationships, express greater satisfaction with life, and are less symptomatic. In one study, only 18 percent of PACT clients were hospitalized the first year compared to 89 percent of the non-PACT treatment group. For those PACT clients that were rehospitalized, stays were significantly shorter than stays of the non-PACT group. PACT clients also spend more time in the community, resulting in fewer burdens on family. Additionally, the PACT model has shown a small economic advantage over institutional care. However, this finding does not factor in the significant societal costs of lack of access to adequate treatment (i.e., hospitalizations, suicide, unemployment, incarceration, homelessness, etc.).

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** none known

Other considerations:

Contact information:

Relevant websites:

www.nami.org
www.actassociation.org

Family Effectiveness Training

A Best Practice

Description:

1. **Primary Purpose:** Developed by the Center for Family Studies as well as Spanish Family Guidance Center, University of Miami, this training combines Brief Strategic Family Therapy (BSFT) and Bicultural Effectiveness Training. BSFT attempts to change family interactions and cultural/contextual factors that influence youth behavior problems. Family relations are a primary target for intervention.

   Family Effectiveness Training (FET) is an evidence-based prevention/early intervention modality developed by the Center for Family Studies at the University of Miami. FET successfully reduces child problems in 6-12 year old Hispanic children and strengthens their families. In addition to its demonstrated effectiveness, FET has the added advantage of being attractive to potential facilitators and client/families alike because it is presented as a socially acceptable, culturally oriented, didactic/experiential package aimed at enhancing family adjustment. FET provides families with the tools to overcome individual, peer and family risk factors through: 1) focused interventions to change targeted maladaptive patterns of interaction, 2) skills building strategies to strengthen families, and 3) development of a bicultural worldview within families to prevent culture clashes between parents and children.

2. **Target Populations:** Latino and African American parents with children ages 6-11 who manifest emotional and behavioral problems

Risk factor(s) addressed

- Family Conflict
- Antisocial Behavior

Protective factor(s) addressed

- Parenting skills
- Family Communication

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Not specified.

Evidence supporting practice:

1. Results indicate that families in the FET treatment group showed significantly greater improvement than control families on independent measures of structural family functioning, on problem behaviors as reported by parents, and on a self-administered measure of child self-concept. Six-month follow-up assessments indicated that the effects of the FET intervention were maintained over time.

Practice implementation:

1. **Staffing requirements:** 1 F/T counselor for 15-20 families but 2 more P/T counselors are recommended
2. **Training requirements:** Facilitators trained in Brief Strategic Family Therapy
3. **Cost of program:** 3 levels of training, ranging from $6,000 to $17,500 plus travel
4. **Use of natural funding:** none known
5. **Implementation timeline:** Treatment involves 12-15 family sessions, approximately 3 months in duration. Each session runs for approximately 2 hours

Other considerations:

Contact information:

Relevant websites:

Monica Zarate
University of Miami
Center for Family Studies
1425 NW 10th Avenue, 3rd Floor
Miami, FL 33136
(305) 243-4592
mzarate@miami.edu

Functional Family Therapy

A Best Practice

Description:

1. **Primary purpose:** FFT is a well-documented family prevention and intervention program that has been applied successfully to a wide range of problem youth and their families in various contexts. Empirically grounded, Functional Family Therapy is a short-term intervention program and one of the few family-focused programs that has been tested for effectiveness with adolescent status-offenders.

2. **Target population:** Youth between ages 11 and 18, especially first time delinquent and pre-delinquent youth, and their parents

   Risk factor(s) addressed
   - Family management problems
   - Family Conflict
   - Persistent antisocial behavior

   Protective factor(s) addressed
   - Family communication and bonding

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: None specified

Evidence supporting practice:

1. The program has demonstrated impact on reducing delinquent behavior in targeted adolescents and follow-up studies (18 months) suggest that the impact is maintained.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** Site certification is a one-year process
3. **Cost of program:** $24,500 per site for entire package plus travel expenses; $2,000 per family. Sites are required to purchase the POSIT, the FAM-III, and the limited OQ.45 site license. These costs are minimal.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** not specified

Other considerations:

Site certification involves a 3-day clinical training for all FFT therapists in a working group, externship training for the clinical lead, follow-up visits, supervision consultations and clinical services system.

Contact information:

Kathie Shafer, Project Manager
(801) 585-1807

Relevant websites:

http://www.fftinc.com

Multisystemic Therapy Program

A Best Practice

Description:

1. **Primary purpose:** MST is an intensive family-based treatment program that addresses the known determinants of serious antisocial behavior in adolescents and their families. MST treats those factors in the youth's environment that contribute to behavior problems, including individual characteristics and family relations. On a highly individualized basis, treatment goals are developed in collaboration with the family, and family strengths are used to facilitate therapeutic change. It applies a home-based model of service delivery (low caseloads, time limited treatment but intensive 24/7 intervention) to promote positive social behavioral and to change how youth function in their settings of home, school and neighborhood. Specific interventions used in MST are based on the best of the empirically validated treatment approaches such as cognitive behavior therapy. It applies intensive quality assurance procedures.

2. **Target population:** Chronic, violent, or substance abusing juvenile offenders ages 10-18 at high risk of out-of-home placement and their families. African American, Caucasians, rural and urban.

   Risk factor(s) addressed
   - Family management problems
   - Antisocial behavior

   Protective factor(s) addressed
   - Family communication and bonding
   - Parenting skills

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** None specified.

Evidence supporting practice:

1. MST has an extensive history of evaluations. These studies have demonstrated reduced long-term rates of criminal offending in serious juvenile offenders, reduced rates of out-of-home placements for serious juvenile offenders, extensive improvements in family functioning, decreased mental health problems for serious juvenile offenders, and favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services.

Practice implementation:

1. **Staffing requirements:** 2-4 MST therapists who are master's level mental health professionals and an on-site supervisor (PhD) constitute a MST team
2. **Training requirements:**
3. **Cost of program:** $15,000 to $24,000 per team for training and program support; $4,000-$8,000 per family; $5,000 license fee, MST therapists and supervisors pay an annual license fee of $200 per person
4. **Use of natural funding:** none known.
5. **Implementation timeline:** none known

Other considerations:

Contact information:

Marshall E. Sewson, MSW, MBA
Manager of Program Development, MST Services
P.O. Box 21269
Charleston, SC 29413-1269
(843) 856-8226

Relevant websites:

www.mstservices.com

Parenting Wisely

A Best Practice

Description:

1. **Primary purpose:** The parenting wisely intervention is a self-administered computer-based program that teaches parents and their children important skills for combating risk factors for substance use and abuse. This program uses a risk-focused approach to reduce family conflict and child behavior problems. A highly versatile program, Parenting Wisely, can be used alone, in a group, or with a practitioner.

2. **Target population:** 9-18 year old youth, especially that at risk for becoming delinquents or substance users Latino, African American, White, and Native Hawaiian and other Pacific Islander parents.

   Risk factor(s) addressed
   - Lack of bonding to parents
   - Aggressive or disruptive behavior
   - Family management
   - Family communication
   - Child abuse or neglect
   - Domestic violence
   - Favorable attitudes toward substance use

   Protective factor(s) addressed
   - Self-esteem
   - Attachment to parents
   - Problem solving skills
   - Family support and cohesiveness
   - Parent-child bonding

Evaluating this practice:

1. Outcome measures used to evaluate practice: Not available except via floppy disk upon order of program materials.

Evidence supporting practice:

1. Thirteen evaluations of the Parenting Wisely program have been conducted. Five studies involved random assignment of parents to treatment and control groups (no treatment or other treatments). Evaluations were conducted in juvenile detention, child protective services, health and mental health centers, probation departments, schools, and in families' homes. Represented among these studies were approximately 990 families of Caucasian (including Appalachian), African American, Hispanic, Asian, and Portuguese origin and primarily from lower income homes. Outcomes included: parents favored healthier problem solving strategies over coercive strategies with each other and with their children. The outcomes for parents receiving the PW intervention include: increased knowledge and use of good parenting skills, improved problem solving, setting clear expectations, reduced spousal violence and violence towards their children. For children, clinically significant behavior improvement occurred between 20% and 55% of the time that their parents used the program. Program completion rates for parents ranged from 83% to 91%.

Practice implementation:

1. **Staffing requirements:** none known

2. **Training requirements:** Staff training is not required, however training is available
3. **Cost of program:** Technical assistance is available by phone or email at no charge; $44.50 - $61.50 for 100 families. High cost includes start-up costs.

   The Parenting Wisely program is contained on a CD-ROM that is formatted for a personal computer. The PC must have a CD-ROM player, and the ability to play video on the computer screen and play sound. Complete program materials include:

   - One interactive CD
   - One Program Manual
   - Five parent workbooks
   - Parent completion certificates
   - Program poster and referral cards
   - Evaluation instruments (on a floppy disk, for duplication)
4. **Use of natural funding:** none known.
5. **Implementation timeline:** From placing the order to installing the program on computers and familiarizing staff with the program, most agencies require 3 to 6 weeks.

Other considerations:

1. Successful implementation of the Parenting Wisely program is enhanced when the program is located in multiple sites in a community.

Contact information:

Family Works Inc.
20 E. Circle Drive, Suite 190
Athens, OH 45701
(866) 234-WISE (9473)

Family Works Inc., West
583 Prim Street
Ashland, OR 97520
Email: *Gordon@mind.net*

Relevant websites:

Familyworks@familyworksinc.com
http://www.familyworksinc.com
http://www.parentingwisely.com

Strengthening Hawaii Families

Description:

1. **Primary purpose:** Strengthening Hawaii Families (SHF) is a cultural values-based primary prevention program that was developed by the Coalition For a Drug-Free Hawaii. SHF seeks to reduce and ultimately prevent such problems as substance abuse, domestic violence, and gang involvement by reducing risk factors and increasing resiliency factors in the family and community. The SHF program provides the tools and the process for elementary-school aged youth (ages 8-11) and their families to build on existing family strengths through values clarification, family skills-building and nurturing connections among families and their community.

2. **Target population:** Elementary school ages youth (ages 8-11) and their families. SHF program is age and developmentally appropriate and provides a culturally comprehensive framework that allows communities to easily and effectively adapt and implement the program for diverse populations. Being a values and assets based program, SHF is appropriate for families in multicultural group settings, which are inclusive and embracing of all ages, ethnic, cultural, and socioeconomic backgrounds.

   Risk factor(s) addressed
   - Family conflict
   - Parental depression

   Protective factor(s) addressed
   - Family cohesion
   - Family organization
   - Family communication

Evaluating this practice:

1. Research found significant improvement in family cohesion, family organization, and family communication among families that participated in SHF; and a significant decrease in family conflict as well as decrease in parental depression. Follow up research done by SMS, Inc. to determine long-term impacts of participation found that past participants reported better relationships among family members, a clearer understanding of parental roles, more awareness of children's needs, improved behaviors for children, and general improvement in communication skills for all family members. Participants also remarked on the amount of bonding and fellowship that accompanied each SHF session.

Evidence supporting practice:

Practice implementation:

1. **Staffing requirements:** Team of four facilitators (two parent facilitators and two children's group facilitators)
2. **Training requirements:** $349 per person. Training of Facilitators requires two days with a maximum of fifteen and a minimum of six people per training.
3. **Cost of program:** Food and/or refreshments, childcare expenses, transportation, supplies such as chart paper, markers, and art supplies, and incentives such as small prizes, "treasure box" items, and family photos.
4. **Use of natural funding:** none known
5. **Implementation timeline:** none known

Other considerations:

1. The Strengthening Hawaii Families program is age and developmentally appropriate and provides a culturally comprehensive framework that allows communities to easily and effectively adapt and implement for diverse populations.

Contact information:

Alan Shinn
1130 North Nimitz Highway, Suite A-259
Honolulu, HI 96817
(808) 545-3228
cdfh@pixi.net

Relevant websites:

www.strengtheningfamilies.org

Brief Strategic Family Therapy

Description:

1. **Primary purpose:** BSFT is a family-based intervention aimed at preventing and treating child and adolescent (ages 8-17) behavior problems including mild substance abuse. BSFT was developed at the Center for Family Studies, a division of the University of Miami Medical School's Department of Psychiatry and Behavioral Sciences, in 1975 and has since been tested and refined in clinical studies. BSFT is based on the fundamental assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences, and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently is a primary target for intervention. The goal of BSFT is to improve the youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus

reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.

2. **Target population:** BSFT has been tailored to work with inner city, minority families, particularly African American and Hispanic families and therapists are trained to assess and facilitate healthy family interactions based on cultural norms of the family being helped.

   Risk factor(s) addressed
   - Behavior problems
   - Mild substance abuse

   Protective factor(s) addressed
   - Family communication and cohesion

Evaluating this practice:

1. BSFT has been rigorously evaluated in a number of studies with experimental designs. The approaches have been found to be effective in improving youth behavior, reducing recidivism among youthful offenders, and in improving family relationships.

Evidence supporting practice:

Practice implementation:

1. **Staffing requirements:** BSFT therapists and a clinical supervisor. In mild to moderate cases, it has been found that a reasonable clinical caseload for a full time therapist is 20 active cases. Therapists usually have master's level training and three years of supervised clinical experience. Cultural competence to work with minority families and communities.
2. **Training requirements:** 3day intensive workshop, monthly phone consultation for 12 months, and a follow up 2 day skill development workshop.
3. **Cost of program:** $18,000.00 plus travel and long-distance expenses. Office space & transportation costs.
4. **Use of natural funding:**.
5. **Implementation timeline:**

Other considerations:

Contact information:

José Szapocznik, PhD
(Contact) Carleen Robinson-Batista
1425 NW 10th Ave., 3rd Floor
Miami, FL 33136
(305) 243-2226

Relevant websites:

Social Adjustment Program for Southeast Asians

Description:

1. **Primary purpose:** The Social Adjustment Program is a culturally specific mental health program serving Hmong, Cambodian, Laotian, and Vietnamese immigrants and refugees living in the Twin Cities east metro area. The social adjustment program combines Western mental health practices with the traditional healing methods of the cultures it serves. Services are provided to Southeast Asian youth and adults by bilingual and bicultural counselors trained in Western mental health practices. These counselors are supervised by professionals in the fields of psychiatry and social work. Core services of the Social Adjustment Program are:
   - Mental health assessment
   - Individual counseling
   - Group counseling
   - Family counseling
   - Case management

2. **Target population:** Southeast Asian immigrants living in the Twin Cities east metro area.

   Risk factor(s) addressed
   - Persistent mental illness
   - Post-traumatic stress disorder
   - Depression
   - Chemical abuse or chemical dependency
   - Domestic violence
   - Other emotional and behavioral problems

   Protective factor(s) addressed
   - Cultural strengths

Evaluating this practice:

1. **Outcome measures used to evaluate practice**
   - GAF
   - Client satisfaction
   - Staff rating of improved patient functioning
   - Patient self-rating of improved functioning

Evidence supporting practice:

1. The Social Adjustment Program is evaluated annually by the Wilder Research Center. The evaluations are based on data collected from clients and program staff at intake and six months after intake. Ninety percent of adults and 87 percent of the youth showed improvement in their problems as rated by staff. Ninety-five percent of adults and 87 percent of youth rated themselves as improving. On the Global Assessment of Functioning, 65 percent of adults, and 64 pe4rcent of youth showed clinically significant improvement. 95% of adult clients and 97% of youth clients were "satisfied" or "very satisfied" with the overall benefits of the social Adjustment Program. 81% of adults and 92% of youth said they would recommend the program to others who might need similar services.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** none known

Other considerations:

Contact information:

Linda Gensheimer, Director
(651) 647-9676
lcg@wilder.org

Relevant websites:

The TAMAR Project: Maryland Women and Violence

Description:

1. **Primary purpose:** Known as the "Women, Co-occurring Disorders and Violence" study, the purpose is to develop, deliver, and evaluate specialized services for women who have histories of traumatic abuse as well as co-occurring mental health and substance abuse disorders. Trauma assessment and services for the children of the women in the study are also provided. The Maryland Group's TAMAR project is one of fourteen programs around the US selected for this multi-site federal study, and the only one based in the

criminal justice system. This project will serve identified trauma survivors in three Maryland County detention centers and their children, beginning while the women are incarcerated and continuing after their release into the community. The TAMAR project seeks to develop an integrated, trauma-oriented mental health/addictions service system for women in the correctional system in Calvert, Dorchester, and Frederick Counties.

2. **Target Population:** Women in the correctional system in three Maryland County detention centers.

Risk factor(s) addressed

- Exposure to traumatic stress (rape)
- Drug abuse
- Victimization
- Suicide attempts

Protective factor(s) addressed

- Symptom management skills
- Connection to post-release treatment and resources

Evaluating this practice:

Evidence supporting practice:

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:**

Contact information:

Relevant websites:

http://www.sidran.org/tamar.html

Faith Based Prevention Model

(Formerly Jackson Church Program)

Description:

1. **Primary purpose:** The Health Advisory Council developed the Jackson County Alcohol and Other Drug Prevention Partnership Concept. The group consists of six African-American churches that had successfully implemented health promotions projects funded by the Department of Health and Human Services, Office of Minority Health, American Heart Association, and the Florida Dept. of Health and Rehab. Services. The founding group was concerned and wanted their "grands and great-grands" to grow up in a drug free environment-therefore they recruited other minority organizations and majority providers of drug, health, and educational services to participate in the new partnership. The objectives included the idea that at the end of the five year funding period the Jackson County Alcohol and other Drug Prevention Partnership will be an ongoing and functional process for identifying alcohol and other drug problems; determining health priorities and necessary resources; designing a formal prevention plan; and selecting, implementing and evaluating appropriate intervention strategies. At the conclusion of the five year funded project, the Health Advisory Council will have influenced County Health policy (educational, medical, and social service), as well as some health and drug behavioral practices of African American, Jackson County residents. Health promotion interventions will be implemented at church sites, as a part of community awareness activities, and within the selected community partners systems.
2. **Target population:** This partnership is focused on African Americans

Risk factor(s) addressed

- Substance abuse
- Parenting skills

Protective factor(s) addressed

- Parenting skills
- Spirituality

Evaluating this practice:

Evidence supporting practice:

1. Evaluations of this partnership revealed significant accomplishments that include: developing and evaluating a coordinated approach to prevention planning in a rural area with organizations utilizing the locality development approach; behavioral lifestyle changes via the church prevention programs stressing the target populations' culture and value systems that reinforced school activities; "Old South" cultural practices allowed the African American community to improve the quality of life for all Jackson County residents.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** A variety of manuals are available which detail steps necessary to develop a community partnership. These include: The Partnership Training Manual and How to Develop a Church-Based Program for the Prevention of Drug and Alcohol Abuse: A Work Manual
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** This partnership has existed for several years and is ongoing

Other considerations:

Contact information:

Mary Sutherland, PhD
Florida State University
2639 N. Monroe St., Suite 145B
Tallahassee, FL 32303
(850) 488-0055

Relevant websites:

www.samsha.gov

Dando Fuerza a la Familia

Description:

1. **Primary purpose:** The Dando Fuerza a La Familia project was developed to reduce the risk factors in children of substance abusing parents (COSAPS) by improving the family environment and the parents' abilities to nurture and provide appropriate learning opportunities for their children. Parents who are substance abusers have substantial parent and family relations problems. To make lasting changes, several elements were necessary for an effective intervention. The intervention was long in duration (14 weeks) and the trainer model responses to the child were provided while coaching the parents in better parenting behavior. The intervention involved learning prosocial skills. These elements are incorporated into a culturally appropriate curriculum and activities designed in order to maximize an effective intervention. The three main goals are: 1) to develop a version of the Strengthening Families Program manuals that is culturally, socially, and linguistically appropriate for use with Mexican-American families; 2) to reduce the risk

of ATOD use among youth and families; and 3) to proactively identify services that were needed for COSAPS and their families.

2. **Target population:** consisted of children of substance abusing parents, male and females, between the ages of 6 and 8 years, with roots in the Mexican-American border communities and with a parent(s) who had undergone a substance abuse treatment episode 12 months prior to entering the program.

Risk factor(s) addressed

- Violent behavior

Protective factor(s) addressed

- Knowledge of alcohol and drug consequences
- Parent bonding
- Effective control techniques

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: none known.

Evidence supporting practice:

Evaluation of this program revealed the following:

- Students in the experimental group significantly increased educational aspirations, school performance, and attendance between pre- and post test
- Students in the experimental group significantly increased knowledge of ATOD consequences between pre and post test
- Students in the experimental group significantly improved interaction among peers and reduction of violence driven behavior between pre and post test
- The experimental group showed a significant increase in parent bonding with the child and effective control techniques between pre and post test.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** Families participate for 14 weeks, once a week for two hours

Other considerations:

Contact information:

José Soria, MA
Aliviane, NO-AD, Inc.
7722 North Loop
El Paso, TX 79915
(915) 782-4000
email: *jsoria@aliviane.org*

Relevant websites:

NA

Strengthening Multi-Ethnic Families And Communities

A Best Practice

Description:

1. **Primary purpose:** This model program integrates various prevention and intervention strategies aimed at reducing violence against self, family, and community. The short-term objectives are to increase parent sense of competence, positive parent/child interactions, build child self-esteem and social competency skills and more parental involvement in community activities.

2. **Target populations:** Ethnic and culturally diverse parents with children 3-18 years old who are interested in raising children with a commitment to leading a violence-free life style.

   Risk factor(s) addressed
   - Child behavior problems
   - Acculturation issues

   Protective factor(s) addressed
   - Family bonding
   - Parenting skills
   - Cultural strengths

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: none known.

Evidence supporting practice:

1. Research shows significant improvements in parent sense of competence, family/parent/child interactions, and child competence and behavior. Overall completion rate of participants is 83%, with 99% of parents recommending the program to others. Parents (regardless of demographic factors) report increases in positive family/parent/child interactions (decrease in negative), parent/child communication strategies and discipline methods, better relationships with their children, enhanced child management and anger management skills, as well as more competence in accessing and utilizing community resources.

Practice implementation:

1. **Staffing requirements:** 1-2 facilitators
2. **Training requirements:** 5-day training workshop; $535-$625 per person, plus travel
3. **Cost of program:** $17 for Parent Manual
4. **Use of natural funding:** none known
5. **Implementation timeline:** none known

Other considerations:

Contact information:

Marilyn L. Steele, PhD
1220 S. Sierra Bonita Ave.
Los Angeles, CA 90019
(323) 936-0343

Relevant websites:

www.teachmorelove.org
www.strengtheningfamilies.org

Parents Anonymous Adult Group

A Best Practice

Description:

1. **Primary purpose:** The proven effective Parents Anonymous prevention program involves parents or caregivers, including parents at risk or involved with Child Protective Services. The program is dedicated to strengthening families through mutual support. Meeting weekly with other parents and a trained facilitator, parents learn to use appropriate resources and to build positive relationships. This program provides a space

to problem solve with other parents, receive support, and expand their network of support from others to help reduce stress and isolation.

2. **Target population:** Any adult who may feel stress or concern about their parenting.

Risk factor(s) addressed

- Unrealistic expectation of child
- Harmful behaviors
- Social isolation

Protective factor(s) addressed

- Self-esteem
- Parenting competencies
- Social support

Evaluating this practice:

Evidence supporting practice:

Research substantiates that Parent Anonymous Program diminishes the impact of risk factors while significantly increasing the resiliency of parent and children and decreasing incidents of child abuse and neglect and other at-risk or harmful behavior. Research shows that the program increases ability of parent to deal with stress.

Practice implementation:

1. **Staffing requirements:** 1 parent group leader, 1 trained facilitator
2. **Training requirements:** none known.
3. **Cost of program:** $2,000 per group per year to $10,000 per year
4. **Use of natural funding:** none known.
5. **Implementation timeline:**

Other considerations:

Contact information:

Parents Anonymous, Inc.
675 W. Foothill Blvd., Suite 220
Claremont, CA 91711-3475
(909) 621-6184

Relevant websites:

www.parentsanonymous.org

Dolores Mission Women's Cooperative Child Care Center

Description:

1. **Primary purpose:** This comprehensive program does more than merely provide child care services. It offers opportunities for community members to participate in a variety of educational programs, including teacher training programs that prepare participants to become certified pre-school teachers. In 2003, mental health services began to be offered.
2. **Target population:** Developed within the Mexican-American community, it is appropriate for all ethnicities.

   Risk factor(s) addressed
   - Parenting competencies
   - Mental health issues

   Protective factor(s) addressed
   - Job development
   - Self-Esteem

Evaluating this practice:

Evidence supporting practice:

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:**

Other considerations:

Contact information:

420 N. Soto St.
Los Angeles, CA 90033
(323) 881-0000

Relevant websites:

DMWC@proyectopastoral.org

Prolonged Exposure Therapy For Post-Traumatic Stress Disorder

Description:

1. **Primary purpose:** Prolonged Exposure (PE) therapy is a cognitive-behavioral treatment program for individual suffering from posttraumatic stress disorder. The program consists of a course of individual therapy designed to help clients' process traumatic events and thus reduce trauma-induced psychological disturbances. PE therapy reduces PTSD symptoms via psycho education, imaginal exposure, and in-vivo exposure.

2. **Target population:** Victims of trauma and violence; adults 18-70 years in age who have suffered either single or multiple traumas and are currently suffering PTSD symptoms.

   Risk factor(s) addressed
   - PTSD symptomatology
   - Excessive or unrealistic fears
   - Avoidant coping style

   Protective factor(s) addressed
   - Self-esteem and self-efficacy
   - Skills for coping with stress
   - Ability to concentrate

Evaluating this practice:

None specified.

Evidence supporting practice:

Research indicates that 70% to 90% of clients who receive PE therapy no longer meet the criteria for PTSD diagnosis. It is the most studied treatment program for PTSD and has broad empirical support from studies of clients with PTSD resulting from various types of trauma. Treatment effects were maintained at 12-month follow-up.

Practice implementation:

1. **Staffing requirements:** Supervision
2. **Training requirements:** 2-day basic training to 5-day in-depth training
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** Standard treatment consists of 9-12 once-or twice weekly sessions, each lasting 90 minutes

Other considerations:

Contact information:

Center for the Treatment and Study of Anxiety
Department of Psychiatry
University of Pennsylvania
3535 Market Street, 600 N
Philadelphia, PA 19104

Relevant websites:

www.samsha.gov
www.med.upenn.edu/ctsa

Multidimensional Family Therapy

Description:

1. **Primary purpose:** Multidimensional Family Therapy (MDFT) is a family-based treatment developed for adolescents with drug and behavior problems and for substance abuse prevention with early adolescents. The MDFT intervention has evolved over the last 17 years within a federally funded research program designed to develop and evaluate family-based drug abuse treatment for adolescents. This approach has been recognized as one of a new generation of comprehensive, multi-component, theoretically-derived and empirically-supported adolescent drug abuse treatments. A multidimensional perspective suggests that symptom reduction and enhancement of prosocial and appropriate developmental functions occur by facilitating adaptive developmental events and processes in several domains of functioning.

   The treatment seeks to significantly reduce or eliminate the adolescent's substance abuse and other problem behavior, and to improve overall family functioning. For the parent(s), objectives include blocking parental abdication by facilitating parental commitment and investment; improving the overall relationship and day to day communication between parent and adolescent; and increased knowledge about and changes in parenting practices (e.g., limit setting, monitoring, appropriate autonomy granting). The treatment approach has multiple components, assessment and intervention occurs in several core areas of the teen's life simultaneously.

2. **Target population:** The MDFT model has been applied in a variety of community based clinical settings targeting a wide range of populations. These clinical groups have comprised ethnically (white, African American, and Hispanic) and linguistically (Spanish/English) diverse adolescents at risk for abuse and/or abusing substances and

their families. The parents of adolescents targeted in MDFT controlled studies have had a range of economic and educational levels, yet the majority of families treated have been from disadvantaged inner-city communities. Adolescents treated in MDFT trials have ranged from high-risk early adolescents, to multi-problem, juvenile justice involved, dually diagnosed female and male adolescent substance abusers. It is adaptable to multiple settings as well.

Risk factor(s) addressed

- Substance abuse
- Poor family communication
- Parent management skills

Evaluating this practice:

Evidence supporting practice:

Four randomized efficacy studies have been conducted on MDFT and two others are nearly completed. A study conducted in the San Francisco-Oakland area compared the efficacy of MDFT with two well-established drug abuse treatments, multifamily educational intervention (MFEI) and adolescent group therapy (AGT). Participants in the study were 95 drug-using adolescents and their families who completed treatment and were assigned to one of the three conditions. Assessments were administered at treatment intake and at one-year follow-up and consisted of 1) drug use, 2) problem behaviors, 3) school performance, and 4) family functioning. At the end of treatment the general pattern of results indicated improvement among youth in all three conditions, MDFT participants showing the largest and most diverse gains. Importantly, and speaking to the durability of the MDFT intervention, these significant decreases in drug abuse and behavior problem not only remained stable but these changes continued to occur at the one year follow up assessment. MDFT also produced significant changes in important prosocial and protective domains. MDFT families showed significant improvements in family functioning, and teens receiving MDFT demonstrated superior gains in their school performance at one year follow up, relative to comparison treatments.

Practice implementation:

1. **Staffing requirements:** Depends on number of adolescent clients. Case loads are normally low (6-10) so that the therapist can work intensively with each adolescent and family. The MDFT clinical team is comprised on one clinical supervisor for two or four therapists and budget permitting, one to two case manager therapist assistants. Most therapists using this approach have had a master's degree and an average of 2-3 years of experience. MDFT has been implemented in over 16 sites throughout the US. Details of certification are available from the program developer.
2. **Training requirements:** Intensive several day workshop. The initial course is followed with booster sessions on site and extensive telephone/video conferencing that emphasizes the implementation of MDFT in the particular sites with therapists own current cases.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.

5. **Implementation timeline:** none known.

Contact information:

Dr. Howard A. Liddle
Center for Treatment Research on Adolescent Drug Abuse
Dept. of Psychiatry and Behavioral Sciences
University of Miami School of Medicine
Dominion Tower 1108; 1400 NW 10th Avenue; M-711
Miami, FL 33136
(305) 243-6434
hliddle@med.miami.edu

Relevant websites:

Asian Youth Alliance

Description:

1. **Primary purpose:** The Asian Youth Alliance Program (AYA) is a multi-level, ethnic-specific prevention program developed by Asian American Recovery Services in Daly City, CA. The long-term goals of decreasing high risk behaviors and substance use among Chinese and Filipino youth living in Daly City are accomplished by successfully altering intermediary knowledge, attitudinal, and skill deficits related to these. The AYA Program achieves these goals by building a consortium of Asian-focused youth-serving agencies to better meet the needs of youth while also addressing the needs of youth in specific Asian communities through curriculum-based prevention interventions. AYA was formulated on the basis of empirical studies delineating risk and protective factors unique to the Asian group's targeted as well as anecdotal information concerning the specific problems present in Daly City in relation to each of the outcome domains targeted.

2. **Target population:** The AYA program serves high-risk Filipino and Chinese youth ages 15-20 and 15-18 respectively. The Family Strengthening Intervention also serves Filipino parents and other family members. A majority of AYA youth and their families are foreign born and live in relative isolation due to cultural and language barriers as well as weakened family bonds which have been disrupted by immigration.

   Risk factor(s) addressed
   - Tolerance for drugs
   - Social anxiety

Protective factor(s) addressed

- Cultural pride

Evaluating this practice:

Evidence supporting practice:

An experimental design was used to determine if AYA achieved in intermediate outcomes. While the program was successful in decreasing intermediary risk (tolerance for drugs, social anxiety) and increasing intermediary protective (cultural pride) factors, further evaluations of the program are warranted to determine if changes in these variables will produce anticipated changes in related high-risk behaviors and substance abuse outcomes.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** Curricula for Chinese and Filipino program components; assessment and consent forms; evaluation instruments.
4. **Use of natural funding:** none known.
5. **Implementation timeline:**

Community empowerment

- one-time start-up activities include the establishment of an AYA consortium of agencies that serve targeted ethnic groups. Memoranda of understanding are obtained from participating agencies that set forth roles of consortium members, the decision making process, policies, and procedures to be observed by member agencies.
- ongoing activities include renewing written agreements delineating roles and responsibilities of member agencies (once a year) and convening regular meetings of consortium member agencies (monthly).

Community Awareness Campaign

- This component is implemented over the course of one year. Door to door neighborhood outreach efforts are used to increase Filipino and Chinese Residents' awareness of ATOD use and the existence of community resources serving high risk youth.

Curriculum Based Interventions

- The Family Strengthening Intervention is implemented over a 5-week period. This component includes the following activities:
- Ten two-hour structured workshop sessions focusing on youth acquisition of culturally congruent life skills held twice a week
- a one-time workshop entitled "Making Connections: the Filipino family"
- The individual effectiveness intervention is implemented over 6-7 weeks. This component includes the following activities.
- Twelve two-hour sessions each covering an important life skill (e.g., effective communication, building self-esteem) held twice a week

Other considerations:

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Relevant websites:

www.aars-inc.org/aya

The Village

Description:

1. **Primary purpose:** The Village Integrated Service Agency, a program of the Mental Health Association of Los Angeles, provides a coordinated, comprehensive range of services to people with schizophrenia and other serious and persistent mental illnesses. This visionary model was established through a statewide competition to design and implement an integrated service delivery system that uses capitated, or fixed level, funding.

   The goal of the Village is to "empower adults with psychiatric disabilities to live, learn, socialize, and work in the community." To accomplish this goal, the Village integrates services, support, opportunity and encouragement.

   The Village Integrated Service Agency adheres to the following principles:

   - All members are encouraged to work and are supported on the job by their personal service coordinator and other Village staff. The Village also provides members with opportunities for paid employment in a variety of settings.
   - The Village uses a menu approach to help members develop customized service plans. Members select from a list of psychiatric, employment, housing, health, financial and recreation options.
   - Each service plan incorporates self-help, peer support, family support and community involvement.

2. The Village provides services to 276 individuals with schizophrenia and other serious and persistent mental illness. Services target those individuals who have used mental health services at a moderate or high rate.

Risk factor(s) addressed

- Mental illness
- Lack of housing
- Lack of employment

Protective factor(s) addressed

- Social and community support

Evaluating this practice:

Evidence supporting practice:

By emphasizing services that support individual in the community, the Village has reduced expenditures on more costly kinds of care. During the initial three-year period of the Village program, less than 20% of the Village members required hospital treatment. The number of hospitalizations was reduced and the length of stay in hospital settings was shortened. The Village spent only 10% of its funds on the most expensive services: hospital services, acute residential services and other 24-hour care programs. In contrast, California's public system spends an average of 55% of its funds on such care.

Just as significant were the improvements in the members' living, working and social lives. Approximately 60% of Village members lived independently, either alone or with a roommate or spouse. About 30% of all Village members worked or attended school.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** none known

Other considerations:

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Relevant websites:

www.mhala.org

The APIC Model: An Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders

A Best Practice

Description:

1. **Primary purpose:** The APIC model is to Asses the inmates clinical and social needs, and public safety risks; to Plan for the treatment and services required to address the inmate's needs; to Identify required community and correctional programs responsible for post-release services; and to Coordinate the transition plan to ensure implementation and avoid gaps in acre with community-based services.

   Almost all jail inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest. While there are no outcome studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs to propose a model. The APIC Model is a set of critical elements that, if implemented, are likely to improve outcomes for persons with co-occurring disorders who are released from jail.

2. **Target population:** jail inmates with co-occurring disorders

   Risk factor(s) addressed
   - Recidivism
   - Psychiatric Symptoms
   - Substance abuse

   Protective factor(s) addressed

Evaluating this practice:

Evidence supporting practice:

While there are no outcome studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs by Steadman, McCarty, and Morrissey (1989); the American Association of Community Psychiatrists continuity of care guidelines (2001); and the American Psychiatric

Associations' task force report on psychiatric services in jails and prisons (2000), to create a best practice model that has strong conceptual and empirical underpinnings and can be expeditiously implemented and empirically evaluated.

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:**

Other considerations:

Contact information:

Relevant websites:

www.samhsa.gov

Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD)

Description:

1. **Primary purpose:** This project aims to improve treatment for bipolar mood disorder. The overall goal of the STEP-BD project is to improve treatment of bipolar mood disorder by finding the best way to deliver the most effective treatment available and to provide answers to the many important questions confronting the field.

   Since bipolar mood disorder is a complex condition, meeting this goal requires systematic assessment of treatment outcome in a large sample of patients over a long period.

   The coordinating center will establish a network of up to 20 treatment centers in which some 5,000 patients will be treated by specially trained psychiatrists and clinical specialists. These practitioners will use common assessment procedures and implement

therapeutic interventions as called for by treatment guidelines that integrate pharmacological interventions and several psychosocial interventions.

The coordinating center will analyze data from these centers to determine impact of a wide variety of treatments on disease-specific outcomes, quality of life/functional outcome and economic outcomes. Additional data will be collected that are focused on adherence to guidelines, as well as the influence of treatment setting and of regional and ethnic factors on treatment outcomes.

2. **Target population:** Ages eligible for study: 15 years and above. Open to both genders. General inclusion criteria:
   - Current age 15 or older
   - Meet DSM-IV criteria for Bipolar I Disorder, Bipolar II Disorder, Bipolar Disorder NOS, of Cyclothymic Disorder

   Participants will be asked to remain in the study for up to five years so that the investigators can document and evaluate long-term treatment outcome. Participants will meet with their STEP-BD psychiatrist for periodic evaluations and/or treatment adjustments during the course of the study, fill our various self-rating forms, and when applicable, participate in psychotherapy. One of the psychotherapy options, Family-Focused Therapy, will require participants and their families to attend counseling sessions together. Overall, the estimated amount of time required from participants in the study is 2 to 4 hours per month.

Evaluating this practice:

Evidence supporting practice:

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:**

Other considerations:

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Relevant websites:

www.clinicaltrials.gov

Emerson Davis Family Development Center

Description:

3. **Primary purpose:** The Emerson-Davis Family Development Center (Emerson-Davis) is a residential treatment program for adults with mental illness and a history of homelessness. Emerson-Davis is located in Brooklyn, NY and consists of 22 one-bedroom apartments for single adults seeking reunification with their children, and 16 two-bedroom apartments for families. The program for families at Emerson-Davis centers on comprehensive case-management and in-home family development services to promote independence and good parenting among residents. A range of services for children in residence with their parents is also available on-site. Emerson-Davis operates eight "satellite" apartments in the community that are available to families after "graduation" from the residential program. Independent living is central among goals for all families at Emerson-Davis.

   Parents are supported to develop individual and family goals, and service plans that address the broad psychosocial needs of both parents and children are the center of the intervention

4. **Target population:** Emerson-Davis provides services for adults (18+ years) with serious and persistent mental illness and a history of homelessness (requirements of New York/New York funding) who wish to live with their children and work toward independence. Parents must be eligible for SSI benefits, and be willing to authorize Emerson-Davis and ICL to be payee of these benefits. Emerson-Davis also requires participants to be drug-free for at least one-year, stable with respect to psychiatric symptoms, and to have custody of their children or have a reunification plan. Children must be twelve years or younger at the time of admission.

Risk factor(s) addressed

- Mental illness
- Homelessness

Protective factor(s) addressed

Evaluating this practice:

Emerson Davis collects data on family characteristics, family outcomes, and family satisfaction with the program. Adherence to service plans developed with case managers and family development specialists are high, ranging from 87% to 100%. Surveys of staff indicate that they perceive that 86% of parents and 90% of children show positive outcomes with respect to psychiatric symptoms, overall functioning and development. Substance abuse relapse rates are low, with 3.6% of parents having some type of relapse. Twelve and one-half percent of the parents require psychiatric hospitalization annually, but can return to the residence and resume family life after discharge. Children can often be cared for in the residence, but sometimes must enter foster care temporarily. There are plans to begin more rigorous data collection on clinical outcomes for both children and parents.

Evidence supporting practice:

Practice implementation:

1. **Staffing requirements:** none known.
2. **Training requirements:** none known.
3. **Cost of program:** none known.
4. **Use of natural funding:** none known.
5. **Implementation timeline:** none known

Other considerations:

Contact information:

Relevant websites:

www.samhsa.gov

San Francisco General Hospital: Consultation/Liaison Program

Description:

1. **Primary purpose:** The Consultation/Liaison to OB/GYN (C/L) program at the San Francisco General Hospital is a specialized psychiatric consultation service at the hospital. The program focuses on providing psychiatric consultation to women receiving inpatient and outpatient obstetrical and gynecological services. It allows women with psychiatric and/or severe substance abuse problems, including women with serious mental illness, to receive psychiatric care during their regular prenatal and postpartum healthcare visits.

2. **Target population:** Women 18 years and older with psychiatric concerns who receive OB services at San Francisco General Hospital. The clinic serves 32% Latina women, with a high percentage of recently immigrants, 28% are African-American, and 13% are Asian-American.

   Risk factor(s) addressed
   - Serious Mental Illness
   - Substance Abuse
   - Mental Illness
   - Domestic violence

   Protective factor(s) addressed
   - Women health
   - Body-image

Evaluating this practice:

Evidence supporting practice:

Anecdotal accounts note continued success in normalizing concerns related to pregnancy, mental health, and relationships with partners and family members. Some women with SMI were able to transition to a local, community-based program and then able to transition to independent living.

Practice implementation:

1. **Staffing requirements:** Trained psychiatrist
2. **Training requirements:** none known
3. **Cost of program:** none known

4. **Use of natural funding:** Dept. of Psychiatry, San Francisco General Hospital
5. **Implementation timeline:** none known

Other considerations:

Contact information:

Relevant websites:

www.mentalhealth.org

Cognitive Behavioral Treatment For Depression

Description:

1. **Primary purpose:** This manualized program has empirical evidence of the effectiveness of cognitive behavioral treatment for depression, including in primary care settings, especially for low-income women. Delivered in small group format, the intervention consists of four modules with each module lasting 4 weeks. It allows new members to participate in the group at 4 week interval. The manual is available in English and Spanish.
2. **Target population:** Depressed women ages 18-70, low-income

   Risk factor(s) addressed
   - Depression

   Protective factor(s) addressed

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Beck Depression Inventory.

Evidence supporting practice:

Research consistently documents that participants show decreased depressive symptoms and improved quality of functioning.

Practice implementation:

1. **Staffing requirements:** 2 trained group facilitators
2. **Training requirements:** none known
3. **Cost of program:** none known
4. **Use of natural funding:** none known.

5. **Implementation timeline:** Four modules, each module consists of 4 weeks of treatment

Other considerations:

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Relevant websites:

Family Support Services/PACE (FSS/PACE) Program

Description:

1. **Primary purpose:** The Family Support Services/PACE (FSS/PACE) program is a program of the Mid-Eastern Iowa Community Mental Health Center (MCMHC), located in Iowa City, Iowa. PACE stands for Parents, Advocacy, Coordination and Education. The program provides clinical case-management for families in which a parent has a serious and persistent mental illness, and has minor children living in the home. The primary goal of FSS/PACE is to prevent or reduce child welfare involvement and unplanned hospitalizations, and to increase the quality of life for families while building a bridge between mental health services and other service delivery systems.

   FSS/PACE case managers form supportive, therapeutic relationships with families. Building on families' strengths, case managers focus on the development of problem solving skills, mental health counseling, and education for both parents and children about mental illness.

2. **Target population:** Prior to 2000, FSS/PACE worked with parents with serious mental illness who were involved with child welfare and had either lost custody of their children or were at risk for custody loss. Since 2000, FSS/PACE has targeted families in which a parent has mental illness but has established custody of her or his children.

   Risk factor(s) addressed
   - Mental illness

Protective factor(s) addressed

Evaluating this practice:

Evidence supporting practice:

Diagnoses. The most frequent diagnosis among the parents served by FSS/PACE is Major Depressive Disorder, experienced by a third of participants. Other diagnoses include Bipolar Disorder, Schizophrenia, Generalized Anxiety Disorders, Post-Traumatic Stress Disorder, Dysthymia, and Obsessive-Compulsive Disorder. Some of the children involved also qualify for psychiatric diagnoses. Most common among these are Attention Deficit Hyperactivity Disorder, and Oppositional Defiant Disorder.

Co-occurring Disorders and Issues. FSS/PACE families experience a variety of co-occurring issues, including poverty, substance abuse, lack of and high cost of housing, trauma and domestic violence. For many families, the issues of poverty and substance abuse are more problematic than the issues related to mental illness.

Family Outcomes. There has not been any formal evaluation of the FSS/PACE program. Interviews with FSS/PACE staff, community collaborators, and families all provide very good anecdotal reports on the program's success. FSS/PACE staff measure success by several explicit family outcomes. These include decreased hospitalizations, decreased child welfare involvement, increased problem solving skills, increased self esteem, increased decision-making skills, increased parenting skills, increased knowledge of child development, increased medication management, increased appointment adherence, increased quality of life, increased self-advocacy, increased confidence in parenting and a positive personality change.

Practice implementation:

5. **Staffing requirements:** none known.
6. **Training requirements:** none known.
7. **Cost of program:** none known.
8. **Use of natural funding:** none known.
9. **Implementation timeline:** none known.

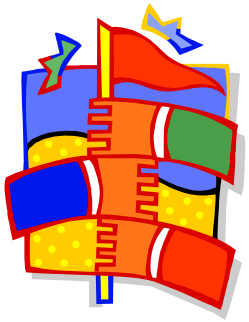
Other considerations:

Contact information:

Relevant websites:

www.samhsa.gov

Gay, Lesbian, Transgender & Bisexual Individuals



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A Review of the Literature

As far back as 1935, Sigmund Freud wrote to the anxious mother of a homosexual son that: "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness…" (Freud, 1935 as cited in Bayer, 1987). Nevertheless, the American Psychiatric Association included homosexuality under the grouping of sociopath personality disturbances in the first edition of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-I, American Psychiatric Association, 1952). By the time of the second edition of the DSM (DSM-II, American Psychiatric Association, 1968), the diagnosis of homosexuality was moved under the general heading of sexual deviations.

Alfred Kinsey and colleagues studied a group of American white males, and published data suggesting that for a certain percentage of the population was sexually stimulated by other males (Kinsey, Pomeroy, & Martin, 1948). Later, in 1953, Kinsey, Pomeroy, Martin, & Gebhard conducted similar research with females. Research was emerging in the 1950s, demonstrating that homosexuality, per se, did not constitute a mental disorder. The pioneering work of Evelyn Hooker (1957) demonstrated that homosexual males were similar to heterosexual males on tests of psychopathology.

Homosexuality was removed from the Diagnostic and Statistical Manual of Psychiatric Disorders in the third edition (DSM-III, American Psychiatric Association, 1980), but a diagnosis of ego-dystonic homosexuality was added. This diagnosis was used to indicate individuals that were distressed about their gay, lesbian, or bisexual sexual orientation. There was no corollary for heterosexual individuals that were distressed about their sexual orientation. The diagnosis of "ego-dystonic homosexuality" was dropped from the revision of the third edition (DSM-III-R, American Psychiatric Association, 1987), although a related disorder "ego-dystonic sexual orientation" remains in the International Statistical Classification of Diseases and Related Health Problems- Tenth Edition (ICD-10; Source: World Health Organization). Nevertheless, the American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, and the National Association of Social Workers all have taken the position that homosexuality and bisexuality are not mental disorders.

The diagnosis of gender identity disorder remains in the current edition of the DSM. This diagnosis has been used to pathologize children and adults whose experience and identification of their gender is opposite to that assigned to them at birth; however, it has also been used to help. The diagnosis is controversial but is the only diagnosis given that allows for transgender individuals wishing to have hormone therapy or surgery (to make their bodies match their gender identity) to be reimbursed by insurance. It should be noted, however, that very few people are reimbursed by insurance for Sexual Reassignment Surgery, and many insurance companies carry clauses stating that they will not pay for such surgery. In order to get hormones; it is often necessary to refer to the mental health aspect of the treatment

because insurance companies will not pay for hormones if they are identified simply as part of the reassignment process.

An understanding of terminology is important in this discussion.[3] *Gender identity* is the inward and individual experience of being male or female, or ambivalence about maleness or femaleness, and *Gender Role* or *Presentation* is the public expression of that Gender Identity. *Transgender* originally referred to people who changed their social role (gender role expression or presentation) to live fully in the gender role different from that assigned at birth, and did so without changing their bodies through surgery or medication. Currently the term *transgender* has been expanded, and may refer to all individuals who experience internal conflict with their physical sex, and/or their assigned gender role. Thus, the term *transgender* may now apply to any person who struggles internally over gender identity or whose physical characteristics and gender expression differ from their gender as assigned at birth. The key difference is that the term now includes the full range of gender identity concerns, from internal distress through medical and surgical change. *Transsexual* refers to people that change their primary social gender roles *and* their physical bodies. They make use of medication and surgery to bring their bodies into harmony with their inner sense of gender identity. *Gender non-conforming/gender variant* are synonymous terms sometimes used in gender identity literature to refer to persons whose social gender role presentations do not fall into the usually accepted perimeters. *Intersexed* refers to individuals that are born with genital structures that are different from the majority. This is not transsexual or transgender (see the Intersex Society of North America Website at http://www.isna.org/. *Questioning* is a term created to include individuals who are exploring gender and/or sexual identity and expression. Overall, however, there are many debates over terminology, and these definitions are not unanimously accepted by all with expertise with this population. New terms are appearing regularly as the literature on gender and identity grows. An approach that asks each client or patient to discuss in detail his or her own self-descriptions, and begins from that point, will help avoid rigid adherence to particular definitions.

The removal of homosexuality from the DSM is not an indication that prejudice against lesbian, gay, bisexual and transgender individuals is merely an historical phenomenon. Violence against lesbian, gay, bisexual and transgender youth and adults is still a present reality. D'Augelli (1998) summarized data from a number of surveys and research studies demonstrating that lesbian, gay, and bisexual youth were more likely to be victimized within their families and in the community. Violence against lesbian, gay, and bisexual youth takes the form of verbal harassment by peers, threat of physical violence, physical attack, rape, incest and destruction of personal property. Fifty-two percent of the women that participated in the National Lesbian and Gay Health Foundation study (Bradford, Ryan, & Rothblum, 1994) reported that they had been physically assaulted. Lesbian, gay, bisexual and transgender youth and adults are a stigmatized minority group. As such, they face the daily stress of being members of a stigmatized group (DiPlacido, 1998). A website, "Remembering Our Dead" names hundreds of transgender individuals who have been murdered because of their gender identity issues (*http://www.gender.or/remember/#*). Such minority stress negatively affects the psychological well being of lesbian, gay, bisexual and transgender individuals.

Marsha Botzer for her elucidation of the various terms association with transgender.

Lesbian, gay, bisexual and transgender youth that are victimized in their family of origin are more likely to runaway from home. Cochran, Stewart, Ginzler and Cauce (2002) found that lesbian, gay, bisexual and transgender youth run away from home more frequently than their heterosexual counterparts, and are victims of physical violence from family members (particularly for males) or following homelessness. In their study of lesbian, gay and bisexual homeless youth in Seattle, the authors found reports of higher incidence of substance abuse, higher self-report ratings of symptoms of psychopathology, and more sexual partners than heterosexual homeless youth.

In a study of 137 gay and bisexual male youths, Remafedi, Farrow, & Deisher (1991), found that approximately one third (41/137 reported some form of intentional self-destructive act, with 21% of those resulting in hospitalization or medical care. The subjects had come from the Midwest and the Pacific Northwest, and the sample was multi-racial 82% white, 13% African American, 4% Hispanic and 1% Asian. Race and ethnicity were not significant variables in the results. Huxdly and Brandon (1981) surveyed 72 transsexual youths and found that 53% had made suicide attempts.

Herrell, Goldberg, True, Ramakrishnam, Lyons, Elsen, & Tsuang, (1999) found higher risk of suicidal ideation and suicide attempts among males who had sex with men than their twin brothers. They evaluated data from a male-male twin registry of veterans who served in the U.S. military between 1965 and 1975. This and other studies used reported sexual behavior as indicative of sexual orientation, women were excluded from the sample, and the sample was ethnically homogeneous, limiting the generalizability of the findings. Whereas Remafedi, Farrow and Deisher found that suicide attempters were more likely to use illicit drugs than non-attempters were, Herrell and colleagues (1999) found that higher rates of suicidality could not be explained by abuse of drugs or alcohol. Remafedi, Farrow and Deisher (1991) and Herrell et al, 19999) concluded that suicidality was not the direct result of depressive symptoms, or other psychopathological diagnoses such as anxiety disorders or personality disorders. Other studies have indicated that gay and lesbian youth are likely to report having attempted suicide more than non-gay counterparts (e.g. Remafedi, 1994). Gilman, Cochran, Mays, Hughes, Ostrow and Kessler (2001) found similar trends for women with homosexually active women having higher rates of suicide attempts than heterosexually active women do.

More recently, however, Savin-Williams (2001) criticize much of the published data on lesbian, gay, and bisexual youth suicide risk because of problems in sample selection, vague definitions of suicide, and the use of unreliable measures of sexual orientation and suicide attempts. Savin-Williams found suicide attempt rates at 13% for the young women in his study when he distinguished false from actual attempts, and eliminated suicidal ideation from the definition of suicide attempts. Savin-Williams maintained that these rates were only slightly over the rate reported for non-gay-identified youths, and suggest that earlier data may have overestimated the risk for lesbian, gay and bisexual youth. In a second study with both male and female participants, Savin-Williams found that young men who rated themselves "predominantly heterosexual, but significantly homosexual" according to the Kinsey scale (Kinsey, Pomeroy & Martin, 1948) were more likely to report a suicide attempt than other

sexual minority male groups. Those participants who identified themselves as gay or bisexual according to the Kinsey scale were no more likely to attempt suicide than heterosexual participants, suggesting that ambivalence about sexual orientation may play a greater role in suicidal behavior in adolescents than sexual orientation per se. Savin-Williams also criticized the use of samples from lesbian, gay and bisexual support groups warning that these youth may be at higher risk of suicide, but that they do not represent all lesbian, gay and bisexual youth. Safren and Heimberg (1998) compared lesbian, gay and bisexual youth in support programs to demographically similar youth in other types of support programs on suicidality and related variables. The groups differed on depression, hopelessness, and suicidal ideation. However, when statistically controlling for social support, coping, and stress, these differences disappeared. Thus, the authors conclude that environmental factors, and not sexual orientation, play a role in distress among this population.

Research continually confirms that lesbian, gay, bisexual and transgender youth and adults are vulnerable to abuse and violence in the larger community. Such environmental pressures confound any understanding of behavioral health problems in this population. Concluding that being homosexual, bisexual or transgender is, in itself, problematic, does not account for the emotional toll that living in hostile environments has on lesbian, gay, bisexual and transgender youth and adults.

Research supports the conclusion that lesbian, gay, and bisexual adults suffer from specific psychological problems at higher rates than their heterosexual counterparts. The Benjamin Society also suggests that transgender individuals are vulnerable to psychological distress. Gilman and colleagues (2001) analyzed data from the National Comorbidity Study and compared rates of mental disorders among people who have had same-sex sexual partners to rates among those who report exclusively opposite-sex partners. Mood and anxiety disorders were more prevalent among respondents who had one or more same-sex sexual partners than those who did not. The National Comorbidity Study confused sexual behavior with sexual orientation, however, thus confounding the data. People that have same-sex sexual partners but do not recognize themselves as having gay, lesbian, or bisexual sexual orientations are likely to differ than those who do. Sexual identity was not considered, and there was no determining if identification as gay, lesbian or bisexual served as a risk factor or protective factor. The study also lacked power due to the small number of respondents reporting same-sex sexual partners. Cochran and Mays (2000) reported higher rates of depression and panic among men with same-sex partners and higher rates of alcohol and drug dependence among women with same-sex partners. Cochran, Sullivan and Mays (2003) using data from individuals that self-identified as lesbian, gay or bisexual, found that gay and bisexual men were more likely than heterosexual men to be diagnosed with a mental disorder. This study is of particular significance because the authors examined data from the MaArthur Foundation National Survey of Midlife Development in the United States (MIDUS; Brim, et al., 1996) that drew eligible respondents between the ages of 25 and 74 years old through a random-digit-dial telephone sample from the contiguous United States. This questionnaire asked respondents if they would describe their sexual orientation as heterosexual, homosexual or bisexual. Asking this one question differs significantly from other large population based data that ask only for the gender of sexual partners since sexual behavior must be differentiated from sexual orientation or identity. Asking a question about sexual orientation

allows respondents to identify themselves in an interview, as they are likely to identify themselves in life. Th Cochran, Sullivan and Mays (2003) confirmed what other studies had found, that there was an elevated risk for mood, anxiety, and substance use among gay, lesbian, and bisexual individuals. Specifically, gay and bisexual men were 3.0 times more likely to be diagnosed with major depressive disorder and 4.7 times more likely to be diagnosed with panic disorder. Lesbian and bisexual women were more likely to be diagnosed with generalized anxiety disorder than heterosexual women. Gay, lesbian and bisexual men and women were more likely to be diagnosed with two or more of the five disorders assessed by the MIDUS. Approximately 58% of lesbian, gay, and bisexual participants in their sample did not evidence any of the five disorders assessed by the MIDUS. Therefore we can conclude that, while gay, lesbian, and bisexual people (and we can infer transgender individuals) are more vulnerable to psychological disorders resulting from life stress, this population as a whole is quite resilient. The MIDUS questionnaire provides interesting and important data, but there are limitations, particularly that it screened for only five disorders, and that there was a small sample of lesbian, gay, and bisexual men and women identified.

Another significant discovery in the Cochran, Mays, and Sullivan (2001) article was that lesbian, gay and bisexual men and women were more likely to have used one of the four types of mental health services (seeing a mental health provider, seeing a general physician for a mental or emotional complaint, attending a self-help group, or taking a prescribed medication for a mental or emotional complaint). Among the gay and bisexual men, 85.3% reported that they had received at least one of the four types of mental health services compared to 45.2% of the heterosexual men. Between the lesbian and bisexual women, 94% reported receiving at least one of the four types of mental health services compared to 54% of the heterosexual women. These higher rates of usage of mental health services can be interpreted in a number of ways. Cochran, Mays and Sullivan explain that gay, lesbian and bisexual men and women seek mental health services for a variety of reasons apart from treatment for mental or emotional problems. They seek assistance in issues generated by being a sexual minority, and, in some cases, assistance in coping with HIV.

In summary, the available literature on lesbian, gay and bisexual men and women suggests that a homosexual or bisexual sexual orientation per se does not indicate the presence of a psychiatric disorder. The prevalence of gender identity disorders, according to The Harry Benjamin International Gender Dysphoria Association's Standards of Care For Gender Identity Disorders, Sixth Version is 1 in 11,900 males and 1 in 30,400 females. The stigmatization of transgender, transsexual, or questioning individuals varies across culture, so the behavioral expression of "gender dysphoria" (an older term) will also vary across cultures. The diagnosis of "gender identity disorder" provides access to treatment for those biological males and biological females that experience their gender differently from biological determinants but the presence of a diagnosed "disorder" should not indicate that transgender individuals per se have a psychopathological condition.

Lesbian, gay, bisexual and transgender men and women may, be vulnerable to a number of emotional problems because of being stigmatized groups. Research has suggested higher rates of mood disorders, anxiety disorders and substance use disorders among lesbian, gay,

and bisexual men and women. Furthermore, according to the Benjamin Standards of care, unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders and borderline personality disorder. Treatment of these comorbid disorders will enhance the lives of lesbian, gay, bisexual and transgender youth and adults.

Since lesbian, gay, and bisexual men and women seek help from mental health professionals at relatively high rates, it is important for the mental health community to have a clear understanding of the needs of this population. Transgender individuals have traditionally been wary of the mental health community, because, until quite recently, mental health professionals either have seen them as psychologically disturbed or have used the mental health system to monitor and occasionally block access to hormonal or surgical methods for gender reassignment.

Treatment approaches to many of the mental health and emotional problems to which gay, lesbian, bisexual and transgender youth and adults are vulnerable have not adequately demonstrated efficacy with this population. Data on treatment with gay, lesbian, bisexual and transgender clients is scarce. We review the literature on appropriate treatment with lesbian, gay, bisexual and transgender clients, and then review the literature on empirically supported treatments. Because the data is limited, these treatments can only be considered promising practices for this population, although studies utilizing the approaches with lesbian, gay, bisexual or transgender clients has been reviewed. There are other resources available for this population as well, usually in the form of counseling centers or non-profit organizations that make treatment available to sexual minority communities. Once again, however, the programs exist, but clear data about the effectiveness of the programs are not prevalent.

The American Psychological Association adopted guidelines for psychotherapy with lesbian gay, and bisexual clients (American Psychological Association, 2000). The basic premise of the American Psychological Association's guidelines is that being lesbian, gay or bisexual does not constitute a mental illness. Whenever therapy is conducted with this population therapists should, recognize how their attitudes and knowledge about the population is relevant to assessment and treatment, seek consultation when indicated, understand the ways in which social stigma effects the mental health and well-being of lesbian, gay, bisexual (and transgender) individuals, understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect a client's presentation and the therapeutic process. Therapists are furthermore encouraged to be knowledgeable about the importance of lesbian, gay, and bisexual relationships; understand the particular challenges faced by lesbian, gay, and bisexual parents; recognize that family may be defined in a broader sense than legal or biological relatives; understand that a client's homosexual or bisexual orientation may have an impact on relationships within the family of origin. Additionally, psychologists are encouraged to recognize challenges of being lesbian, gay, bisexual and a member of a racial or ethnic minority; recognize that bisexual people face particular challenges; understand the special problems and risks that exist for lesbian, gay, and bisexual youth and older adults as well as those with physical, sensory, and/or cognitive/emotional disabilities. Empirically supported therapies that have been developed with heterosexual clients or with participant samples where the sexual orientation is unknown can transfer easily to lesbian, gay, and

bisexual individuals if guidelines such as those developed by the American Psychological Association are followed.

The Harry Benjamin International Gender Dysphoria Association's Standard of Care for Gender Identity Disorders, Sixth Version also provides standards for mental health professionals. The document describes nine tasks of the mental health professional:

1. Accurately diagnose gender disorder
2. Accurately diagnose any co-morbid psychiatric conditions
3. Counsel the individual about treatment options and implications
4. Engage in psychotherapy.
5. Ascertain eligibility and readiness for hormone and surgical therapy
6. Make formal recommendations to medical and surgical colleagues
7. Be a collegial member of a team of professionals
8. Educate family members, employers, and institutions
9. Be available for follow-up for patients. (Harry Benjamin Society, PDF file - pg 6).

As one can see, the both the APA guidelines and the Benjamin Standards are quite broad in regards to the types of psychosocial services provided to gay, lesbian, bisexual or transgender clients. Taking the literature on vulnerabilities of these populations together with the guidelines and standards, one can combine the research on empirically supported treatments for specific disorders, understanding of lesbian, gay, bisexual and transgender communities and offer promising practices for these communities. There are also programs for prevention of drug and alcohol abuse that can be used with lesbian, gay, bisexual and transgender clients, and specific community outreach programs to this community. Many outreach programs, however, provide valuable service by offering support groups and drop in centers, but do not have outcome data available that addresses efficacy with particular problems experienced by this community.

General categories of "affirmative-psychotherapy" (e.g. Fassinger, 2000; Ritter & Terdrup, 2002) or "queer positive therapies" as well as feminist perspectives on psychotherapy (e.g. Brown, 1994) have all been used with lesbian, gay, bisexual and transgendered/transsexual men and women. These orientations cut across the traditional schools of psychotherapy such as psychodynamic, humanistic, and cognitive-behavioral. Allowing for psychotherapists from any traditional school of thought to conduct competent affirmative therapy, these overarching ideas share certain understandings in common. Such diverse perspectives as psychoanalysis and cognitive-behavioral therapies have been applied with lesbian, gay, and bisexual clients (see Glassgold & Iasenza, 1995 and Martell, Safren, & Prince, in press, respectively). The primary understanding is that people cannot be judged according to one standard, and that traditional mental health diagnoses and treatment have been based on a number of assumptions that are incorrectly applied to lesbian, gay, and bisexual men and women. For example, the assumption that heterosexuality is the standard by which loving relationships must be judged, or that developing heterosexual love relationships signals "mature" psychosexual development are rejected. Feminist therapy is particularly important

in the treatment of transgender or transsexual individuals, because traditional ideas of gender as something that is hard-wired into a person based on biological sex at birth are rejected.

The Society of Clinical Psychology (American Psychological Association - Division 12) developed a task force to identify empirically supported treatments (Chambless, et al., 1996) that have been evaluated in randomized clinical trials, in multiple research cites, and with adequate control groups. The task force identified several treatment approaches that hold promise for the lesbian, gay, bisexual and transgender community, given that evidence suggests that they may be vulnerable to depression, generalized anxiety disorder, panic disorder, and substance use or dependence disorders. Several important treatments are reviewed below.

TREATMENTS FOR ALCOHOL AND SUBSTANCE USE DISORDERS AND DEPENDENCE

Although the data are not definitive that lesbian, gay, bisexual and transgender individuals are at greater risk for substance abuse, substance use can impair judgment, which is particularly dangerous in light of the AIDS epidemic. Cochran, Keenan, Schober, & Mays (2000) found that men who had sex with men did not differ in rates of alcohol consumption than men who had exclusively heterosexual relationships, but they did find that lesbian and bisexual women had higher rates of alcohol use than exclusively heterosexual women. Some studies suggest that a majority of lesbian and gay youth in substance abuse treatment programs present with polysubstance abuse, with marijuana and alcohol being the most frequently used substances (Shifrin, & Solis, 1992). These authors also found crack cocaine addiction among 1/3 of 75 homeless lesbian or gay youth.

While many individuals benefit from 12-step programs, and such programs have been shown to be as effective as cognitive-behavioral interventions (Snow, Prochaska, & Rossi, 1994), many individuals do not attend 12-step meetings because of the spiritual and religious overtones of the approach. In fact, a small study of support choices of gay men and lesbians compared with heterosexual men and women in pursuit of abstinence showed that gay men and lesbians' positive associations with Alcoholics Anonymous correlated with higher than expected continued drinking (Holleran & Novak, 1989). A cost-effective (Miller, Meyers, & Hiller-Sturmhöfel, 1999), the Community Reinforcement Approach (Meyers & Smith, 1995) seeks to reduce substance abuse and promote sobriety by making changes in the daily environment of the client. The approach utilizes motivation techniques and positive reinforcement to make the client's sober environment more reinforcing than the one involving alcohol or drugs (Smith & Meyers, 2000). This highly collaborative therapy allows the client to be involved in determining what contingencies maintain his or her drinking behavior and what will elicit change (Wolfe & Meyers, 1999). The approach is one of the "top six" treatment modalities for substance abuse disorders that have strong empirical support (Miller, et al., 1995) and it has been used in studies with opiate abusers as well as alcohol abusers (Smith, Meyers, & Delaney, 1998). Three meta-analytic studies have attested to the efficacy of the approach (Finney & Monahan, 1996; Holder et al., 1991, & Miller et al., 1995), and rate it as highly cost-effective (Smith, Meyers, & Miller, 2001). This approach has been endorsed by NIDA. This approach has been used as part of an aftercare treatment for adolescents who completed at least 7-days residential treatment for alcohol or marijuana abuse with promising results (Godley, Godley, Dennis, Funk, & Passetti, 2002). A promising

approach that is just beginning to garner empirical support is the Seeking Safety program (Najavits, L. M., 2002), which has been used primarily with women but is now being used with both men and women. Seeking Safety is a treatment for co-morbid substance abuse and posttraumatic stress disorder, or a traumatic history without PTSD. There has been one published outcome study that demonstrated effectiveness of the treatment (Najavits, Weiss, Shaw, & Muenz, 1998) but the study lacked an adequate control group, therefore limiting results. There are several positive research reports under review at this time.

TREATMENTS FOR ANXIETY DISORDERS

Cognitive-behavior therapy has been successfully implemented for use with generalized anxiety disorder. It has been shown to be more effective than non-directive therapy (Borkovec & Costello, 1993), analytic therapy (Durham, et al., 1994) and benzodiazepine medication (Power et al., 1990). There are several treatment manuals available, including a treatment that is more cognitively focused (Beck & Emery, 1985) and a broader, cognitive-behavioral treatment (Zinbarg, Craske, & Barlow, 1993). Cognitive-behavior therapy can be flexibly applied with each client. Therapists attending to the guidelines set forth by the American Psychological Association (2000) and the ethical standards regarding treatment of diverse populations can implement cognitive-behavioral strategies for generalized anxiety disorder with lesbian, gay, bisexual and transgender clients with little difficulty. A similar treatment approach is applied for panic disorder with and without agoraphobia. Panic Control Treatment (Barlow & Craske, 1994) includes the standard techniques of cognitive-behavior therapy for other disorders, for example, cognitive restructuring and modifying expectations about fearful situations, but it includes exposure techniques. The exposure techniques for panic without agoraphobia are to interoceptive sensations and the interpretations of such sensations. For panic with agoraphobia, exposure to the actual feared stimulus is necessary. Panic Control Therapy has been compared with relaxation alone, Panic Control Therapy combined with relaxation and a waiting-list control (Barlow, Craske, Cerney, & Klosko, 1989) and has been shown to be more effective than waiting list. Clients who received Panic Control Therapy either alone or in combination with relaxation were panic free at the conclusion of the study. Eighty-one percent of the patients that had received panic control therapy alone remained panic free two years after the completion of treatment (Craske, Brown, & Barlow, 1991). Although Panic Control Therapy is usually conducted over 6 - 12 weeks of individual therapy, it has been successfully applied with bi-monthly therapist contact, with bi-monthly 10-=minute telephone contact (Côté, Gauthier, Laberge, Cormier, & Plamondon, 1994) and has been self-directed by the client in an 8-week treatment program (Lidren et al., 1994). While gay men, lesbian women, and bisexual men and women do not appear to have greater vulnerability to social phobia, social avoidance can be dangerous in risky sexual situations when assertiveness is necessary for maintaining one's health. Cognitive-behavioral therapy has been successfully applied in groups for social phobia (Heimberg, Dodge, Hope, Kennedy, Zollo, & Becker, 1990). Heimberg and colleagues (1990) found CBGT to be as effective after a 12-week trial as Phenelzine with 75% of CBGT clients showing improvement. Although there is not current outcome data available, CBGT is being utilized with gay male youth to help teach them to better negotiate safe sex practices and to be assertive with sexual partners.

Anxiety disorders impose a substantial cost on society and are associated with impairment of workplace performance (Greenberg, Sisitsky, Kessler, Finkelstein, Berndt, Davidson, Ballenger, & Eyer, 1999). Relatively short-term cognitive-behavioral treatments can reduce the cost to society and can be conducted in groups making ample use of psycho-educational material, thus reducing cost of treatment. The treatment has been demonstrated to be a treatment of choice for adults with anxiety disorders, and has been successfully implemented with children and adolescents suffering from common anxiety problems - separation anxiety, social phobia, and generalized anxiety disorder (Albano, & Kendall, 2002).

TREATMENTS FOR DEPRESSION

By far the most well studied treatments have been those for the treatment of major depressive disorder (MDD). There are several psychosocial treatments that have shown to be best practices in the treatment of depression, and are promising practices to be used with lesbian, gay, bisexual and transgender clients. Cognitive Therapy for Depression (Beck, Rush, Shaw, & Emery, 1989) is designed to change the dysfunctional beliefs and behaviors that are associated with MDD. Also referred to as cognitive-behavioral therapy for depression, it has been shown to be as effective as tricyclic antidepressant medications (Hollon, et al., 1992; & Simons, Murphy, Levine, & Wetzel, 1986); and only one study (Elkin, et al., 1989), admittedly one of the largest treatment outcome studies to date, did not find CBT to be equivalent to medication. CBT for depression can be conducted with individuals or in groups (Greenberger & Padesky, 1995; Padesky & Greenberger, 1995) and there are several excellent training manuals available (J.S. Beck, 1995). CBT for depression is also an efficacious treatment for children and adolescents (Vostanis, Feehan, Grattan, & Bickerton, 1996). The treatment has also been used with non-white samples, and has been shown to be efficacious in treating depression and hopelessness in a sample of African-American women who were drug dependent and HIV sero-positive (Johnson, 2001).

Interpersonal Therapy for Depression (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) has also been shown to be an effective treatment. This time-limited program targets the client's difficulty in interpersonal relationships' unresolved grief, role transitions, and interpersonal deficits. Given the enormity of change that can occur in the lives of lesbian, gay, bisexual and transgender clients, IPT may prove to be of particular interest for use with this population. IPT has demonstrated efficacy in two randomized clinical trials (Elkin, et al., 1989; & Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974) and has been shown to be an effective ongoing maintenance therapy following recovery from MDD (Frank, Kupfer, Perel, Cornes, Jarett, Mallinger, Thase, McEachran, & Grochocinski, 1990; & Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974). A treatment manual is available (Klerman, Weissman, Rounsaville, & Cheveron, 1984).

The addition of cognitive-behavioral or interpersonal therapies to standard primary care treatment for depression has been shown to improve outcome, although increasing cost slightly with some studies reported costs offset by reduction in use of specialty mental health resources (e.g. Katon, Toy-Byrne, Russo, & Cowley, 2002; Lave, Frank, Schulberg, & Kamlet, 1998; Von-Korff, Katon, Bush, Lin, Simon, Saunders, Ludman, Walker, & Unutzer, 1998).

Not only cognitive-behavioral or interpersonal approaches have been shown to be efficacious. Another promising treatment is Brief Dynamic Psychotherapy (Crits-Christoph & Barber, 1991; Donovan, 1987; Levenson, Butler, & Beitman, 1997). Though representing a variety of approaches to dynamic therapy in a brief format, this approach typically includes the use of a focal inquiry to locate recurrent disturbance, management of resistance, and resolution of missing capabilities (Gustafson, 1984). The goals include symptom improvement and increased insight (Gaston, Marmar, Thompson, & Gallagher, 1988; Hoglend, 1995). The authors of articles on this treatment have emphasized the need to assess patient suitability for the therapy, which includes circumscribed problems, motivation, and quality pretreatment relationships (Barber, Luborsky, Crits-Christoph, & Diguer, 1995). Brief dynamic psychotherapy has been successfully used in a group format (Cornish & Benton, 2001).

OUTCOME MEASURES

There are several questionnaires and inventories that can be used to measure outcomes in trials of these treatments. The Generalized Anxiety Disorder Questionnaire-IV (GAD-IV; Newman, Fuelling, Kachin, & Constantino, 2001) can be used as a brief screening device. Likewise, the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) can be used to assess pre and post treatment worry. It has been translated in to several different languages (Chorpita, Tracey, Brown, Colica, & Barlow, 1997) and there is a weekly assessment version to measure change over time (Stöber & Bittencourt, 1998). The Agoraphobic Cognitions Questionnaire (ACQ) and the Body Sensations Questionnaire (BSQ) (Chambless, Caputo, Bright, & Gallagher, 1984) are useful measures of panic disorder. For social phobia, the Brief Social Phobia Scale (BSPS; Davidson, Potts, Richichi, Ford, Krishnan, Smith, & Wilson, 1991) is an 18-item measure that also has a computerized version (Kobak, Schaettle, Greist, Jefferson, Katzelnick, & Dottle, 1998). Several measures of depression can be useful. For adults, the Beck Depression Inventory - Second Edition (BDI-II; Beck, Steer, & Brown, 1996) is widely used. The Brief Symptom Inventory (Derogatis, 1993) can also be used. For adolescents between the ages of 13 - 18, the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987) can be used. A clinician rated measure of depression, the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) is a standard measure used in research.

OTHER PRACTICES THAT HOLD PROMISE FOR GAY, LESBIAN, AND TRANSGENDER YOUTH AND ADULTS

According to Marsha Botzer, founder of the Ingersoll Gender Center in Seattle, contact with others that share similar experiences is vitally important for transgender, intersexed, or questioning youth and adults. The idea for such a center began in 1977. The Ingersoll Gender Center has been offering groups and individual counseling for the transgender community in Seattle since 1984. DeBord and Perez (2000) suggest that for lesbian women, gay men and bisexual men and women the need to find community and share experiences makes group intervention an opportune treatment. Unfortunately, there has been little outcome research on support groups or group counseling with this population, although many agencies offer such groups. DeBord and Perez (2000) describe the principles of group counseling put forth by Yalom (1995) and suggest that they are applicable to lesbian, gay, bisexual and transgender individuals who often feel isolated by the majority culture. Group interventions are often the

chosen treatment modality of lesbian and gay clients (Holahan, & Gibson, 1994). Peer counseling groups such as TalkSafe in New York City have been used to promote safe sex behavior among HIV-negative or untested gay and bisexual male youth. Seattle Counseling Services for Sexual Minorities also offers individual therapy and support groups for lesbian, gay, bisexual, transgender, and questioning youth and adults. Lambert House, a center for lesbian, gay, bisexual, transgender and queer youth offers support groups for transgender youth meaning those in their teens and early twenties. Seattle AIDS Support Group provides support groups for HIV-positive men and women, and their loved ones, and provides a support group for gender-varied people called "Gender Outlaws." This latter group is primarily for young adults in their mid-twenties and thirties. Most of these agencies receive funding through DSHS, although Ryan White Funds have been made available in the past for prevention programs with LGBT youth, and other granting agencies have provided funds for programming. There is little grant funding available for transgender programs.

References

Albano, A-M, & Kendall, P. C. (2002). Cognitive behavioral therapy for children and adolescents with anxiety disorders: Clinical research advances. *International Review of Psychiatry, 14(2),* 129-134.

American Psychiatric Association (1952). *Diagnostic and statistical manual of mental disorders* (1st ed.). Washington, DC: Author

American Psychiatric Association (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd edition, revised.). Washington, DC: Author

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author

American Psychiatric Association. (1998, December). *APA position statement on psychiatric treatment and sexual orientation*. Washington, DC: Author.

American Psychiatric Association. (2000). American Psychiatric Association commission on Psychotherapy by Psychiatrists position statement on *therapies focused on attempts to change sexual orientation (reparative or conversion therapies)*. Washington, DC: Author.

American Psychological Association. (2000). *Guidelines for psychotherapy with lesbian, gay and bisexual clients*. Washington DC: Author.

Antony, M. M., Orsillo, S. M., & Roemer, L. (2001). *Practitioner's guide to empirically based measures of anxiety*. New York: KluwerAcademic/Plenum.

Barber, J. P., Luborsky, L., Crits-Christoph, P., & Diguer, L. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63 (1),* 145-148.

Barlow, D.H. (2001a). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford.

Barlow, D. H., & Craske, M. G. (1994). *Mastery of your anxiety and panic (MAP II).*

Boulder, CO: Graywind Publications.

Barlow, D. H., Craske, M. G., Cerny, J. A., & Klosko, J. A. (1989). Behavioral treatment of panic disorder. *Behavior Therapy, 20,* 261-282.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression: A treatment manual.* New York: Guilford.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the BDI-II.* San Antonio, TX: The Psychological Corporation.

Beck, J. S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press.

Borkovec, T. D., & Costello, E. (1993). Efficacy of applied relaxation and cognitive-behavioral therapy in the treatment of generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 61(4),* 611-619.

Bradford, J., Ryan, C., & Rothblum, E. D. (1994). National lesbian health care survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology, 62*, 228–242.

Brown, L. S., (1994). *Subversive dialogues: Theory in feminist therapy.* New York: Basic Books.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S.,

Crits-Christoph, P., et al. (1998). Update on empirically validated therapies II. *The Clinical Psychologist, 51*, 3–16.

Chambless, D. L., Caputo, G. C., Bright, P., & Gallagher, R. (1984). Assessment of 'fear of fear' in agoraphobics: The Body Sensations Questionnaire and the Agoraphobic Cognitions Questionnaire. *Journal of Consulting and Clinical Psychology, 52,* 1090-1097.

Chorpita, B. F., Tracey, S. A., Brown, T. A., Collica, T. J., & Barlow, D. H. (1997). Assessment of worry in children and adolescents: An adaptation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 35,* 569-581.

Cochran, B. N., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health, 92*, 773–777.

Cochran, S. D., Keenan, C., Schober, C., & Mays, V. M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. population. *Journal of Consulting and Clinical Psychology, 68(6),* 1062-1071.

Cochran, S. D. & Mays, V. M. (2000). Relation between psychiatric syndromes and behaviorally defined sexual orientation in a sample of the US population. *American Journal of Epidemiology, 151*, 516–523.

Cochran, S. D., Sullivan, J. G. & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71,* 53–61.

Cornish, P. A., & Benton, D. (2001). Getting started in healthier relationships: Brief Integrated dynamic group counseling in a university counseling setting. *Journal For Specialists in Group Work, 26* (2), 129-143.

Côté, G., Gauthier, J. G., Laberge, B. Cormier, H. J., & Plamondon, J. (1994). Reduced therapist contact in the cognitive behavioral treatment of panic disorder. *Behavior Therapy, 25,* 123-145.

Craske, M. G., Brown, T. A., & Barlow, D. H. (1991). Behavioral treatment of panic disorder: A two-year follow-up. Behavior Therapy, 22, 289-304.

Crits, Christoph, P., & Barber, J. P. (Eds.) (1991). *Handbook of short-term dynamic psychotherapy*. New York: Basic Books.

D'Augelli, A. R. (1998). Developmental implications of victimization of lesbian, gay, and bisexual youths. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 187–210). Thousand Oaks, CA: Sage.

Davidson, J. R. T., Potts, N. L. S., Richichi, E. A., Ford, S. M., Krishnan, R. R., Smith, R. D., & Wilson, W. (1991). The Brief Social Phobia Scale. *Journal of Clinical Psychiatry, 52,* 48-51.

Derogatis, L. R. (1993). Brief Symptom Inventory (BSI) administration, scoring, and procedures manual (3rd ed.). Minneapolis, MN: National Computer Systems.

DiPlacido, J. (1998). Minority stress among lesbians, gay men, and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In, G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 138–159). Thousand Oaks, CA: Sage.

Donovan, J. M. (1987). Brief dynamic psychotherapy: Toward a more comprehensive model. *Psychiatry: Journal for the Study of Interpersonal Processes, 50 (2),* 167-183.

Durham, R. C., Murphy, T. Allan, T., Richard, K., Treliving, L. R., & Fenton, G. W. (1994). cognitive therapy, analytic psychotherapy and anxiety management training for generalized anxiety disorder. *British Journal of Psychiatry, 165,* 315-323.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, s. M., Collins, J. F., Glass, D. R., Pilkonis, P. A., Leber, W. R., Docherty, J. P., Fiester, S. J., & Parloff, M. B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry, 46,* 971-982.

Fassinger, R. E. (2000). Applying counseling theories to lesbian, gay, and bisexual clients: Pitfalls and possibilities. In, R. M. Perez, K. A. DeBord, & K. J. Bieschke, *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 107-132). Washington D.C.: American Psychological Association.

Finney, J. W., & Monahan, S. C. (1996). The cost-effectiveness of treatment for alcoholism: A second approximation. *Journal of Studies on Alcoholism 57,* 229-243.

Frank, E., Kupfer, D. J., Perel, T. M., Cornes, C. L., Jarett, D. J., Mallinger, A., Thase, M. E., McEachran, A. B., & Grochocincski, V. J. (1990). Three-year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry, 47,* 1093-1099.

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. American *Psychologist, 46*, 964–972.

Gaston. L., Marmar, C. R., Thompson, L. V., & Gallagher, D. (1988). Relation of patient pretreatment characteristics to the therapeutic alliance in diverse psychotherapies. *Journal of Consulting and Clinical Psychology, 56 (4),* 483-489.

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *American Journal of Public Health, 91*, 933–939.

Glassgold, J. M., & Iasenza, S. (Eds.) (1995). *Lesbians and psychoanalysis: Revolutions in theory and practice.* New York: Free Press.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment, 23(1),* 21-32.

Gonsiorek, J. C. (1982). The use of diagnostic concepts in working with gay and lesbian populations. In J. C. Gonsiorek (Ed.), *Homosexuality and psychotherapy: A practitioner's handbook of affirmative models* (pp. 9–20). New York: Haworth Press.

Gustafson, J. P. (1984). An integration of brief dynamic psychotherapy. *American Journal of Psychiatry, 141 (8),* 935-944.

Greenberg, P. E., Sisitsky, T., Kessler, R. C., Finkelstein, S. N., Berndt, E. R., Davidson, J. R. T., Ballenger, J. C., & Fyer, A. J. (1999). The economic burden of anxiety disorders in the 1990s, *Journal of Clinical Psychiatry, 60(7),* 427-435.

Greenberger, D. & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think.* New York: Guilford Press.

Hamilton, M. (1960). A rating scale for depression. Journal of Neurology, *Neurosurgery, and Psychiatry, 23,* 56-62.

Heimberg, R. G., Dodge, C. S., Hope, D. A., Kennedy, C. R., Zollo, L., & Becker, R. E. (1990). Cognitive-behavioral group treatment for social phobia: Comparison to a credible placebo control. *Cognitive Therapy and Research, 14*, 1-23.

Heimberg, R. G., Juster, H. R., Brown, E. J., Holle, C., Makris, G. S., Lueng, A. W., Schneier, F. R., Gitow, A., & Liebowitz, M. R. (1994, November). Cognitive-behavioral versus pharmacological treatment of social phobia: Post-treatment and follow-up effects. Paper presented at the annual meeting of the Association for Advancement of Behavior Therapy, San Diego, CA.

Herrell, R., Goldberg, J. G., True, W. R., Ramakrishnan, V., Lyons, M., Elsen, S., et al. (1999). Sexual orientation and suicidality: A co-twin control study in adult men. *Archives of General Psychiatry, 56*, 867-874.

Hoglend, P. (1995). Brief dynamic psychotherapy in psychiatry. *Nordic Journal of Psychiatry, 49 (Suppl 34),* 81-83.

Holahan, W. & Gibson, S. A. (1994). Heterosexual therapists leading lesbian and gay therapy groups: Therapeutic and political realities. *Journal of Counseling and Development, 44*, 591-594.

Holder, H., Longabaugh, R., Miller, W. R., & Rubonis, A. V. ((1991). The cost effectiveness of treatment for alcoholism: A first approximation. *Journal of Studies on Alcoholism, 52*, 517-540.

Holleran, P. R., & Novak, A. H. (1989). Support choices and abstinence in gay/lesbian and heterosexual alcoholics. *Alcoholism Treatment Quarterly, 6(2),* 71-83.

Hollon, S. D., DeRubeis, R. J., Evans, M. D., Wiemer, M. J., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1992). Cognitive therapy and pharmacotherapy for depression: Singly and in combination. *Archives of General Psychiatry, 49*, 774-781.

Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques, 21*, 18–31.

Huxdly, J. & Brandon, S. (1981). Partnership in transsexualism: Part I. Paired and non paired groups. *Archives of Sexual Behavior, 10,* 133-141.

Johnson, J., D. (2001). The effects of a brief cognitive-behavioral group intervention on the depression and hopelessness of drug dependent, human immunodeficiency virus-positive,

African-American women (immune deficiency). *Dissertation Abstracts International: Section B: The Sciences and Engineering, 62(1-B),* 551.

Jones, M. A. & Gabriel, M. A. (1999). Utilization of psychotherapy by lesbians, gay men, and bisexuals: Findings from a nationwide survey. *American Journal of Orthopsychiatry, 69,* 209–219.

Katon, W. J., Roy-Byrne, P., Russo, J., & Cowley, D. (2002). Cost effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder, *Archives of General Psychiatry, 59(12),* 1098-1104.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male.* Philadelphia: W. B. Saunders.

Klerman, G. L., DiMascio, A., Weissman, M., Prusoff, B., & Paykel, E. S. (1974). Treatment of depression by drugs and psychotherapy. *American Journal of Psychiatry, 131*, 186-190.

Klerman, G. L, Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression.* New York: Basic Books.

Kobak, K. A., Schaettle, S. C., Greist, J. H., Jefferson, J. W., Katzelnick, D. J., & Dottle, S. L. (1998). Computer-administered rating scales for social anxiety in a clinical drug trial. *Depression and Anxiety, 7*, 97-104.

Lave, J. R., Frank, R. G., Schulbert, H. C., & Kamlet, M. S. (1998). Cost-effectiveness of treatments for major depression in primary care practice. *Archives of General Psychiatry, 55(7),* 645-651.

Levensen, H., Butler, S. F., & Beitman, B. D. (1997). *Concise guide to brief dynamic psychotherapy.* Washington D. C.: American Psychiatric Press.

Lidren, D. M., Watkins, P. L., Gould, R. A., Clum, G. A., Asterino, M., & Tulloch, H. L. (1994). A comparison of bibliotherapy and group therapy in the treatment of panic disorder. *Journal of Consulting and Clinical Psychology, 62,* 865-869.

Luborsky, L. & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method*. New York: Basic Books.

Martell, C. R., Safren S. A., & Prince, S. E. (In press). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients.* New York: Guilford Press.

Meyer, I. H., & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In G. M. Herek (Ed.), *Stigma, and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals: Psychological perspectives on lesbian and gay issues* (Vol. 2, pp. 160–186). Thousand Oaks, CA: Sage.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behavior Research and Therapy, 28*, 487-495.

Meyers, R. J. & Smith, J. E. (1995). Clinical guide to alcohol treatment: The community reinforcement approach. New York: Guilford Press.

Miller, W. R., Brown, J. M., Simpson, T. L., Handmaker, N. S., Bien, T. H., Luckie, L. F., Montgomery, H. A., Hester, R. K., & Tonigan, J. S. (1995). What works? A methodological analysis of the alcohol treatment outcome literature. In R. K. Hester & W. R. Miller (Eds.), Handbook of alcoholism treatment approaches: Effective alternatives (2nd ed., pp. 12-44). Boston: Allyn Bacon.

Miller, R. W., Meyers, R. J., & Hiller-Sturmhofel, S. (1999). The community-reinforcement approach. Alcohol Research & Health, 23, 116-121.

Najavits, L. M., Weiss, R. D., Shaw, S. R., Muenz, L. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with Post-traumatic Stress Disorder and Substance Dependence. Journal of Traumatic Stress, 11, 437-456.

National Association of Social Workers (1996). *Code of Ethics of the National Association of Social Workers.* Retrieved October 2, 2000, from *http://www.naswdc.org/Code/ethics.htm*

Newman, M. G., Zuellig, A. R., Kachin, K. E., & Constantino. M. J. (2001). The reliability and validity of the GAD-Q-IV: A revised self-report measure of generalized anxiety disorder. Manuscript submitted for publication. Cited in M. M. Antony, S. M. Orsillo, & L. Roemer (Eds.), *Practitioner's Guide to Empirically Based Measures of Anxiety,* 2001, New York: Kluwer Academic/Plenum Publishers.

Padesky, C. A., & Greenberger, D. (1995). *Clinician's guide to Mind over Mood* New York: Guilford Press.

Peterson, R. A., & Reiss, S. (1993). Anxiety Sensitivity Index Revised test manual. Worthington, OH: IDS Publishing Corporation.

Power, K. G., Simpson, R. J., Swanson, V., Wallace, L. A., Feistner, A.T.C., & Sharp, D (1990). A controlled comparison of cognitive-behavior therapy, diazepam, and placebo, alone and in combination, for the treatment of generalized anxiety disorder. *Journal of Anxiety Disorders, 4*, 267-292.

Purcell, D. W., Campos, P.E., & Perilla, J.L. (1996). Therapy with lesbians and gay men: A cognitive behavioral perspective. *Cognitive and Behavioral Practice, 3*(2), 391-415.

Remafedi, G. (1994). The state of knowledge on gay, lesbian, and bisexual youth suicide. In G. Remafedi (Ed.), *Death by denial: Studies of suicide in gay and lesbian teenagers* (pp. 7–14). Boston: Alyson.

Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics 87 (6),* 869-875.

Reynolds, W. M. (1987). Reynolds Adolescent Depression Scale: Professional manual. Odessa, FL: Psychological Assessment Resources.

Ritter, K. Y. & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men.* New York: Guilford.

Safren, S. A., & Heimberg, R. G. (1998). Suicidality in gay, lesbian, and bisexual youth. *The Behavior Therapist, 21,* 147–152.

Safren, S.A., Hollander, G., Hart, T.A., Heimberg, R.G. (2001). Cognitive-behavioral therapy with lesbian, gay, and bisexual youth. *Cognitive and Behavioral* Practice, 8, 215-223.

Savin-Williams, R.C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance use, prostitution, and suicide. *Journal of Consulting and Clinical Psychology, 62*, 261-269.

Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology, 69*, 983–991.

Savin-Williams, R.C., & Cohen, K.M. (1996). Psychosocial outcomes of verbal and physical abuse among lesbian, gay, and bisexual youths. In R.C. Savin-Williams & K.M. Cohen (Eds.), *The lives of lesbians, gays, and bisexuals: Children to adults* (pp. 181-194). Orlando, FL: Harcourt Brace.

Shifrin, F., & Solis, M. (1992). Chemical dependency in gay and lesbian youth. *Journal of Chemical Dependency Treatment, 5 (1),* 67-76.

Simons, A. D., Murphy, G. E., Levine, J. L., & Wetzel, R. D. (1986). Cognitive therapy and pharmacotherapy for depression. *Archives of General Psychiatry, 43,* 43-48.

Smith, J. E., & Meyers, R. J. (2000). The community reinforcement approach for treating alcohol problems. In M. J. Dougher (Ed.), Clinical Behavior Analysis. (pp. 207- 230). Reno: Context Press.

Smith, J. E., Meyers, R. J., & Delaney, H. D. (1998). The community reinforcement approach with homeless alcohol-dependent individuals. *Journal of Consulting and Clinical Psychology, 66,* 541-548.

Smith, J. E., Meyers, R. J., & Miller, W. R. (2001). The community reinforcement approach to the treatment of substance use disorders. *American Journal on Addictions, 10(Supplement),* 51-59.

Snow, M. G., Prochaska, J. O., & Rossi, J. (1994). Processes of change in Alcoholics Anonymous: Maintenance factors in long-term sobriety. *Journal of Studies on Alcohol, 55,* 362-371.

Stöber, J. & Bittencourt, J. (1998). Weekly assessment of worry: An adaptation of the Penn State Worry Questionnaire for monitoring changes during treatment. *Behaviour Research and Therapy, 30,* 33-37.

Taub, J. (1999). Bisexual women and beauty norms: A qualitative examination. *Journal of Lesbian Studies, 3,* 27–36.

Von-Korff, M., Katon, W., Bush, T., Lin, E. H. B., Simon, G. E., Saunders, K., Ludman, E., Walker, E., & Unutzer, J. (1998). Treatment costs, cost offset, and cost- effectiveness of collaborative management of depression. *Psychosomatic Medicine, 60(2),* 143-149.

Vostanis, P., Feehan, C., Grattan, E., & Bickerton, W-L. (1996). Treatment for children and adolescents with depression: Lessons from a controlled trial. *Clinical Child Psychology and Psychiatry, 1(2),* 199-212.

Wolfe, B. L., & Meyers, R. J. (1999). Cost-effective alcohol treatment: The community reinforcement approach. *Cognitive and Behavioral Practice, 6,* 105-109.

Resource Guide

LGBT-Affirmative/Feminist Therapies

Description:

Lesbian, Gay, Bisexual, and Transgender (LGBT) – Affirmative Therapies and Feminist Therapies are approaches to treatment that transcend typical theoretical ideas or treatment models. The approaches share common philosophical concepts that allow practitioners of other treatments (e.g. cognitive-behavioral therapies; community-based programs) to practice competently with lesbian, gay, bisexual and transgender clients. Philosophical ideas at the heart of both of these approaches are:

- Emphasis on the individual and the context of each person's experience.
- Heterosexuality is not assumed the norm by which to compare all people.
- Gender and sexual orientation are seen as constructs that vary from culture to culture.
- Lesbian, gay, bisexual sexual orientations are considered of equal value as heterosexual orientations.
- Gender is not identified by biology alone.

Evaluating this practice:

Outcome measures used to evaluate practice: LGBT-affirmative and feminist approaches to treatment have been studied from theoretical perspectives, but there are few traditional outcome studies. Outcome measures used in general practice to determine improvement in client symptoms can be used in this approach. However, therapists must take care not to use instruments that are gender biased, or that invalidate lesbian, gay, bisexual or transgender experience. For example, outcome measures for treating social anxiety that refer only to "fear of interactions with attractive persons of the opposite sex" imply heterosexuality and disallow anxiety about attraction to someone of the same sex. Likewise, "marital" therapy questionnaires invalidate unmarried, cohabitating couples. Finally, demographic data that forces people to choose between male or female in gender questions can invalidate the experience of transgender, transsexual, intergender, or questioning individuals. These cautions should be applied to make program outcome measures culturally sensitive to the population being evaluated.

Evidence supporting practice:

The evidence supporting the practice of lesbian, gay, bisexual affirmative, or feminist approaches comes less from traditional randomized clinical trials, and more from surveys of harm that has been done to lesbian, gay, bisexual or transgender individuals in therapy. Since affirmative and feminist approaches are mostly philosophical stances that can be applied with most traditional therapies, the evidence from studies of where therapy has failed this population is most useful (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991)

1. **Peer reviewed research:** There have been a number articles or book chapters written on the issues facing lesbian, gay, bisexual or transgender individuals in therapy. Because traditional outcome studies do not apply as easily to such a philosophical stance that does not require specific therapeutic techniques, the research on appropriate response is best utilized to inform practitioners (American Psychiatric Association, 1994; American Psychological Association, 2000). Professional codes of ethics also address this issue (e.g. American Psychological Association, 2002; National Association of Social Workers, 1996).

Practice implementation:

1. **Staffing requirements**: Affirmative and feminist approaches can be applied to traditional individual therapies and to groups. A psychologist or mental health professional with expertise in the area would be required to supervise other counselors. Staffing needs would be dictated by the number of clients seen in a given program and whether they were seen in individual therapy or groups.

2. **Training requirements**: This approach can be applied to any of the traditional, empirically supported approaches referred to in this document. Training can be accomplished through reading appropriate literature on lesbian, gay, bisexual and transgender development and on feminist or contextual philosophy. A workshop to address the specific questions of staff can also be used. On-going supervision can be conducted in groups to assure that staff is culturally sensitive to this population.

3. **Cost of program**: Applying a lesbian, gay, bisexual and transgender affirmative approach to treatment would not raise cost of programming after the initial training.

4. **Use of natural funding**: Adding this approach to traditional practices of an agency can be funded by any process in which programming as usual is funded. Initial training, could be funded from an ongoing in-service education budget.

Other considerations:

Contact information:

American Psychological Association – Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
Association of Gay and Lesbian Psychiatrists

Relevant websites:

www.apa.org/div44
www.aglp.org

Community Reinforcement Approach

Description:

1. **Primary purpose:** The Community Reinforcement Approach (Meyers & Smith, 1995) to treating substance abuse problems was designed to make changes in a client's daily environment, reduce substance abuse and promote healthy living. This broad-spectrum behavioral approach utilizes social, recreational, familial, and vocational reinforcers to assist in the recovery process. The overall goal is to make the client's sober environment more reinforcing than one involving alcohol or drugs (Smith & Meyers, 2000). The treatment approach utilizes motivational techniques and positive reinforcement. The client is actively involved in determining what contingencies maintain his or her drinking behavior and what will elicit change (Wolfe & Meyers, 1999).

2. **Target populations**: The community reinforcement approach has been shown to have good evidence of effect with alcohol abusers. The approach has not been directly applied with lesbian, gay, bisexual or transgender clients. However, using the Guidelines for psychotherapy from the American Psychological Association (Amer. Psychological Assoc., 2000), practitioners could easily apply this approach to lesbian, gay, bisexual, or transgender substance abusers. The community reinforcement approach, and models incorporating aspects of this approach have been used with adults and adolescents (Godley, Godley, Dennis, Funk, & Passeti, 2002) who abuse alcohol and marijuana.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: The community reinforcement approach has been measured according to number of days of abstinence for alcohol abusers, and urinalysis for studies with opiate abusers (Smith, Meyers, & Delaney, 1998). It has been reported as one of the "top six" treatment modalities that have strong empirical support based on meta-analytic evaluations (Miller, et al., 1995).

Evidence supporting practice:

1. **Peer reviewed research**: This treatment approach has been studies in several randomized clinical trials. There have been three meta-analytic studies that have concluded that it is one of the top six treatment modalities for substance abuse (Finney & Monahan, 1996; Holder et al., 1991; Miller et al., 1995). An assertive continuing care program that incorporated case management and the adolescent community reinforcement approach was used to study marijuana and alcohol use, and access to

continuing care fore 114 adolescents discharged after at least 7-days in residential treatment. The participants receiving assertive continuing care (that includes CRA) were more likely to initiate continuing services and to be abstinent from marijuana, and have reduced alcohol consumption three months following discharge. Smith, Meyers, & Miller reviewed the treatment studies on community reinforcement approach and found that in three meta-analytic studies the approach was ranked as one of the most efficacious and cost-effective alcohol interventions.

2. **Other supporting documents**: There is a treatment manual available (Meyers & Smith, 1995).

Practice implementation:

1. **Staffing requirements**: This is an individual treatment modality, and would require that the number of clinical staff be sufficient to meet the caseload for individual therapy.

2. **Training requirements**: This approach incorporates several standard behavior therapy practices and could be easily learned by mental health professionals with basic behavioral backgrounds. A treatment manual can be used to assist in training.

3. **Cost of program**: In meta-analytic studies, the treatment fell in the category of low to medium cost (from $0 - $599). Outcome studies in outpatient settings have demonstrated that alcohol-dependent patients received an average of five to eight weekly sessions of community reinforcement approach treatment and is likely to be highly cost-effective and easily transferred to outpatient settings (Miller, Meyers, & Hiller-Sturmhöfel (1999).

4. **Use of natural funding**: This program is endorsed by NIDA and backed by empirical research. It is an individually administered psychotherapeutic technique and would be reimbursable by insurance, or is affordable for some clients to pay fee for service.

Other considerations:

Contact information:

Relevant websites:

http: //www.peele.net/faq/cra.html

Cognitive-Behavior Therapy for Generalized Anxiety Disorder

Description:

1. **Primary purpose**: Given the findings that gay men, lesbians and bisexual men and women have higher rates of generalized anxiety than heterosexual counterparts, it is reasonable to apply psychosocial treatment that has been empirically evaluated with this population when individuals meet diagnostic criteria for generalized anxiety disorder. Cognitive-behavior therapy (CBT) addresses several components of anxiety, targeting the physiological component through progressive relaxation, the behavioral component through graduated exposure exercises to reduce avoidance, and the cognitive component through cognitive restructuring to modify anxious thoughts and lack of self-confidence.

2. **Target populations**: Cognitive-behavior therapy has been used with a variety of client populations and with a variety of disorders. CBT for anxiety disorders has been shown to be efficacious in a number of studies, but has never been evaluated specifically with a gay, lesbian or bisexual population. it is indicated, however, for adults with generalized anxiety disorder. There is also evidence that cognitive-behavioral therapy is efficacious in the treatment of common childhood anxiety disorders - separation anxiety, social phobia, and generalized anxiety disorders (Albano & Kendall, 2002).

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: There are several useful, inexpensive assessment tools for evaluating the effectiveness of CBT for generalized anxiety disorder. The Generalized Anxiety Disorder Questionnaire-IV (GADQ-IV; Newman, Zuellig, Kachin, & Constantino, 2001) can be used as a brief screening for GAD. It can be used at pre-test and as a post-test measure. The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) is an good tool for assessing general tendency to worry, and is a 16-item self-report questionnaire. The scale has been translated into Chinese, Dutch, French, German, Greek, Italian, Spanish , and Thai, and there is a child and adolescent version (Chorpita, Tracey, Brown, Colica, & Barlow, 1997). There is also a weekly assessment version to measure change over time (Stöber & Bittencourt, 1998)

2. **Qualitative evaluation**: Client report of reduction in worry, and increases in approaching previously avoided situations can be used to assess improvement.

Evidence supporting practice:

1. **Peer reviewed research**: Cognitive-behavior therapy for generalized anxiety disorder has been shown to be more effective than non-directive therapy (Borkovec & Costello, 1993), analytic therapy (Durham, et al., 1994) and benzodiazepine medication (Power et al., 1990).

2. **Other supporting documents**: Beck, A. T., & Emery, G. (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic Books. Zinbarg, R. E., Craske, M. G., & Barlow, D. H. (1993). Therapist Guide to Mastery of Your anxiety and worry. Boulder, CO: Graywind Publications.

Practice implementation:

1. **Staffing requirements**: Although little research has been done on cognitive-behavior group therapy for generalized anxiety disorder, CBGT has been successfully utilized with other disorders such as social phobia. conducting the therapy in a group format could reduce staffing requirements, with one staff member per 8 to 10 clients.

2. **Training requirements**: General background in mental health counseling. There are workshops available around the country that consists of two-day, to one-week training.

3. **Cost of program**: There is little cost offset data, however, most CBT protocols consist of brief therapy lasting from 12 to 20 weeks.

4. **Use of natural funding**: CBT has been successfully employed in outpatient treatment settings that do not rely on grant funding.

Other considerations:

Contact information:

Center for Anxiety and Related Disorders

Relevant websites:

www.bu.edu/anxiety/

Panic Control Treatment

Description:

1. **Primary purpose**: There is some evidence that gay and bisexual men are more vulnerable to panic disorder with and without agoraphobia than heterosexual men. Panic control treatment (Barlow & Craske, 1994) has demonstrated results reducing panic up to two-years following treatment. The treatment focuses on exposing the client to interoceptive sensations that resemble the physiological experience of panic. Cognitive restructuring is used to reduce the client's misconceptions about anxiety. Breathing retraining corrects tendencies to hyperventilate in some clients with panic disorder. For panic with agoraphobia, in-vivo exposure (i.e. exposure to the actual feared situation) is necessary and has been shown to be the most effective treatment for agoraphobia.

2. **Target populations**: Adults with panic disorder, with and without agoraphobia. There are no data on the use of this treatment exclusively with lesbian, gay, bisexual or transgender individuals.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: There are several questionnaires that can be used to evaluate the outcome of this practice with clients. The Agoraphobic Cognitions questionnaire (ACQ) and the body sensations questionnaire (BSQ; Chambless, Caputo, Bright, & Gallagher, 1984).

Qualitative evaluation

1. **Evidence supporting practice:** Peer reviewed research: Barlow, Craske, Cerney, & Klosko, (1989) compared panic control treatment with relaxation alone and panic control treatment combined with relaxation to a waiting-list control. All three treatment conditions were more effective than waiting list, 87% of clients in the panic control treatment conditions (alone or combined) were panic free at the conclusion of the study. Eighty -one percent of the clients who had received panic control therapy alone remained panic free at two-year follow-up (Craske, Brown, & Barlow, 1991).

2. **Other supporting documents**: There is a training manual available. Barlow, D. H., & Craske, M. G. (1994). Mastering your anxiety and panic (maps II). Boulder, CO: Graywind publications. Graywind publications also sell a series of training tapes for therapists (approximately $500 for the set).

Practice implementation:

1. **Staffing requirements**: Panic control therapy is an individualized treatment and requires one-on-one time with a therapist. However, studies comparing weekly therapist contact with bi-monthly one -hour contact, supplemented by bi-monthly 10-minute telephone contact have shown that the reduced therapist contact is equally effective to weekly one-hour sessions (Côté, Gauthier, Laberge, Cormier, & Plamondon, 1994). Furthermore, Panic control therapy has been conducted in group format, and can be conducted using a self-help manual, self-directed by the client, both in an 8-week treatment program (Lidren et al., 1994).

2. **Training requirements**: Staff can be easily trained in this method with use of the therapist guide and training tapes.

3. **Cost of program**: Direct costs are difficult to determine, but this treatment is considered a cost-effective treatment for panic with or without agoraphobia.

4. **Use of natural funding**: This is a brief, inexpensive therapy and can easily be funded without grant money.

Other considerations:

Contact information:

Center for Anxiety and Related Disorders

Relevant websites:

www.bu.edu/anxiety/

Cognitive Behavioral Group Therapy for Social Phobia

Description:

1. **Primary purpose**: The purpose of cognitive behavioral therapy (Heimberg, Dodge, Hope, Kennedy, Zollo, & Becker, 1990) for social phobia is to use in-session exposure exercises, cognitive restructuring and homework exposure to reduce negative self-evaluation and improve social functioning of clients with social phobia. This treatment is particularly important with young men who have sex with men because social anxiety can reduce adherence to safe sex behaviors.

2. **Target populations**: There have not been large scale treatment studies of CBGT with lesbian, gay, bisexual or transgender adolescents or adults, but studies are underway using this approach to encourage safer sex practices by increasing social skills with gay and bisexual male youth.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: The brief social phobia scale (BSPS; Davidson, Potts, Richichi, Ford, Krishnan, Smith, & Wilson, 1991) is an excellent measure utilizing observer-ratings. It is an 18-item measure consisting of three subscales: fear, avoidance, and physiological arousal. There is also a computerized version of the BSPS; Kobak, Schaettle, Greist, Jefferson, Katzelnick, & Dottle, 1998).

2. **Qualitative evaluation**: CBGT lends itself well to qualitative studies of reports of the group members' experiences both within group and in external social settings.

Evidence supporting practice:

1. **Peer reviewed research**: There have been several peer reviewed articles attesting to the efficacy of cognitive-behavioral group treatment for social phobia. A large multi-site study (Heimberg, et al., 1994) found CBGT to be as effective as phenelzine after 12-weeks of treatment, with 75% of clients showing improvement, and clients treated with CBGT maintained gains at follow-up whereas a number of those treated with phenelzine did not.

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements**: Because treatment is conducted in a group format, therapists/client ratios of 1 to 8 or 10 are sufficient.

2. **Training requirements**: Therapists with experience in general mental health counseling can be easily trained in this approach.

3. **Cost of program**: Treatment consists of 12-weeks of group intervention sessions meeting once per week. This is a relatively low cost program.

4. **Use of natural funding**: The treatment is for people diagnosed with social phobia and would be reimbursable by insurance.

Other considerations:

Contact information:

Center for Anxiety and Related Disorders

Relevant websites:

www.bu.edu/anxiety/

Cognitive Therapy For Depression

Description:

1. **Primary purpose**: Cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1989) also referred to as cognitive-behavioral therapy for depression is one of the most widely studied treatments for major depressive disorder. The purpose of this treatment is the amelioration of dysfunctional beliefs and behaviors commonly associated with major depressive disorder.

2. **Target populations**: Cognitive therapy for depression has been successfully applied with a variety of patient populations. There are several single-case examples of using this approach with lesbian, gay, and bisexual adults. Cognitive-behavioral therapy has also been shown to be efficacious in the treatment of childhood and adolescent depression (Vostanis, Feehan, Grattan, & Bickerton, 1996). Furthermore, brief cognitive-behavioral therapy has been efficacious in treatment of depression and hopelessness in a sample of

African-American women who were also drug dependent and HIV-seropositive (Johnston, 2001)

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: There are three screening methods for measuring the outcome of treatment with CT for depression. The beck depression inventory - Second Edition (BDI-II; Beck, Steer, & Brown, 1996), is a widely used self-report measure. An additional self-report measure, the Brief Symptom Inventory (Derogatis, 1993) can also be used with adolescents and adults. For adolescent clients, the Reynolds adolescent depression scale (RADS; Reynolds, 1987) is useful for youth between the ages of 13 - 18.

2. **Qualitative evaluation**

Evidence supporting practice:

1. **Peer reviewed research**: The effectiveness of the cognitive-behavioral treatment for depression has been demonstrated in numerous studies. It has been shown to be as effective as tricyclic antidepressant medications (Elkin et al., 1989; Hollon et al., 1992, Simons, Murphy, Levine, & Wetzel, 1986) and has been shown to be equally effective in all but the Elkin et al. study, which has not been replicated.

2. **Other supporting documents**:; There are several good treatment manuals. The original Beck, Rush, Shaw, & Emery, 1979 is an excellent training manual. J. S. Beck, 1995 is also a useful manual. There are several self-help programs as well, most notably Mind Over Mood by Greenberger & Padesky, 1995 which has an accompanying therapist manual (Padesky & Greenberger, 1995) that has suggestions for conducting group treatment.

Practice implementation:

1. **Staffing requirements**: CBT for depression is roughly a 12 - 24 week protocol, and can be run in groups, reducing staffing needs.

2. **Training requirements**: Training in CBT for depression is available in a number of workshops, and there are training tapes available from the beck institute of cognitive therapy.

3. **Cost of program**: Like other CBT treatments, the treatment for depression is a minimal to moderately expensive treatment. Cost-offset data has shown that CBT added to practice as usual in a primary care setting improves treatment outcome for depressed patients, but no significant cost-offsets were found (Lave, Frank, Schulberg, & Kamlet, 1998). However, Von-Korff and colleagues (1998) did find a modest cost offset due to reduced use of specialty mental health services when consulting psychologists provided brief cognitive-behavioral therapy supplemented by educational materials and enhanced pharmacotherapy management in a primary care setting.

4. **Use of natural funding**: the program can utilize natural funding easily.

Other considerations:

Contact information:

Beck Institute for Cognitive Therapy and Research
Center for Cognitive Therapy – Newport Beach

Relevant websites:

www.beckinstitute.org
www.padesky.com

Interpersonal Therapy for Depression

Description:

1. **Primary purpose**: Interpersonal therapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) is a time-limited (12-16 week) treatment intervention that suggests that a client's interpersonal relationships may play a significant role in onset and maintenance of depressive symptoms. Problem areas addressed in IPT are the client's difficulty in interpersonal functioning, unresolved grief, role transitions and interpersonal deficits.

2. **Target populations**: IPT has been studied in two large randomized control trials, and appears to have favorable results with the general population. There have been no studies directly related to gay, lesbian, bisexual or transgender men and women. The treatment appears to work best with clients that have low rather than high levels of social dysfunction.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: The Hamilton rating scale for depression (HRSD; Hamilton, 1960) has been used in clinical studies of IPT for depression and is a good, clinician administered measure of depression. The Reynolds Adolescent depression Scale (RADS; Reynolds, 1987) can be used for clients aged 13-18.

2. **Qualitative evaluation**

Evidence supporting practice:

1. **Peer reviewed research**: There have been two major randomized control trials of IPT (Elkin, et al., 1989; Klerman, DiMascio, Weissman, Prusoff, & Paykel,1974), and as an ongoing maintenance therapy following recovery (Frank, Kupfer, Perel, Cornes, Jarett, Mallinger, Thase, McEachran, & Grochocinski, 1990; Klerman, DiMascio, Weissman, Prusoff, & Paykel,1974).

2. **Other supporting documents**: Klerman, G. L, Weissman, M. M., Rounsaville, B. J., & Cheveron, E. S. (1984). Interpersonal psychotherapy of depression. New York: Basic Books.

Practice implementation:

1. **Staffing requirements**: Requires one to one therapist/client contact.

2. **Training requirements**: A training program in Pittsburgh is available that requires 40 hours of training and supervision of two cases using videotapes.

3. **Cost of program**: As the other treatments in this resource list, IPT is a short-term, cost-effective treatment.

4. **Use of natural funding**: Easily funded by insurance, Medicare, or client self-pay.

Other considerations:

Contact information:

Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213
(412) 624-2211

Relevant websites:

Brief Dynamic Psychotherapy for Depression

Description:

1. **Primary purpose**: Brief Dynamic Psychotherapy is an application of psychodynamic principles to the treatment of depression in a focused, short-term format. Brief Dynamic Psychotherapy makes use of the Core Conflictual Relationship Theme method (Luborsky & Crits-Christoph) that focuses on identifying relationship episodes that clients typically talk about or enact in therapy sessions. Clients are then helped to find ways of coping with such conflicts. The treatment is short-term for practical rather than theoretical purposes, and no outcome studies have tested the benefit of shorter term versus longer-term therapy.

2. **Target populations**: The Brief Dynamic Psychotherapy approach has been used with a number of individuals. However, certain capacities in clients are considered necessary for the treatment to be effective. Clients must be have the capacity to form and sustain trusting and mutual relationships and they should be motivated and able to discuss central problems early in therapy, otherwise treatment would focus on helping clients to develop such capacities (Gaston, Marmar, Thompson, & Gallagher, 1988). The treatment has been used with elderly depressed patients (Gaston, et al., 1988) and with a general outpatient population meeting diagnostic criteria for Major Depressive Disorder (Barber, Luborsky, Crits-Christoph, & Diguer, 1995). There are no studies reporting specific use with lesbian, gay, bisexual or transgender populations.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Brief Dynamic Psychotherapy has been compared to behavior therapy and cognitive therapy for depression. However, the goals of treatment are different in brief dynamic therapy than in the cognitive-behavior therapies, and comparisons are difficult. Nevertheless, brief dynamic therapy has been shown to improve client's ratings on traditional measures of depression.

Evidence supporting practice:

1. **Peer reviewed research**: This treatment approach has been used successfully in the treatment of depression. The goals of this therapy are symptom improvement and increased insight (Hoglend, 1995).

2. **Other supporting documents**: There is a treatment manual for this treatment, which brings together a diverse literature on the topic to guide therapists in this approach (Crits-Christoph & Barber, 1991) and a brief guide to the approach (Levenson, Butler, & Beitman, 1997).

Practice implementation:

1. **Staffing requirements**: This is an individual treatment modality, and would require that the number of clinical staff be sufficient to meet the caseload for individual therapy. There is limited evidence that the approach can be conducted in a group format (Cornish & Benton, 2001).

2. **Training requirements**: This approach incorporates several standard psychodynamic therapy practices and could be easily learned by mental health professionals with basic such backgrounds. In empirical studies, therapists have had one year of post-graduate training in a psychodynamic approach. A treatment manual can be used to assist in training.

3. **Cost of program**: The cost of implementing this approach has not been determined. However, it has been applied individually in six to twenty sessions of therapy and would, therefore, be considered a moderately expensive treatment.

4. **Use of natural funding**: This approach can be conducted with funding from fee for service reimbursement or government supplemental funding for mental health care.

Other considerations:

Contact information:

Relevant websites:

Group Counseling Theory

Promising Strategy

Description:

1. **Primary purpose**: DeBord and Perez (2000) suggest that group counseling offers unique benefits to lesbian, gay, and bisexual clients. For transgender individuals, discrimination and hostility at the workplace, in the community and in the medical community can lead to feelings of isolation and shame. Contact with other transgender individuals that suffer the same challenges in a hostile environment can lead to improved mental health, and may prevent serious depression or hopelessness. Therefore, group counseling is useful for this group of individuals as well. Group counseling offers participants the opportunity to share concerns and insights with others facing similar life challenges. Yalom (1995) presented several goals of group counseling: instilling hope, recognizing the universality of experience, imparting information, developing social skills, imitating the behavior of others through observation, an opportunity for altruism, group cohesion, interpersonal learning, and catharsis.

2. **Target populations**: There are very few studies with gay and bisexual men, and relatively no studies with women or transgender adults. However, the treatment is well suited for lesbian, gay, bisexual, and transgender youth and adults, and is the treatment that is self-selected by many LGBT people (Holohan & Gibson, 1994).

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:

2. **Qualitative evaluation**: group process and group dynamics have been reported most frequently in anecdotal descriptions of the positive outcomes of group counseling.

Evidence supporting practice:

1. **Peer reviewed research**: There is little empirical evidence supporting group therapy in general. However, evidence from cognitive-behavioral group therapy for social phobia, and for depression, suggests that group counseling and therapy is a highly effective technique.

2. **Other supporting documents**: Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.

Practice implementation:

1. **Staffing requirements**: Staff to client ratios can vary depending on the type of group. Facilitated support groups can be substantially large in number, whereas psychotherapy groups for specific problems such as social phobia, should be limited to 8 to 10 clients.

2. **Training requirements**: There is little formal training available for group therapy.

3. **Cost of program**: Costs will vary according to the type of group run.

4. **Use of natural funding:**

Other considerations:

Contact information:

Relevant websites:

Ingersoll Gender Center

Promising Program

Description:

1. **Primary purpose**: Ingersoll gender center offers support groups, referrals to Ingersoll trained therapists, and referrals to physicians and surgeons.

2. **Target populations**: The Ingersoll Gender Center serves the transgender, intergender, transsexual and questioning community. Individuals with gender concerns, their friends and family are all welcome to utilize services.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:

2. **Qualitative evaluation**: Ingersoll Gender Center has been serving the transgender community in Seattle since 1977 and is one of a handful of such centers providing resources for transgender youth and adults.

Evidence supporting practice:

1. **Peer reviewed research**: none

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements**: Not Available

2. **Training requirements**: Counselors are trained in the Benjamin Standards.

3. **Cost of program**

4. **Use of natural funding**

Other considerations:

Contact information:

206-329-6651

Relevant websites:

www.ingersollcenter.org

Talk Safe

Promising Program

Description:

1. **Primary purpose**: Talk Safe is a counseling program in New York City that seeks to assist gay and bisexual men to maintain safer sexual practices and remain HIV-Negative. It offers risk-reduction and personal counseling delivered by trained peer volunteers and licensed psychologists.
2. **Target populations**: HIV-Negative or serostatus unknown gay and bisexual men.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Participant reports of increase or decreases in high-risk sexual behaviors.
2. **Qualitative evaluation**: There is no qualitative evaluation of this program to date.

Evidence supporting practice:

1. **Peer reviewed research**: There is no quantitative evaluation of the effectiveness of this program to date, although such research is currently being investigated.
2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements**: Talk Safe can be run by peer volunteers but requires a mental health practitioner to oversee the program. The program in New York City has one psychologist as director, a master's level mental health provider on staff and a psychology extern who volunteers time.
2. **Training requirements**: Training for peer counselors requires 3 to 4 modules of 3-hours duration each.
3. **Cost of program**: There is little cost to this program other than staff salaries.
4. **Use of natural funding:**

Other considerations:

Contact information:

Relevant websites:

www.talksafe.org

Seeking Safety

Description:

1. **Primary purpose**: Seeking Safety is a therapy to help people attain safety from PTSD and substance abuse. It is conducted in group and individual format and has been used with people with trauma histories that do not meet criteria for PTSD as well as those who do. The goals of the program are safety in relationships, thinking, behavior and emotions; integrating treatment for PTSD and substance abuse at the same time; focusing on ideals that counteract the loss of ideals; attention to clinician processes. There are four content areas of Seeking Safety: cognitive, behavioral, interpersonal, and case management.
2. **Target populations**: Seeking Safety has been implemented with women and with men in a variety of settings, including outpatient settings, community mental health centers, prisons and VA settings. It has been conducted with adolescents as well as adults, and in a population of low-income urban women.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:
2. **Qualitative evaluation:**

Evidence supporting practice:

1. **Peer reviewed research**: There have been seven studies demonstrating the utility of Seeking Safety as a treatment for co-morbid PTSD and substance abuse although only one, Najavits, Weiss, Shaw, & Muenz (1998), has been published, the rest are under review.
2. **Other supporting documents**: Najavits, L. M. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford Press.

Practice implementation:

1. **Staffing requirements**
2. **Training requirements**
3. **Cost of program**
4. **Use of natural funding**

Other considerations:

Contact information:

Relevant websites:

www.seekingsafety.org

Other Resources on Transgender Issues:

King County site for mental health
http: //www.metrokc.gov/health/glbt/transemotions.htm

Another site:
www.Emindhealth.com

Transgender page:
http: //www.emindhealth.com/consumer/s_resources.html?channel_id=2&s_channel_id=4

Research from the Benjamin Association:
A specific paper on Trans and substance issues [discusses depression, anxiety]:

http:
//www.symposion.com/ijt/ijtvo06no02_03.htm#Challenges%20Transgendered%20Substance%20Users%20Face

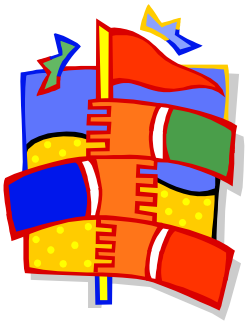
Other Papers from the Association:
http: //www.symposion.com/ijt/index.htm

Agencies in the Seattle Area that offer services to Transgender clients and patients:
Ingersoll Gender Center
http: //www.ingersollcenter.com

Seattle Counseling Service
http: //www.seattlecounseling.org/counseling03.htm

Seattle Aids Support Group
http: //www.sasg.org/

Co-Occurring Mental Health and Substance Abuse Disorders



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A Review of the Literature

COMORBID SUBSTANCE USE AND PSYCHIATRIC DISORDERS AMONG ADULTS

Prevalence

Since the 1980's, increasing recognition has been given to the issue of comorbid psychiatric and substance use disorders (SUDs), otherwise known as dual disorders. Community and clinical studies show that dual disorders are prevalent (e.g., Kessler et al., 1996; Ross, Glaser, & Germanson, 1988; Rounsaville et al., 1991; Regier et al., 1990). In the National Comorbidity Study, a nationally representative population study, about 41-65% of participants with any lifetime substance use disorder also had a lifetime history of at least one mental health disorder (Kessler et al., 1996). The most common individual diagnosis was conduct disorder (29%), followed by major depression (27%), and social phobia (20%). Among those with a lifetime history of any mental disorder, 51% had a co-occurring addictive disorder, with those respondents with conduct disorder or adult antisocial personality having the highest prevalence of lifetime SUDs (82%), followed by those with mania (71%), and PTSD (45%). In the Epidemiologic Catchment Area Study, lifetime prevalence of alcohol use disorder was highest among persons with bipolar disorder (46%) and schizophrenia (34%; Regier et al., 1990).

In 501 patients seeking addictions treatment, 78% had a lifetime psychiatric disorder in addition to substance abuse and 65% had a current psychiatric disorder. The most common lifetime disorders were antisocial personality disorder, phobias, psychosexual dysfunctions, major depression, and dysthymia (Ross et al., 1988). Similarly, in 298 patients seeking treatment for cocaine use disorders, 73.5% met lifetime and 55.7% met current criteria for a psychiatric disorder (Rounsaville et al., 1991). These rates were accounted for by major depression, bipolar spectrum conditions such as hypomania and cyclothymic personality, anxiety disorders, antisocial personality, and history of childhood attention deficit disorder.

Dual Diagnosis and Treatment Course and Outcomes

Clients with dual disorders have a poorer treatment course and outcomes than those with single disorders. They have poorer treatment retention rates, and symptom and functional outcomes (e.g., Drake, Mueser, Clark, & Wallach, 1996; Osher et al., 1994, Project MATCH, 1997; McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Ouimette, Gima, Moos, & Finney, 1999; Project MATCH, 1997a). For example, in a 6-month follow-up of male substance abuse patients, patients with a high level of psychiatric symptoms did not improve after treatment, whereas patients with a low level of psychiatric symptoms did improve (McLellan et al., 1983). Other work examining dual disorders has found that patients with comorbid affective or anxiety disorders participate less in continuing care and experience poorer outcomes (e.g., Ouimette, Ahrens, Moos, & Finney, 1997; 1998; Ouimette, Finney, & Moos, 1999; Rounsaville, Kosten, Weissman, & Kleber, 1986) whereas patients with personality disorders are harder to retain in treatment (e.g., Kofoed, Kania, Walsh, & Atkinson, 1986)

Research on dually disordered patients has examined addictions treatment characteristics associated with better outcomes. Greater amount of substance abuse treatment, such as more counseling sessions, may be associated with better outcomes (Moggi, Ouimette, Moos, & Finney, 1999). Although some have proposed that cognitive-behavioral treatments are warranted for dual diagnosis patients (e.g., Project MATCH, 1997a,b), results from multi-site studies have not supported this view. For example, in Project MATCH (1997a,b) a large scale randomized clinical trial of substance abuse treatments, patients with less severe psychiatric symptoms were more likely to be abstinent after 12-Step than after cognitive-behavioral treatment. Moreover, antisocial personality disorder clients were briefly drinking less intensely after attending 12-Step than cognitive-behavioral treatment. In an evaluation of Department of Veterans Affairs substance abuse treatment (Ouimette, Finney, & Moos, 1997; Ouimette, Gima et al., 1999), dually diagnosed patients did not vary in their outcomes after 12-Step, CB, and eclectic treatments. In that same evaluation, Moggi and colleagues (1999) found that the programs adhering to a more "dual diagnosis-focused" climate - programs that were supportive, well organized, intensive, and psychiatric medication-focused – produced better outcomes for dual diagnosis patients.

Dual diagnosis patients who attend more outpatient continuing care show better substance use, psychiatric and employment outcomes (e.g., Jerrell & Ridgely, 1995; Swindle, Phibbs, Paradise, Recine, & Moos, 1995). Dual diagnosis patients also benefit from self-help group participation about substance use outcomes (e.g., Ouimette, Humphreys et al., 2001; Ouimette, Moos, & Finney, 1998; Ouimette, Moos, & Finney, 2003).

Although the strategies reviewed above appear helpful, the effects of traditional addictions treatment for dual diagnosis patients appear to be modest. A consensus has emerged in the literature that integrated substance use and mental health disorder treatment programs are needed to best treat these patients (Drake et al., 2001; Minkoff, 2001). In support of this position is findings that integrated care models outperform non-integrated care on patient outcomes (for reviews see Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998; Mueser, Noordsy, Drake, & Fox, 2003). The strongest evidence comes from six controlled outcome studies of outpatient integrated treatments, some of which are reviewed below, which resulted in better patient outcomes than standard care (Mueser et al., 2003).

Guidelines for Effective Integrated Dual Diagnosis Treatment

Based on clinical and research experience, a team of experts in co-occurring substance use and psychiatric disorders has identified key elements of effective evidence-based treatment for clients with dual diagnoses (Drake et al., 2001). As briefly mentioned above, effective dual diagnosis treatment integrates mental health and substance abuse interventions. Specifically, the same clinician or team of clinicians should address clients' mental health and substance use issues in a coordinated fashion and deliver these interventions in the same setting. In an effective treatment system, the treatment should appear seamless to the patient with a unified philosophy, set of goals and recommendations.
Drake and colleagues (2001) described the critical components of evidence-based dual diagnosis treatment. According to these authors, the presence of these strategies is usually associated with better outcomes while their absence is associated with poorer outcomes. The components are the following: (1) Staged interventions: effective programs have stages that

address the clients' needs such as working on forming a therapeutic alliance or trusting relationship, persuading clients to get involved in treatment, helping motivated clients acquire skills and attain goals, and promoting stable remission/relapse prevention; (2) Assertive outreach: effective programs engage clients and their families through intensive case management, possibly in the clients' homes to help them gain access to needed services and maintain a consistent treatment program over months/years (this is important in reducing treatment dropout and noncompliance); (3) Motivational interventions: effective programs motivate patients to engage in treatment (see also Bellack & DiClemente, 1999); (4) Active treatment/counseling: effective programs use cognitive-behavioral or evidence based treatments; (5) Social support interventions: effective programs improve the social environment of clients, so that it promotes recovery; (6) Long-term perspective: Effective programs have a long-term, community-based perspective; (7) Comprehensiveness: effective programs integrate the dual disorder focus into all aspects of the treatment system rather than having an isolated discrete substance use disorder or mental health intervention; (8) Cultural sensitivity and competence: Effective programs tailor services for their specific client population; however, the preceding components still remain essential parts of the treatment system.

In 1995, the Substance Abuse and Mental Health Services Administration funded the Managed Care Initiative to develop standards of care for the treatment of patients in managed care. A national consensus expert panel was appointed for co-occurring disorders, which issued a consensus report (Managed Care Initiative Panel on Co-Occurring Disorders, 1998). In a brief review of this report, Minkoff (2001) describes several important issues in developing adequate treatment systems for dually diagnosed patients. First, treatment systems need to welcome and be accessible to dually diagnosed patients. Specific views need to be held about comorbidity: both disorders should be seen as primary and as such, each needs to be addressed throughout treatment. These disorders must be seen as chronic, relapsing disorders that require stage-specific treatments. Treatment needs to be delivered by persons or programs with expertise in both disorders, to promote a long-term perspective, to engage patients regardless of their level of motivation, and to outreach to hard-to-reach patients (e.g., the homeless client). Fiscal and administrative groups need to support these goals; systems should identify quality and outcome measures. Lastly, practice guidelines are important to establish.

Summary

Given this accumulating evidence that comorbid substance use and psychiatric disorders are common in community and clinical studies, Minkoff (2001) has argued that dual disorders "…should be expected rather than considered an exception." A variety of mental health disorders are comorbid with substance use disorders, making those with dual disorders a heterogeneous group and possibly indicating the need for treatment protocols to address specific comorbidities. Those with dual disorders have a difficult treatment course.

Interestingly, research on dual diagnosis patients in single-focus programs (e.g., substance use disorder treatment) suggests some treatment strategies, such as greater intensity of care, both in terms of frequency of visits and a longer-term focus, and advocating social support/community interventions that are in-line with expert panel recommendations.

Nonetheless, these programs produce modest outcomes highlighting the need for integrated mental health and substance use disorder systems of care. To this aim, experts in the field have outlined components of effective care – one component includes providing evidence-based integrated treatment during the active treatment/counseling phase. The remainder of this paper reviews the empirical evidence for integrated treatment protocols designed for adults and adolescents with dual disorders. This paper is organized according to type of comorbid psychiatric disorder in adults and adolescents and concludes with future directions for the field.

TREATMENTS FOR SEVERE MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

A significant clinical problem is substance abuse by individuals with psychotic disorders. It is estimated that the lifetime prevalence of substance abuse among individuals with schizophrenia is about 50% with 20-65% having current substance abuse (for a summary see Bennett, Bellack, & Gearon, 2001). In the Epidemiologic Catchment Area Study (Regier et al., 1990), the lifetime prevalence of any SUD was 16.7% in the general population whereas the rate was 56% among individuals with bipolar disorder. Patients with substance abuse and severe mental illness have a poorer and more difficult treatment course than patients with single disorders (for a review see Dixon, 1999). This section outlines several integrated programs that have been developed for patients with substance use disorders and severe mental illness, schizophrenia, and bipolar disorders.

Assertive Community Treatment

Assertive Community Treatment (ACT) is an evidence-based model of care developed for individuals with severe mental illness (Test, 1992). Components of ACT include multidisciplinary teams that provide comprehensive services in the patient's living environment and take continuous responsibility (24 hours a day) for a group of patients. While ACT appears to be effective in treating mental health outcomes, it may be less effective when substance use disorder treatment services are not provided by the ACT team (Drake et al., 1998). More recently, ACT has been revised to include integrated SUD treatment (Stein & Santos, 1998).

Drake and colleagues (1998) conducted a three-year randomized trial of ACT for dual disorders compared to usual case management. Patients in this study were diagnosed with schizophrenia, schizoaffective, or bipolar disorder and had an active substance use disorder. A total of 223 participants entered the study. Participants were mostly male, young, and unemployed. A notably high retention rate was reported across treatments (about 90%).

The integrated intervention included nine essential features of ACT. Services were provided in the community using assertive engagement, along with a high intensity of services. Therapists had small caseloads and provided services on a 24-hour basis. A multi-disciplinary treatment team approach was used. In addition, close work was done with the patient's support system and continuity of staffing was emphasized. Four additional criteria related to dual disorders were also implemented: the treatment team provided substance abuse care; they used a stage wise dual disorders model; dual disorders treatment groups were offered; and the team's exclusive focus was on patients with dual disorders.

Assessments were completed at baseline and every 6 months thereafter. Overall, both treatments showed good retention, reduced substance use, and increase in days in stable community residences. Results showed that ACT performed better than standard case management on 2 of 5 substance use outcomes, however groups did not differ on remission rates. In addition, ACT patients fared better on two quality of life measures, overall life satisfaction and financial support adequacy. No group differences emerged on stable community days and psychiatric symptoms. Furthermore, in an evaluation of the cost-effectiveness of the interventions, ACT was not significantly more cost-effective than standard case management (Clark et al., 1998).

The authors proposed that results might not have been as strong as expected due to the conduct of the study in New Hampshire. New Hampshire has a reputation for an excellent community mental health system; so standard case management had many features shared with ACT including low case numbers per therapist and conduct of treatment within small mental health centers with excellent internal communications.

Integrated Motivational Interviewing, Cognitive-Behavior Therapy, and Family Intervention

Barrowclough and colleagues (2001) described a program of integrated treatment for patients with schizophrenia and substance abuse. Routine care was integrated with three interventions: motivational interviewing, individual cognitive-behavior therapy, and family or caregiver intervention. In addition, each patient was assigned a "family support worker," who provided information, gave advice on benefits, advocated for the patient, provided emotional support and practical help. The intervention was planned for a nine-month period.

Participants entered the study in patient-caregiver dyads and were randomized to the integrated treatment plus routine care (n=18) or routine care alone (n=16). A total of 95% of participants in the integrated care condition completed their program. Assessments were completed at intake and 9- and 12-months following the initiation of treatment. Integrated care patients fared better than routine care patients on measures of global functioning at 9 and 12 months. At 12 months, integrated care participants had fewer positive symptoms of schizophrenia than routine care participants did but no sustained differences emerged between groups on negative symptoms of Schizophrenia or on social functioning, At 12 months, fewer integrated care patients had relapsed than routine care patients (33% versus 67%). Moreover, the mean change from baseline to 12 months in percentage of days abstinent from all drugs was greater for participants in integrated care relative to those in routine care. No differences emerged between groups in level of dependence symptoms or on drug and alcohol use problems.

Family Intervention for Dual Disorders

Family Intervention for Dual Disorders (FIDD; Mueser & Fox, 2002) adapts both single and multiple-family group formats for patients with severe mental illness and substance use disorders and their families. Single-family intervention is the primary venue of intervention, which is designed to teach family information and skills to manage the relative's dual disorder. The course of this time-limited treatment can last 9 months to 2 years and can be home-based. Importantly, the clinician providing FIDD should be part of the patient's treatment team. Multiple family group is seen as an adjunct treatment and usually time-

unlimited. The latter is based on the Treatment Strategies for Schizophrenia Study (Mueser et al., 2001).

Pilot data from six families suggests that FIDD can help improve client outcomes. All clients in the study improved on substance use outcomes over the course of one year. FIDD is currently being evaluated with a larger sample of patients and their families.

Behavioral Treatment for Substance Abuse in Schizophrenia

Several problems associated with symptoms of schizophrenia may make recovery difficult (Bellack & DiClemente, 1999). For example, negative symptoms such as anhedonia may inhibit patients' ability to experience pleasure and positive reinforcement when not using substances. Based on these and other observations, Bellack and colleagues developed a new treatment approach that addresses these patients' unique deficits in motivation, cognitive ability, and social skills (Bellack & Gearon, 1998; Bennett, Bellack, & Gearon, 2001).

Behavioral Treatment for Substance Abuse in Schizophrenia (BTSAS; Bellack & DiClemente, 1999; Bellack & Gearon, 1998; Bennett et al., 2001) is an adaptation of Social Skills Training (SST; Bellack, Mueser, Gingerich, & Agresta, 1997), an evidence-based behavioral treatment for schizophrenia. BTSAS has five components: (1) monthly motivational interviews to address treatment goals; (2) urine drug screen contingency wherein patients receive small amounts of money for abstinence; (3) social skills training to teach patients to refuse drug offers; (4) psychoeducation on substance use and schizophrenia; and (5) problem solving and relapse prevention. BTSAS is a six-month, twice weekly group therapy that utilizes two therapists to provide a more intensive therapy experience. The treatment does not require abstinence or a commitment to abstinence for enrollment; it employs a harm reduction approach. However, patients are encouraged to select abstinence as a goal. Other important aspects of the therapy include its non-confrontational and non-critical tone; empathy and positive reinforcement are emphasized.

In a pilot study of BTSAS among community and VA patients, participants met twice weekly for six months, with a once-a-month session for motivational interviewing (Bennett et al., 2001). A total of 42 patients with schizophrenia and substance use disorders consented to participate. A total of 28 of the 42 (67%) attended BTSAS; fourteen of the 28 remaining patients (50%) dropped out after attending 3 sessions. Of the final 14 patients, five were classified as "good progress" patients using the criteria of having clean urine drug screens on 70% or more of their tests. The remaining nine were classified as "poor progress" based on 45% or more of their tests being positive over the course of treatment. Good progress patients showed less drug use post-treatment relative to poor progress patients.

An interesting finding was that those who dropped out were similar in level of readiness to change as those within the good progress group. The authors report that participants who dropped out reported other barriers to treatment including hospitalization, jail, and scheduling conflicts. These barriers suggest the need for better integration of care into the larger system. To address these issues, a new study of BTSAS is attempting to improve communication between the BTSAS staff and the recruitment site clinic staff and better

integrate BTSAS into the existing services. Current ongoing research is evaluating BTSAS through a randomized controlled trial.

Integrated Group Therapy

Given that bipolar disorder is associated with highest risk of coexisting substance use disorder in some community studies (e.g., Regier et al., 1990) and this comorbidity complicates the course of either alone (Keller et al., 1986), a treatment addressing this dual diagnosis appears warranted. Accordingly, Weiss, Najavits, & Greenfield (1999) developed an integrated group therapy (IGT) for bipolar and SUDs. IGT focuses on and integrates themes relevant to both disorders in addressing and managing patients' risk for relapse. Weiss et al. (2000) assigned participants in sequential blocks to either IGT (n = 21) or assessment only (non-IGT; n = 24). Treatment lasted for 12 to 20 weeks, with symptoms being assessed at baseline and monthly thereafter during treatment, and at a 3-month follow-up.

Seventy-seven percent of participants completed the scheduled assessments. Treatment retention for IGT was also high; participants attended, on average, about 72% of the groups. A comparison of the two groups showed that IGT participants had better alcohol and drug outcomes, greater percentage of days abstinent, and were more likely to have three or more months of abstinence than the non-IGT group. Moreover, IGT participants improved more on symptoms of mania but not symptoms of depression than non-IGT participants. No differences emerged on medication compliance or psychiatric hospitalization during the study period. Lastly, the extended version of the treatment (20 weeks) had a greater impact on abstinence rates than the shorter version of IGT (12 weeks).

TREATMENT FOR POSTTRAUMATIC STRESS AND SUBSTANCE USE DISORDERS

PTSD is common in the general population: about 9% of women and men meet criteria for lifetime PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Among treatment seeking samples, approximately 20-33% of patients with substance use disorders meet criteria for current PTSD (e.g., Brown, Recupero, & Stout, 1995; Najavits, Gastfriend, et al., 1998). PTSD is common among veterans: In Fiscal Year 1998, clinician derived diagnoses indicated that about 25% of SUD patients seen in either substance abuse or psychiatric units had current PTSD (Piette, Baisden & Moos, 1999).

In a nationally representative community-based sample of Vietnam combat veterans, 22% of the men with current combat-related PTSD also met criteria for a current substance use disorder (Kulka et al., 1990). Among combat veterans seeking PTSD treatment, 84% had at least one comorbid SUD (Keane & Wolfe, 1990). SUDs and PTSD thus frequently co-occur in community and clinical samples and across treatment venues.

Of significance is the negative prognostic implication of SUD-PTSD comorbidity: PTSD renders substance abuse patients more vulnerable to poorer treatment outcomes (e.g., Brown, Stout, & Mueller, 1999; Ouimette, Ahrens, Moos, & Finney, 1997; 1998; Ouimette et al., 1999). Substance abuse is also viewed as having negative implications for patients seeking PTSD treatment; patients continuing to use substances have less successful PTSD outcomes than those who abstain (Perconte & Griger, 1991).

The following describes four integrated treatment programs developed for PTSD and SUD comorbidity. Seeking Safety, a coping skills therapy, is the most researched now. Two other programs, Cocaine Dependence PTSD Therapy and Assisted Recovery from Trauma and Substances, may be distinguished from Seeking Safety by the inclusion of a cognitive-behavioral prolonged exposure component. Lastly, Transcend was developed specifically for Vietnam Veterans with chronic PTSD and substance use disorders.

Seeking Safety

Seeking Safety is a present-focused coping skills therapy to help people attain safety from both PTSD and substance abuse (Najavits, 2002, 2003). The key principles of Seeking Safety include safety as the larger goal of treatment, working on PTSD and substance abuse at the same time, a focus on ideals to counteract the loss of ideals from the experience of having PTSD and a substance use disorder, and addressing cognitive, behavioral, interpersonal, and case management areas for client's functioning. In addition, the therapy focuses on clinician processes, such as helping clinicians work with countertransference issues. Each session of Seeking Safety has an identified "topic" (e.g., asking for help, self-nurturing) that addresses themes relevant to both PTSD and substance abuse and that includes the development of coping skills related to the issue.

In the first pilot study of 35 women with SUD-PTSD in a 24-session version of Seeking Safety, from intake to a 3-month follow-up, significant reductions were found in substance use and trauma-related symptoms (Najavits, Weiss, Shaw, & Muenz, 1998). Patients also improved on substance use, depression, suicide risk and thoughts, dysfunctional attitudes about substance use, problem-solving, and social adjustment. However, there was no improvement in PTSD symptoms, and patients reported an increase in somatic symptoms from intake to follow-up.

Patients in the program rated the following treatment aspects as more helpful: the focus on abstinence and on coping skills, the therapist, and treatment overall. They gave lower helpfulness ratings to the short length of the program and to aspects of the group membership (i.e., option to call other group members outside of sessions, the assignment of a group partner, and the support of other group members). The retention rate for the treatment was 63% (defined as those who attended at least 25% of the sessions).

More recently, Seeking Safety was delivered to 18 women in a minimum-security correctional setting (Zlotnick, Najavits, & Rosenhow, in press). The treatment was used as a voluntary adjunct usual services, was offered in a 24-session group format over 3 months. Assessments were completed pre-post-treatment (during incarceration), and 6 and 12 weeks post-release. Attendance rate was high – participants attended an average of 83% of all sessions. Only two of 18 dropped out after starting therapy. At post-treatment, nine of the 17 women (53%), at 6-weeks, 7 of 16 women (44%), and at 3-months, 7 of 15 women (46%) no longer met criteria for a PTSD diagnosis. Significant decreases were noted in PTSD symptoms, drug use, and legal problems from pre-treatment to 6- weeks' post-release and from post-treatment to 3-months post-release. Recidivism rate (i.e., return to prison) was

33% and use of illegal substances was 35% at the 3-month interval suggesting that a longer-term model may be more effective with this population (i.e., a continuum of care approach).

Several other studies of Seeking Safety are being completed in various populations, including males, low urban women, adolescent girls, outpatient males, and veterans.

Concurrent Treatment of PTSD and Cocaine Dependence

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD; Back, Dansky, Carroll, Foa, & Brady, 2001; Brady, Dansky, Back, Foa, & Carroll, 2001) combines cognitive-behavioral exposure treatment for PTSD with coping skills training for substance use disorders. CTPCD is a twice-weekly, 16-session individual outpatient therapy for comorbid PTSD and cocaine dependence, although it is believed that it could be useful for patients with PTSD and any type of SUD. Initial therapy goals are to establish the skills necessary to obtain sobriety and to inoculate patients against the risk of relapse when completing exposure therapy. First, core SUD coping skills are taught along with an overview and rational for exposure therapy, followed by prolonged exposure.

Brady et al. (2001) conducted an open-trial of CTPCD using 39 outpatients. Thirty-eight percent completed the study (defined as those completing 10 or more sessions); using the Najavits et al. (1998) completion standard of 25% or more sessions, the completion rate rose to 69%. Completers showed a reduction in PTSD symptoms as well as alcohol and drug use, depression and employment outcomes pre- to post-treatment and pre-treatment to a 6-month follow-up. Timing of the dropouts did not appear to implicate the exposure portion of the treatment as the reason. Ongoing research is evaluating CTPCD in various contexts, including a community mental health center and using a group format (Coffey, Schumacher, Brimo, & Brady, in press).

Assisted Recovery from Trauma and Substances (ARTS)

Assisted Recovery from Trauma and Substances (ARTS; formerly called Substance Dependence PTSD Therapy - SDPT), was developed for patients with varied SUDs and traumas (Triffleman, 2000, 2002; Triffleman, Carroll, & Kellogg, 1999). This 20-week twice-weekly individual therapy adapts and integrates three therapies: Cognitive-Behavioral Coping Skills Treatment (Carroll, Donovan, Hester, & Kadden, 1993), Stress Inoculation Therapy (Meichenbaum & Cameron, 1983), and in vivo systematic desensitization (Meichenbaum, 1994). In phase I, stabilization from recent substance use with the goal of abstinence and alliance building are emphasized. Patients are taught abstinence-oriented trauma-informed coping skills (i.e., examinations of cognitions and dysphoria associated with cravings; generation of alternative cognitions, and management of emotional and physical states). Phase II focuses on decreasing PTSD symptoms through education, stress inoculation (e.g., learning coping skills to deal with current reminders of the trauma), and in vivo prolonged exposure, with the purpose of desensitizing patients to trauma-related stimuli that they have avoided.

ARTS has been evaluated in one small randomized controlled trial. A total of 19 participants were randomized to ARTS or a 12-Step therapy. Patients improved in both treatments on

PTSD symptoms, substance use, and psychiatric severity but not on biological measures of substance use. Research is ongoing that will further evaluate the effectiveness of ARTS.

Transcend

Transcend is a 12-week partial hospitalization program developed for Vietnam combat veterans with chronic SUD-PTSD comorbidity that focuses on decreasing PTSD symptoms and promoting an addiction-free lifestyle (Donovan, Padin-Rivera, & Kowaliw, 2001). The program is based on concepts from constructivist, dynamic, cognitive-behavioral, and 12-step paradigms/theories. The treatment approach integrates behavioral skills training and trauma processing with an emphasis on meaning and self-acceptance/forgiveness, relapse prevention training, and peer social support. The program includes six weeks of skill development and six weeks of trauma processing. Participants receive ten hours of group therapy per week.

Donovan et al. (2001) evaluated Transcend in a sample of 46 male veterans with SUD-PTSD. A total of 10% did not complete the full treatment program. Assessments were completed at intake, 6-months and 1-year following treatment. All three assessment were completed on 76% of the sample, with 91% completing at least one assessment. Results showed that PTSD symptoms significantly decreasing at both 6- and 12-months following treatment relative to pretreatment with one exception: PTSD arousal symptoms did not change from pretreatment to the 12 month follow-up. In comparison to pre-treatment, alcohol consumption, drinking to intoxication, and polysubstance drug abuse were significantly lower at the 6- and 12-month follow-ups.

TREATMENT FOR SOCIAL PHOBIA AND SUBSTANCE USE DISORDERS

According to the National Comorbidity Study, lifetime prevalence of alcohol dependence among persons with social phobias is 24% (Kessler et al., 1996). Among persons seeking treatment, prevalence estimates vary from 2-54% (Lepine & Pelissolo, 1998). Randall, Thomas, & Thevos (2001) concluded that the prevalence rate of this comorbidity is at least 20%.

Randall et al. (2000) noted that individuals with social phobia indicate that they may use alcohol to medicate anxiety symptoms; however, no prospective studies have investigated treatment outcomes for socially phobic alcoholics. Another concern is that if treatment does not address social anxiety, these individuals may be at high risk for relapse. Finally, substance use disorder treatment is often in group format, which may prove difficult for the socially anxious patient.

With these issues in mind, Randall et al. (2001) combined two separate manual guided treatments, one for social phobia and one for alcoholism, to examine their effectiveness in treatment social phobia-alcohol use disorder comorbidity. Participants were recruited from outpatient alcohol use disorder treatment programs, newspaper ads, and referrals. Participants had to report that they used alcohol to cope with anxiety to be included in the study. The dual focus treatment was a 12-session individual treatment based on CBT therapy manual used in Project Match (Project MATCH, 1997) and a manual guided CBT treatment developed by Holmstrom and Thevos (cited in Randall et al., 2001).

Forty-four participants were randomized to receive alcohol use disorder treatment only and 49 to receive the dual focus treatment. Only 55% were termed "completers" (i.e., attending 10 of 12 sessions) with participants in the two groups not differing on attendance. The average number of sessions attended was eight. Participants were assessed at the end of treatment and a 3-month follow-up. Results were somewhat disappointing: although participants improved on drinking outcome measures at the end of treatment, the dual focus group fared worse than the alcohol treatment only group on percent days abstinent, percent heavy drinking days, and total number of drinks consumed at the 3 month follow-up. Both groups improved post-treatment and at the follow-up on social anxiety. One interesting finding was that reduction of social anxiety was not associated with improvement in drinking. The authors proposed that the patients in the dual focus group might have used alcohol to cope with their homework assignments, which involved confronted feared situations. One possible limitation to the effectiveness of this program was that the two treatments were offered as simultaneous treatments as opposed to being more fully integrated into one protocol.

TREATMENT FOR PERSONALITY AND SUBSTANCE USE DISORDERS

Axis II personality and substance use disorders are often co-morbid (Trull, Sher, Minks-Brown, Durbin, & Burr, 2000). Estimates of 44%-60% of substance use disorder patients meet criteria for at least one Axis II personality disorder (Verheul et al., 1995; Verheul, van der Brink, & Hartgers, 1998). Moreover, Axis II comorbidity is associated with poorer outcomes among patients with substance use disorders (e.g., Verheul et al., 1998). Two protocols have been developed to address personality and substance use disorders: Dual Focus Schema Therapy (Ball, 1998), which addresses any of the ten DSM-IV personality disorders; and Dialectical Behavior Therapy for Substance Abusers (DBT-S; Linehan & Dimeff, 1997), which is specific to borderline personality disorder.

Dual Focus Schema therapy

As noted by Ball (1998), one key issue for developing a treatment for comorbid personality and substance use disorders is how to address all ten DSM disorders with one treatment protocol. Ball and Young (1998) developed an integrated treatment, Dual Focus Schema Therapy that targets core early maladaptive schemas and coping styles observed across the ten personality disorders. Thus, this therapy addresses personality disorders by specifying a core set of topics, for which the specific content and delivery are determined by an assessment and conceptualization of client's maladaptive schemas and coping. These maladaptive schemas are seen as the most potent triggers of drug use, which helps the client avoid or to compensate for the activation of an early schema.

Dual Focus Schema Therapy is integrated with a set of common core techniques such as functional analysis, self-monitoring, and coping skills training. Two assumptions of the therapy are: (1) targeted intervention into most problematic areas will affect a broader range of behaviors; and (2) a strong working alliance is essential to change. The treatment consists of 24-sessions and has two stages: (1) early relapse prevention plus identification/education about early maladaptive schemas/coping styles and their associations with SUD and present

lifestyle; and (2) schema change therapy and coping skills work. This therapy is currently being evaluated with federal grant funding.

Dialectical Behavior Therapy for Substance Abusers with Borderline Personality Disorder

Dialectic Behavioral Therapy (1993), a treatment for borderline personality disorder with shown effectiveness, has been adapted for borderline substance abusing clients (Dialectical Behavior Therapy for Substance Abusers with Borderline Personality Disorder – DBT-S; Linehan & Dimeff, 1997; Linehan et al., 1999; Linehan et al., 2002). The modified version includes the standard components of DBT with the addition of several strategies specific to substance abuse. Therapists emphasize a dialectic approach to abstinence, which includes an "unrelenting insistence" on abstinence coupled with acceptance and non-judgmental problem solving/relapse prevention when drug use does occur, with a quick return to an unrelenting insistence on abstinence. In addition, an intervention that focused on replacing "pills with skills" included a 4-month "transitional maintenance" replacement medication protocol to facilitate the use of adaptive coping skills, followed by 4 months of drug tapering to promote skills strengthening, and 4 months of no drug replacement to promote skills generalization. In a recognition of the need for therapy to engage/motivate patients, Linehan et al. (1999; 2002) developed these strategies to improve "attachment" of the client to the therapy and therapist, as well as to help reach out and bring back "lost" patients.

In a study that randomized twelve women to a one-year trial of DBT-S and sixteen women to treatment as usual (TAU - referral to psychotherapy and addictions services in the community), participants completed assessments at intake, 4, 8, 12, and 16-months following intake (Linehan et al., 1999). DBT-S was associated with reduced substance related behaviors (greater percentage days abstinent and clean urine drug screens) and improved global and social functioning over the 16 months following treatment relative to TAU. Both interventions were associated with reductions in parasuicidal episodes and state/trait anger; however, groups did not differ on these outcomes.

Participants in DBT-S had 43 hours of therapy where as TAU only had 23 hours. DBT-S retained more clients; the dropout rate for DBT-S, defined as missing four consecutive weeks of individual or four consecutive weeks of group for any reason, was 36% for DBT-S whereas it was 73% for TAU (defined as never going to therapy or dropping out after a first session). Among those in DBT-S, greater adherence to the treatment protocol was associated with a higher proportion of clean drug screens.

In a second randomized trial of DBT-S, eleven heroin dependent women were assigned to DBT and twelve to a comparison treatment, Comprehensive Validation Therapy with 12-Step (CVT+12S; Linehan et al., 2002). All participants were provided treatment for one-year plus an opiate agonist medication.

CVT+12S was designed to control for the provision of support/validation and other components of treatment not specific to DBT. It included DBT acceptance based strategies and case management when needed. Therapists were nondirective. In addition to psychotherapy, clients attended a 120-minute women's Narcotics Anonymous group and

were encouraged to attend NA meetings as much as possible, with weekly meetings with a sponsor.

CVT+12S had a greater retention rate (100%) versus DBT-S (73%). However, the authors note that the three dropouts from the study came from one therapist, who was the only male therapist. There was no group difference in mean number of individual therapy sessions (mean = 33) attended, but the DBT group attended more skills groups as compared to CVT+12S group's attendance at self-help meetings.

Results indicated that both groups declined in opiate use as indicated by drug screens, until 8 months, when DBT group maintained the decline in use and the CVT group showed a course of increasing drug use during the last 4 months of treatment. Interestingly, when self-reports were compared with urine drug screens, the CVT group was less accurate in reporting drug use than the DBT group. The authors suggested that the greater accuracy of self-reported drug use by the DBT participants might reflect the use of self-monitoring tools (e.g., daily diary) in therapy. Both groups improved on self-reported substance use, depression, and global adjustment over time; no group differences emerged.

The authors concluded that the high retention rates across treatments might reflect the relational focus in the therapies (validation component) as well as the policies and procedures implemented in the clinic to retain these clients. For example, the clinic has a coordinator who sends cards to clients for holidays/events, the absence of lines for medications, the flexibility of therapists in scheduling and being tolerant of missed sessions, and the absence of threats to terminate clients for drug use or other maladaptive behaviors. In addition, if a client misses more than three sessions, the treatment team goes on "high alert" to help individual therapist re-engage the client.

Personality Risk Factors for Comorbid SUD And Mental Health Disorder

Given the research on high comorbidity between personality disorders and substance abuse, Conrod and colleagues have developed a novel approach to addressing personality risk factors for substance abuse (Conrod, Pihl, Stewart, & Dongier, 2000; Conrod, Stewart et al., 2000; Conrod & Stewart in press). Although this is not an integrated treatment program for dual disorders, it is worth mentioning as it has shown effectiveness among women with substance use disorders.

Conrod and colleagues identify four personality types – sensation seeking, anxiety sensitivity, introversion-hopelessness, and impulsivity – that place a person at risk for using specific drug types and developing specific forms of psychopathology. In a community sample of women with substance use disorders, the typology was partially validated. As predicted, *sensation seeking* was associated alcohol dependence, *anxiety sensitivity* with lifetime anxiolytic dependence, somatization and anxiety disorders (i.e., simple phobia and GAD), *hopelessness* associated with opioid dependence, anxiety disorders (i.e., social phobia and panic), and depression, and *impulsivity* was associated with cocaine and alcohol dependence and antisocial personality disorder (Conrod, Pihl et al., 2000).

Conrod, Stewart and colleagues (2000) developed brief 90-minute motivational coping skills interventions to match these specific personality-motivational risk factors for substance abuse. These manuals included psychoeducation about the target personality risk factor and risky substance abuse/maladaptive coping. In a randomized trial, women with substance use disorders were randomly assigned to the matched intervention (n=94), a motivational control intervention involving a motivational film and a supportive discussion with a therapist (n=52) and a motivational-mismatched intervention targeting a different personality profile (n=97).

Clients participated in an initial 3-5 hour assessment and the 90-minute intervention. During the intervention, feedback was given on how their scores on the personality, psychopathology, and drug-related scales deviated relative to norms for similarly aged women without substance use disorders. The facilitator and client discussed reasons for using substances as well as the long-term consequences of substance abuse. Cognitive restructuring exercises and coping self-statements were taught. Participants were given a manual to take home and encouraged to practice the exercises at home.

The various forms of motivational interventions reduced alcohol and prescription drug use and related problems over a 6-month period. Results indicated that those in the matched intervention reduced the frequency and severity of problematic alcohol and drug use more than the control intervention. Although the matched intervention was somewhat more effective than the mismatched intervention on alcohol and drug outcomes, this difference was not significant. In summary, these findings suggest that providing motivational interventions matched to a client's personality may significantly improve their treatment outcomes. Given the importance placed on motivation in dual diagnosis treatment guidelines, this approach could possibly used as a component of dual diagnosis treatment.

COMORBID SUBSTANCE USE AND PSYCHIATRIC DISORDERS AMONG YOUTH

Prevalence of dual disorders among youth

Prevalence studies of youth in the community estimate rates of comorbid substance use and psychiatric disorders at about 60%-76% (e.g., Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Kandel, Johnson, Bird, Weissman, & Goodman, 1999). In a detailed review of this literature, Armstrong and Costello (2002) found that conduct disorder and oppositional defiant disorder had the greatest association with SUDs (about 40-60% youth had a comorbid SUD and a disruptive behavior disorder), followed by the depressive disorders (about 11-32% of youth had comorbid SUD and depression). While the evidence for a significant relationship between SUDs and comorbid anxiety disorders was weaker, PTSD was significantly associated with SUDs. Specifically, in one report, 11% of young adults with lifetime SUDs also had PTSD (Giaconia et al., 2000). Consistent with the latter finding, Kilpatrick and colleagues (2000) found among a national sample of 4,023 adolescents, 16% of adolescents with SUDs also had current PTSD.

In clinical samples, 75% of adolescent SUD patients are estimated to have a comorbid disorder (Crowley et al., 1998; Greenbaum et al., 1996). In the Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A; Hser et al., 2001), a multisite naturalistic evaluation of adolescent drug treatment programs, a total of 992 adolescents received an

intake diagnostic assessment using the Diagnostic Schedule for Children-Revised (Shaffer et al., 1993). Sixty-three percent of participants had a DSM-III-R comorbid disorder (Grella, Hser, Vandana, & Rounds-Bryant, 2001). Specific disorders included conduct disorder (59%), depressive disorder (15%), ADHD (12%), panic disorder (2%), and overanxious disorder (1%). Many had more than one comorbid disorder; most of those with depression and ADHD also had conduct disorder.

In the DATOS-A, compared to those without comorbid psychiatric disorders, those youth with comorbid disorders were younger, more likely to be Caucasian and had committed more illegal acts in the previous year (although there was no difference in arrest rates). Compared to those without psychiatric disorders, those with comorbid disorder started using alcohol and marijuana earlier, had higher rates of weekly use of marijuana, had more heavy use of alcohol, and had higher rates of dependence on alcohol, marijuana, and cocaine. Comorbid youth were more likely to use nicotine and more likely to have had prior drug treatment; their parents had more drug problems. In addition, comorbid youth had more family problems and higher rates of sexual/physical abuse history. Lastly, they had lower levels of commitment to school (Grella et al., 2001).

Comorbidity and treatment outcomes

Although treating substance use disorders in youth can be a challenging task, accumulating research suggests that SUD treatment is effective. For example, the Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A, Hser et al., 2001) evaluated 23 stable community-based adolescent drug treatment programs in four US cities. A total of 1,167 adolescents completed an intake and a 1-year follow-up assessment. At the 1-year follow-up, significant improvement was found on drug use, psychological adjustment (i.e., suicidal thoughts, hostility and self-esteem), school performance (i.e., attendance and grades) and criminal activity. Similar to findings in the adult SUD treatment literature, longer time in treatment predicted lower drug use (i.e., no marijuana use and no drug or alcohol use) and lower arrest rates at follow-up.

Few studies have evaluated the effect of a comorbid psychiatric disorder on SUD treatment outcome for adolescents. In the DATOS-A, Grella and colleagues examined the association between DISC-R assessed comorbid psychiatric disorder and one-year outcomes. After controlling for demographics, type of program attended (i.e., residential, inpatient, or outpatient), treatment retention, and baseline functioning, having a comorbid diagnosis was associated with higher likelihood of weekly marijuana use, use of hallucinogens, engaging in illegal acts, and having been arrested during follow-up. Interestingly, having a comorbid disorder was associated with a greater likelihood of being enrolled in school during the follow-up. Comorbidity was not associated with using marijuana, heavy alcohol use, using cocaine, using stimulants, and suicidal thoughts. In analyses examining type of disorder, the results remained the same with one exception: having a depressive disorder was associated with suicidal thoughts during the follow-up. Limitations to this study include high attrition, reliance on self-report only, and high overlap among conduct disorder and other disorders limiting conclusions about effects of specific types of disorders.

Using data from a randomized trial evaluating Multisystemic Therapy (described below), Randall and colleagues examined 16-month outcomes for 18 adolescents with substance use disorders. Using the Diagnostic Interview Schedule for Children, 27% of participants were diagnosed with an externalizing disorder only, 26% with an internalizing disorder; 15% had both types of disorders; and 31% had neither. After controlling for baseline functioning, having an externalizing disorder predicted increased general delinquency and illicit drug use. Interestingly, having an internalizing disorder buffered the effect of an externalizing disorder on outcomes. In other words, youth who had both an externalizing and internalizing disorder engaged in less criminal activity and in lower illicit drug use than those with an externalizing disorder only. Moreover, having an externalizing disorder predicted more out-of-home placement days and greater family cohesion. Having an internalizing disorder predicted poorer school functioning. Number of comorbid disorders did not predict functioning, so findings appear to be accounted for by type of disorder and not number of diagnoses per se (Randall, Henggeler, Pickrel, & Brondido, 1999). The authors suggest that the externalizing/internalizing distinction may have important clinical implications; externalizing disorders may be part of a larger picture of problem behavior, which includes substance abuse. In contrast, they propose that having a SUD and a comorbid internalizing disorder may reflect a self-medication process.

Given the importance of treatment retention for outcomes, it is important to examine the effect of a comorbid psychiatric disorder on treatment completion. In two studies of clinical samples, having a disruptive behavior disorder (i.e. ADHD, conduct disorder) was associated with treatment noncompletion (Kaminer, 1992; Wise et al., 2001). Thus, externalizing disorders may be indicators for negative treatment outcomes.

Summary

In both community and clinical samples, dual disorders are common among youth with SUDs. The most common comorbid disorder appears to be the disruptive behavior disorders. Those with dual disorders appear to have a more severe clinical picture.

Having a comorbid disorder attenuates the effectiveness of SUD treatment. The variety of comorbid disorders found among adolescents in treatment may indicate a need for treatment programming that addresses the specific comorbidity. Despite the prevalence and effect of dual disorders on SUD treatment, very little is known about effective treatment. Only two programs that integrate mental health and substance use disorder treatment have been developed for adolescents with dual disorders and tested in the empirical literature. The following reviews these two programs and provides suggestions for future research in the area.

CONDUCT DISORDER, SERIOUS EMOTIONAL DISTURBANCE AND SUBSTANCE USE DISORDERS: MULTISYSTEMIC THERAPY

One promising intervention program for youth with dual disorders is Multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). The US Surgeon General cited MST as an evidence based treatment for adolescent substance abuse (US Surgeon General, 1999). This intervention is a family/community-based model that was originally designed to treat serious antisocial behavior in juvenile offenders. It is based on

social-ecological and family systems theories of behavior with the assumption that community and family systems are inter-related. Thus, MST aims to address the multi-determined nature of antisocial behavior, which includes individual-, family-, and community-level targets as well as their inter-connections. By changing the youth's greater social context (i.e., family, peer, school, support system), it seeks to promote prosocial behavior and reduce antisocial behavior. One primary goal is to teach the caregivers how to handle problematic behaviors with the child; the caregiver is seen as key in successful long-term outcomes.

MST is a pragmatic intervention. After conducting a functional analysis of the target behavior, problem-focused treatments with empirical evidence are applied to change the target behavior. To eliminate barriers to treatment, MST is delivered at the family's home and the treatment team assumes responsibility for engaging the family and attaining clinical outcomes. Services are available 24 hours a day/7 days a week. Therapists work in teams and have low caseloads. In addition, MST has a strong quality assurance component, including clinical support with manualized assessments and interventions, clearly articulated treatment principles, having MST expert consultation, and extensive organizational consultation. Experts give local MST supervisors consultation. An Internet based tracking system monitors adherence.

Research evaluations of MST have been positive. Seven randomized controlled trials and one quasi-experimental trial have been completed and published (see Henggeler et al., 2002 for a review). These studies included several populations: inner-city delinquents, violent chronic juvenile offenders, juvenile offenders with substance use disorder, youths with psychiatric emergencies, maltreating families; and juvenile sex offenders. Across these studies, MST has demonstrated success in treating serious antisocial behaviors. In comparison to control groups (e.g., usual services, juvenile justice system services, individual office therapy), MST has improved family relations and functioning, increased school attendance, decreased youth's mental health symptoms/problems (e.g., conduct problems, anxious-withdrawn behaviors, immaturity, psychiatric symptoms) and substance use, and decreased long-term rates of re-arrest. Moreover, in comparison to control conditions, MST has higher treatment completion rates, decreased long-term rates of out-of-home placements, high consumer satisfaction, and cost-savings. Although MST has not been labeled as a treatment for "dual disorders," it has been used within adolescent populations with multiple needs, including those with substance use disorders and psychiatric problems.

The following reviews in depth two completed studies on MST, the first with substance abusing juvenile delinquents and the second with youth with psychiatric emergencies. Two new applications of MST are then discussed that have direct relevance for the treatment of adolescents with dual disorders.

MST as a treatment for juvenile delinquents with substance use disorders.

Adapting MST for delinquents with SUDs is logical given that it addresses many factors related to adolescent substance use and abuse (Pickrel & Henggeler, 1996). In a five-year randomized controlled trial, Henggeler and colleagues compared MST to treatment as usual in the community (Henggeler et al., 2002; Henggeler, Pickrel, Brondino, & Crouch, 1996). A

total of 118 delinquents who met DSM-IIIR criteria for substance abuse (56%) or dependence (44%) (primarily alcohol (87%) and marijuana (68%)) and their families participated in the research. The majority of participants were male (79%) and half were African-American (50%). The participants had an average of 2.9 prior arrests. In addition, families in this study were economically disadvantaged; for example, 25% of participant's parents were unemployed. Important to this review was that 72% met criteria for at least one additional DSM-III-R psychiatric diagnosis based on the Diagnostic Interview Schedule for Children (Shaffer, 1992). Comorbid disorders included conduct disorder (35%), social phobia (19%), simple phobia (16%), oppositional defiant disorder (12%), overanxious disorder (10%), agoraphobia (10%), major depression (9%), and attention deficit disorder (4%). Thus, this was a multiple needs sample, including many adolescents with dual SUD and psychiatric disorders. MST outcomes were assessed post-treatment and at 6 and 12 month follow-ups. Assessments were obtained via multi-methods (i.e., child, parent, biological, archival records)

In an initial evaluation of treatment retention and drop out for the active phase of treatment (i.e., pre- to post-treatment, approximately 4-5 months), a total of 98% of the families were retained in MST for the full course of treatment (Henggeler, Pickrel et al., 1996); 78% of families who were referred for community care received no services during the same time period. This retention rate is particularly impressive given the high rates of treatment dropout seen among youth in SUD treatment. Moreover, given the association between treatment retention and better outcomes among adolescents in SUD treatment (e.g., DATOS-A), this ability to retain youth is important. Henggeler and colleagues attribute this finding to the emphasis in MST on delivery of all services in the natural environment, the responsibility for treatment engagement/outcome being placed on and the availability of the treatment team, and the expectation that families be full collaborators in treatment.

Despite effects on treatment retention, MST effects on outcomes at post-treatment and a 6-month follow-up were modest. As reported by Henggeler, Pickrel, and Brondino (1999), at post-treatment, participants in the MST condition self-reported reductions in alcohol/marijuana use and other drug use relative to those in the usual care condition. However when baseline differences in hard and soft drug use were controlled, treatment effects were not significant. Moderator analyses indicated that these effects appear to be limited to females and younger participants (i.e., under 16 years of age). No significant reductions in self-reported or biological measures of substance use were observed at the 6-month follow-up. A significant reduction in self-reported criminal activity was observed at post-treatment and the 6-month follow-up; however, MST did not differ from usual care. Arrest data gathered from computerized records showed a relative decrease in arrests over time at the 6-month follow-up. Lastly, when out-of-home placements were examined, adolescents in the MST condition had fewer days in out-of-home placements (50% fewer) compared to those in the usual services condition.

Given the relatively modest findings, Henggeler et al. (1999) examined treatment fidelity as a possible explanation. Using their MST Adherence Measure, adherence to MST treatment protocol based on caregiver, therapist, and adolescent reports was low compared to adherence ratings in other MST studies. High adherence was associated with lower rates of

self-reported criminal activity; low adherence was associated with more out-of-home placement days. Findings for drug use were variable dependent on the source of the adherence ratings. For example, high adherence as reported by adolescents was associated with reduced self-reported drug use whereas high adherence as reported by caregivers was associated with increased adolescent alcohol and marijuana use. The authors concluded that MST was not effectively transported from the developers to the supervisors and the therapists in the present study. In addition, it was proposed that MST might need enhancements to address the needs of juvenile delinquents with diagnosed substance use disorders. As a result, several procedures have been implemented in other studies to improve adherence, and as discussed more below, an evidence-based SUD treatment has been integrated with MST and is currently being tested in a randomized controlled trial.

In a paper focusing on school outcomes at posttreatment and the 6-month follow-up, Brown and colleagues found that participants in the MST condition showed a sustained increase in school attendance ascertained by a multi-method strategy using child and parent reports and archival records (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999). Usual care participants showed a decrease in school attendance at posttreatment with a relative increase at 6 months. Thus, groups did not differ on school attendance at the 6-month follow-up. The possibility exists that if MST was ongoing, school attendance may have continued to improve over time.

Schoenwald and colleagues examined the costs of MST during the one-year period from study initiation to the 6-month assessment (Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996). Incremental costs of MST (i.e., cost of MST relative to usual care) were nearly offset by savings incurred as a result in reductions in days of out of home placement during the year. Specifically, a 50% increase in costs associated with MST implementation was associated 46% fewer days incarcerated and 64% fewer days in mental health residential facilities, relative to youth in usual care.

At a four-year follow-up of this same group of adolescents (Henggeler, Clingempeel, Brondino, & Pickrel, 2002), 80 (68% of the original sample) completed the 4-year assessment. Completers did not differ from noncompleters on treatment assignment, demographics, nor baseline drug use variables, comorbid psychopathology, or criminal activity variables. Findings indicated that relative to usual care, MST participation was associated with reductions in aggressive criminal behavior (by archival reports and self-reports) and increased abstinence from marijuana (by biological reports but not by self-reports). No group differences emerged for reducing cocaine use and for decreasing psychiatric symptoms. Thus, results were strongest for reductions in antisocial behavior, particularly aggressive behavior. Similar to the earlier assessments, results for reducing substance use were modest and inconsistent.

MST as a treatment for youth with serious emotional disturbance

The other line of work with MST relevant to this review addresses serious emotional disturbance among adolescents (see Henggeler, Schoenwald, Rowland, & Cunningham, 2002). MST has been adapted to address the needs of youth in psychiatric crisis (i.e., suicidal or homicidal ideation, and psychotic) to provide a community-based alternative to

hospitalization. Some of the modifications include the following: the MST treatment team is expanded to include child and adolescent psychiatric residents and crisis caseworkers (available 24 hours a day/7 days a week). MST supervision is provided daily by a child and adolescent psychiatrist early in treatment, with a reduction later in the course of treatment to 3 times a week. Therapist caseloads are reduced from the usual five families to three families to accommodate for the increase in the intensity of treatment. The clinical protocol includes the development of a comprehensive plan to address safety issues and the integration of pharmacological interventions. Out-of-home placements are planned carefully to insure the safety of the participants and the attainment of treatment goals.

In an NIMH-funded study of MST adapted for youth with serious emotional disturbance, 156 youths who were referred for emergency psychiatric hospitalization participated in a randomized controlled trial of MST versus psychiatric hospitalization (Henggeler, Rowland et al., 1999; Henggeler, Rowland et al., 2003; Schoenwald, Ward et al., 2000). Participants were, on average, 13 years of age (range 10-17 years), mostly male (65%) and African-American (64%; 34% White; 1% each Asian-American and Hispanic), and 72% of families receiving some form of welfare with 75% receiving Medicaid. The presenting problem for potential psychiatric hospitalization included suicidal ideation, plan, or attempt (32%), homicidal ideation, plan, or attempt (15%) and psychosis (11%). Ninety-six percent met DISC DSM-III-R criteria for one or more diagnoses (based on caregiver and youth reports, average of 2 to 3 diagnoses per participant). Based on caregiver reports, the most common diagnoses were oppositional defiant disorder, followed by conduct disorder and major depression. By youth reports, the most common diagnoses were oppositional defiant and conduct disorder, followed by major depression. The majority of participants had previous psychiatric treatment (87%). Moreover, 38% had a history of psychiatric hospitalization and 38% had juvenile justice involvement prior to study entry.

Participants completed five yoked assessments: one within 24 hours of acceptance into the project, one shortly after the participants in the psychiatric hospitalization condition were released from the hospital, one at completion of MST (average 4 months post-recruitment), and 6 months and 12 months post-treatment.

Two papers have presented findings from the 4-month assessment on a sub sample of participants (N=116; Henggeler, Rowland et al., 1999; Schoenwald et al., 2000). Results at the 4-month assessment suggested that MST had a greater effect on externalizing symptoms than hospitalization. However, youths in the hospital condition had better self-esteem at the 4-month assessment than those in the MST therapy. In addition, MST had a greater effect on improving family cohesion and reducing days out of school than hospital care. Both caregivers and youth in the MST condition reported greater treatment satisfaction than the hospital care condition. No differences emerged between treatments on reducing internalizing problems and emotional distress. Lastly, youth in the MST condition had fewer days in out of home placement than those in hospital care. The authors propose that these findings may reflect the focus of each treatment; in particular that MST focuses on the social environment whereas traditional mental health treatment focuses on the individual (Henggeler et al., 1999).

Henggeler and colleagues recently reported on the 156 families who completed the study (Henggeler et al., 2003). Using mixed-effects growth curve modeling, MST was initially more effective than hospitalization on reduction of psychiatric symptoms, out-of-home placements, increasing school attendance, in increasing family structure (e.g., rules and monitoring). However, most of these treatment effects attenuated by the one-year assessment. Based on these results, the developers have further modified MST to better treat adolescents with serious emotional disturbance as reported below.

MST integrated with the Community Reinforcement Approach and MST-based continuum of care model

Due to modest results in the randomized controlled trials of MST among youth with substance use disorders and among those with serious emotional disturbance, Henggeler and colleagues have developed two new models of care for these populations. The first adaptation is for youth with comorbid substance use disorders; this model integrates MST with an evidence-based intervention, the Community Reinforcement Approach (CRA; Budney & Higgins, 1998). According to Randall and colleagues (2001), CRA was chosen because of strong empirical support and it's fit with the MST model. CRA includes tracking substance use through urine screens with rewards given for screens indicating no substance use, functional analyses to identify substance use triggers, self-management plans to address triggers of substance use, and use of drug avoidance skills (Randall, Henggler, Cunningham, Rowland, & Swenson, 2001). Thus by integrating the two models, both the broader social context and specific substance use issues are addressed in treatment. To evaluate the effectiveness of this integrated approach, a randomized trial funded by NIDA and NIAAA is being conducted within juvenile drug courts (see Randall, Halliday-Boykins, Cunningham, & Henggler, 2001). The study examines whether outcomes from drug court are enhanced with the addition of MST and if a condition that includes MST-CRA has a greater influence on positive outcomes relative to MST alone.

MST has also been modified to better address the needs of youth with serious mental illness: MST-based continuum of care is an integrated mental health and substance abuse service system. This adaptation is similar to what is recommended for adults with severe and persistent mental illness (see above description, Drake et al., 1999). In this model, MST service delivery systems include home-based services, intensive outpatient, crisis intervention, family resource specialists/parent partners, therapeutic foster care, respite services, access to residential and hospital beds and integration of evidence-based psychopharmacological treatment. Care is given on an ongoing basis (in contrast, MST is usually offered as a 3-5 month time limited treatment) and the integration of MST into the multiple service delivery systems allows the MST treatment team to have a greater influence over treatment decisions when the youth is placed outside the home. Moreover, a key feature is that the same team (e.g., therapist, psychiatrist, supervisor) treats the adolescent regardless of his/her placement on the continuum of care. This model is currently being evaluated in a randomized trial in Philadelphia about clinical outcomes and cost-effectiveness relative to usual care.

In summary, both of these new models hold promise for the treatment of comorbid substance use and psychiatric disorders. Although not labeled as treatment for "dual disorders", both

address substance use disorders and serious emotional difficulties. The integrated approach fits with what is recommended in the adult literature and makes logical sense given the potential functional relations among multiple and complex symptoms in youth with co-occurring disorders.

POSTTRAUMATIC STRESS AND SUBSTANCE USE DISORDERS: SEEKING SAFETY FOR ADOLESCENT GIRLS

Armstrong & Costello's (2001) comprehensive review of community studies suggested that PTSD was significantly associated with SUDs among youth. In a recent review specific to the dual disorder of SUD-PTSD, Giaconia noted that surprisingly few studies examine this particular dual diagnosis despite contemporary adolescents' risk for SUDs and PTSD (Giaconia, Reinherz, Paradis, & Stashwick, 2003). Among clinical and community samples of adolescents with SUDs, rates of PTSD ranged from 11-47% (Giaconia et al., 2003). Given that rates of trauma are high among adolescents with SUDs (50-75%; Giaconia et al., 2003) and among dually diagnosed adolescents (e.g., 52%; Grella et al., 2001), a focus on the integrated treatment of this particular diagnosis may be prudent. In line with this, Najavits has adapted her adult-focused integrated treatment for SUD and PTSD - Seeking Safety - for adolescent girls with this dual diagnosis. A focus on girls may be warranted by data suggesting that females are somewhat more at risk for this dual diagnosis than men (Giaconia et al., 2003; Najavits, Weiss, & Shaw, 1997; Stewart, Ouimette, & Brown, 2002). A description of the adaptation and some preliminary outcome data follows.

As described above, Seeking Safety is a coping skills oriented therapy for current SUD and PTSD. To address the developmental needs of adolescent girls, Najavits, Gallop, & Weiss (2003) describe several modifications to the protocol: (1) material was conveyed verbally if the client did not want to read written handouts; (2) to evoke emotional material, use of more appropriate techniques such as "displacement" were used; (3) the trauma was discussed if desired by the client; (4) two sessions were allotted to address topics outside the manual; and (5) parental updates on treatment progress were provided, if the client agreed. In addition, parents were invited to attend one session that focused on, "Getting Others to Support Your Recovery."

Eighteen outpatient adolescent girls were randomized to Seeking Safety plus treatment as usual whereas 15 were randomized to treatment as usual alone (Najavits et al., 2003). On average, participants were 16 years of age and Caucasian (79%). The majority were diagnosed with cannabis (79%) or alcohol (67%) use disorders. When asked about if their symptoms, the majority of adolescent girls (75%) believed that their PTSD and SUD symptoms were related. Participants were excluded if they had a history of bipolar I or psychotic disorder, were mandated to treatment, or had characteristics that could interfere with treatment completion (e.g., homelessness). Participants were assessed at intake, post-treatment, and at a 3-month follow-up. Participants completed an average of 12 of the 25 offered sessions over a three-month period; nine of the 12 sessions were Seeking Safety focused.

Post-treatment findings found that clients in Seeking Safety reported reduced substance use, PTSD and trauma-related symptoms, SUD and PTSD-related cognitions, improved

functioning, and less psychopathology than clients in treatment as usual. However, some of the post-treatment gains were not maintained at the 3-month follow-up. Participants reported moderate satisfaction with Seeking Safety as a treatment. Despite several limitations including a small sample size, pre-existing group differences, and multiple statistical tests without correction, this study suggests that Seeking Safety may be a transportable to an adolescent population. The dissipation of treatment gains over time suggests that a longer-term approach may be needed with this population.

PERSONALITY RISK FACTORS AND SUBSTANCE USE DISORDERS: BRIEF MOTIVATIONAL INTERVENTIONS FOR AT-RISK ADOLESCENTS

Although not designed as an intervention for dual disorders, Conrod and colleagues brief coping skills-motivational interventions for personality-motivational risk types for substance abuse warrant mention here. As reviewed above, preliminary data suggested that these brief interventions were effective in reducing alcohol and drug use among women with diagnosed substance use disorders. In a study of adolescents, these personality risk factors (i.e., sensation seeking, anxiety sensitivity and hopelessness) were associated with specific risky drinking motives (e.g., anxiety sensitivity with coping/conformity motives (Conrod & Stewart, in press). Thus, Conrod and colleagues adapted their adult based manuals to be more developmentally appropriate for at-risk teenage drinkers (Conrod & Stewart, in press). These interventions were conceptualized as early interventions to decrease heavy drinking and to prevent the development of mental health and substance use disorders.
In an initial study, these interventions were given to adolescents in a group over two sessions with within and between sessions assigned homework. Twenty-six teens who indicated drinking and personality risks that participated in these interventions. Twenty-five percent reported that they were no longer drinking 4-months after the intervention compared to 8% of 21 teens who were in an assessment-only group (Conrod & Stewart, in press).

In a second wave of data collection, a two-site randomized trial was conducted. Participants were randomized to matched personality-risk motivational intervention or to a no treatment control group. Results indicated that the matched intervention was more effective at reducing drinking quantity and problems than no treatment. Although preliminary, these results are promising and these interventions may provide a good strategy for reducing risk for alcohol abuse in at risk youth as well as comorbid psychopathology (e.g., anxiety sensitivity is associated with anxiety disorders). Relevant to this review, these brief motivational interventions could possibly be used as part of a larger treatment program for adolescents with dual disorders.

CONCLUSION AND FUTURE DIRECTIONS

This review focused on the evidence base for integrated dual diagnosis treatments for adults and adolescents. While guidelines have been set forth (Drake et al., 2001), the evidence base for the efficacy and effectiveness of specific intervention approaches is variable by intervention and in general, relatively small, especially for adolescents. At most, the interventions reviewed here could be classified as “promising” practices.

In reviewing the treatment protocols designed for adults with severe mental illness and substance use disorders, it was found that a comprehensive longer-term approach, addressing

motivational, individual, and family issues, maintained clients in treatment and produced better outcomes than comparison conditions (e.g., Barrowclough et al., 2001). An important finding was that programs could be inadvertently excluding motivated patients by not integrating themselves into existing systems and/or addressing client barriers to treatment (e.g., managing difficult treatment schedules; Bennett et al., 2001). In one randomized trial reviewed that showed treatment effects for an integrated protocol, negative symptoms and social functioning did not improve. Future work should consider ways to bolster treatment results in these areas.

For the anxiety disorders, two main issues were poor retention and a lack of treatment effects in key areas (or maintenance of effects). These issues may reflect a key facet of anxiety disorders - avoidance behaviors - not being adequately addressed by the interventions (Conrod & Stewart, in press). Lack of improvement may also be due to need for longer-term approach. Future work in this area needs to address these concerns.

Results for interventions designed for personality disorders and substance abuse were promising and point to the need for a strong therapeutic alliance, motivation, and appropriate "staging" of interventions. While results from controlled trials of DBT are very promising for patients with comorbid borderline and substance use disorders, there is no published information on the effectiveness of integrated treatments for personality disorders other than borderline that are comorbid with substance use disorders. Thus, a general call for more treatment development and testing of these interventions is warranted.

Among adolescents, the paucity of research in this area is notable. The program of research on MST is one of the most comprehensive reviewed and holds much promise as a best practice for adolescents with mental health and substance use disorders. The MST findings of lack of maintenance of effects over time, in conjunction with similar findings from the Seeking Safety protocol, clearly suggest that briefer interventions may not be adequate for youth with dual disorders. As with the personality disorders, there is a need for general treatment development for youth with comorbid mental health and substance use disorders.

Much progress has been made in designing programs for dual disorders in adults and preliminary work with adolescents appears promising. However, most of these programs need to be evaluated for their efficacy and cost-effectiveness relative to standard care and other programs. Initial work suggests that these programs may need improvement on addressing non-symptom outcomes such as quality of life issues (e.g., vocational problems) and should consider longer-term approaches. Given the popularity of self-help approaches in the United States, the role of social influences in substance use, and concerns about health care costs, an investigation of whether self-help can provide a helpful adjunct to integrated treatment would be useful, particularly for adult populations.

References

Armstrong, T.D., & Costello, E. J. (2002). Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of Consulting & Clinical Psychology, 70*, 1224-1239.

Back, S.E., Dansky, B.S., Carroll, K.M., Foa, E.B., & Brady, K.T. (2001).Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: Description of procedures. *Journal of Substance Abuse Treatment, 21,* 35-45.

Ball, S.A. (1998). Manualized treatment for substance abusers with personality disorders: Dual focus schema therapy. *Addictive Behaviors, 23*, 883-891.

Ball, S.A. & Young, J.E. (1998). Dual focus schema therapy: A treatment manual for personality disorder and addiction. *Unpublished manuscript*.

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S.W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry, 158*, 1706-1713.

Bennett, M.E., Bellack, A.S. & Gearon, J.S. (2001). Treating Substance abuse in schizophrenia: An initial report. *Journal of Substance Abuse Treatment, 20,* 163-175.

Bellack, A.S., & DiClemente, C.C. (1999). Treating substance abuse among patients with schizophrenia. *Psychiatric Services, 50*, 75-80.

Bellack, A.S., & Gearon, J.S. (1998). Substance abuse treatment for people with schizophrenia. *Addictive Behaviors, 23*, 749-766.

Bellack, A.S., Mueser, K.T., Gingerich, S., & Agresti, J. (1997). *Social Skills Training for Schizophrenia.* New York: Guilford.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63*, 569-578.

Brady, K. T., Dansky, B. S., Back, S., Foa, E. B., & Carroll, K. (2001). Exposure Therapy In The Treatment Of PTSD Among Cocaine-Dependent Individuals: Preliminary Findings. *Journal of Substance Abuse Treatment, 21*, 47-54.

Brown, P.J., Recupero, P.R., & Stout, R. (1995). PTSD substance abuse comorbidity and treatment utilization. *Addictive Behaviors, 20*, 251-254.

Brown, P.J., Stout, R.L., & Mueller, T. (1996). Post-traumatic stress disorder and substance abuse relapse among women: A pilot study. *Psychology of Addictive Behaviors, 10,* 124-128.

Brown, T. L., Henggeler, S. W., Schoenwald, S. K., Brondino, M.J., & Pickrel, G.(1999). Multisystemic treatment of substance abusing and dependent juvenile delinquents: Effects on school attendance at posttreatment and 6- month follow- up *Children's Services: Social Policy, Research, and Practice, 2*, 81-93.

Carroll, K., Donovan, D., Hester, R., & Kadden, R. (1993). Cognitive-Behavioral Coping Skills Program. *Unpublished manuscript*.

Clark, R.E., Teague, G.B., Ricketts, S.K., Bush, P.W., Xie, H., McGuire, T.G., Drake, R.E., McHugo, G.J., Keller, A.M, & Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Services Research, 33,* 1285-1308.

Coffey, S. F., Dansky, B. S., & Brady, K. T. (2003). Exposure-based, trauma-focused therapy for substance abusers with PTSD. In P. Ouimette and P. Brown, (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. American Psychological Association, Washington DC.

Coffey, S.F., Schumacher, J., & Brimo, M.L. (in press). Exposure therapy for substance abusers with PTSD: translating research into practice. *Behavior Modification*.

Conrod, P.J., Pihl, R.O., Stewart, S.H. & Dongier, M. (2000). Validation of a system of classifying female substance abusers based on personality and motivational risk factors for substance abuse. *Psychology of Addictive Behaviors, 14*, 243-256.

Conrod, P. J., Stewart, S. H., Pihl, R. O., Côté, S., Fontaine, V., & Dongier, M. (2000). Efficacy of brief coping skills interventions that match different personality profiles of female substance abusers. *Psychology of Addictive Behaviors, 14*, 231- 242.

Conrod, P.J. & Stewart, S.H. (in press). A Critical Look at Dual-Focused Cognitive-Behavioral Treatments for Comorbid Substance Use and Psychiatric Disorders: Strengths, Limitations, and Future Directions. *Journal of Cognitive Psychotherapy*.

Crowley, T.J., Mikulich, S.K., MacDonald, M., Young, S.E., & Zerbe, G.O. (1998). Substance-dependent, conduct-disordered adolescent males: Severity of diagnosis predicts 2-year outcome. *Drug & Alcohol Dependence, 49,* 225-237.

Dixon, L. (1999). Dual diagnosis of substance abuse in schizophrenia: prevalence and impact on outcomes. *Schizophrenia Research, 35*, S93-100.

Donovan, B., Padin-Rivera, E., & Kowaliw, S. (2001). Transcend: Initial outcomes from a posttraumatic stress disorder/substance abuse treatment program. *Journal of Traumatic Stress, 14*, 757-772.

Drake, R.E., Essock, S.M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., Lynde, D., Osher, F.C., Clark, R.E., & Richards, L. Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52,* 469-476, 2001.

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H., Miles, K., & Ackerson, T.H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: a clinical trial. *American Journal of Orthopsychiatry, 68*, 201-215.

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24,* 589-608, 1998.

Drake, R.E., Mueser, K.T., Clark, R.E., & Wallach, M.A. The course, treatment, and outcome of substance disorder in persons with severe mental illness. *Journal of Orthopsychiatry, 66*, 42-51, 1996.

Giaconia, R.M., Reinherz, H.Z., Paradis, A.D., & Stashwick, C.K. (2003). Comorbidity of substance use disorders and posttraumatic stress disorder in adolescents. In P. Ouimette, & P.J.Brown, Pamela (Eds.). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. (pp. 227-242). Washington, DC: American Psychological Association.

Giaconia, R.M., Reinherz, H.Z., Hauf, A., Paradis, A.D., Wasserman, M.S., & Langhammer. D.M. (2000). Comorbidity of substance use and post-traumatic stress disorders in a community sample of adolescents. *American Journal of Orthopsychiatry, 70*, 253-262.

Greenbaum, P.E., Foster-Johnson, L., Petrila, A. (1996). Co-occurring addictive and mental disorders among adolescents: Prevalence research and future directions. *American Journal of Orthopsychiatry, 66*, 52-60.

Grella, C.E., Hser, Y.I., Joshi, V., & Rounds-Bryant, J. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. *Journal of Nervous & Mental Disease, 189,* 384-392

Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G.(2002). Four- year follow-up of Multisystemic therapy with substance-abusing and substance- dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 41,* 868-874.

Henggeler, S.W., Pickrel, S.G., & Brondino, M.J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research. 1*, 171-184.

Henggeler, S. W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry, 153*, 427- 428.

Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C., Sheidow, A.J., Ward, D.M., Randall, J., Pickrel, S.G., Cunningham, P.B., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 543-551.

Henggeler, S.W.,Rowland, M.D.,Randall, J., Ward, D.M.,Pickrel, S.G.,Cunningham, P.B.,Miller, S.L., Edwards, J., Zealburg, J.J., Hand, L.D., & Santos, A.B. (1999).Home based Multisystemic Therapy as an Alternative to the Hospitalization of Youths in Psychiatric Crisis: Clinical Outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry 38*,1331-1339.

Henggeler, S.W., Schoenwald, S.K., Bourduin, C., Rowland, M.D.,& Cunningham, P.B.(2002). *Multisystemic Treatment of Antisocial Behavior in Children & Adolescents*. New York: Guilford.

Henggeler, S.W., Schoenwald, S.K., Rowland, M.D.,& Cunningham, P.B. (2002).*Serious Emotional Disturbance in Children & Adolescents*. New York: Guilford.

Higgins, S.T., Badger, G.J., & Budney, A.J. (2000). Initial abstinence and success in achieving longer term cocaine abstinence. *Experimental & Clinical Psychopharmacology, 8,* 377-386.

Hser, Y.I., Grella, C.E., Hubbard. R.L., Hsieh. S.C., Fletcher. B.W., Brown. B.S, & Anglin, M.D. (2001). An evaluation of drug treatments for adolescents in four US cities. *Archives of General Psychiatry, 58*, 689-95.

Jerrell, J.M., & Ridgely, M.S. (1995). Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorders. *Journal of Nervous and Mental Disease 183,* 566-576.

Kaminer, Y., Tarter, R.E., Bukstein, O.G., & Kabene, M. (1992). Comparison between treatment completers and noncompleters among dually diagnosed substance- abusing adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 31*, 1046-1049.

Kandel DB, Johnson JG, Bird HR, Canino G, Goodman SH, Lahey BB, Regier DA, Schwab-Stone M (1997). Psychiatric disorders associated with substance use among children and adolescents: Findings from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. *Journal of Abnormal Child Psychology, 25*, 121-132.

Keane, T.M., & Wolfe, J. (1990). Comorbidity in posttraumatic stress disorder: An analysis of community and clinical studies. *Journal of Applied Social Psychology, 20,* 1776-1788.

Kessler, R.C., Crum, R.M., Warner, L.A., Nelson, C.B., Schulenberg, J., & Anthony, J.C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of General Psychiatry, 54*, 313-321.

Kessler, R.C., Nelson, C.B., McGonagle, K.A., Edlund, M.J., Frank, R.G., & Leaf, P.J. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*, 17- 31.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52,* 1048-1060.

Keller, M.B., Lavori, P.W., Coryell, W., Andreasen, N.C., Endicott, J., Clayton, P.J., Klerman, G.L., & Hirschfeld, R.M. (1986). Differential outcome of pure manic, mixed/cycling, and pure depressive episodes in patients with bipolar illness. *Journal of the American Medical Association, 13*, 3138-3142.

Kilpatrick DG, Acierno R, Saunders B, Resnick HS, Best CL, Schnurr PP. (2000). Risk factors for adolescent substance abuse and dependence: data from a national sample. *Journal of Consulting & Clinical Psychology, 68,* 19-30.

Kofoed, L, Kania, J, Walsh, T, Atkinson, RM. (1986) Outpatient treatment of patients with substance abuse and coexisting psychiatric disorders. *American Journal of Psychiatry, 143,* 867-872.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., & Weiss, D. S. (1990). *Trauma and the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study*. New York: Brunner/Mazel.

Lepine, J.P., & Pelissolo, A. (1998). Social phobia and alcoholism: a complex relationship. *Journal of Affective Disorders, 50*, S23-8.

Lewinsohn, P.M., Hops, H., Roberts, R.E., Seeley, J.R., & Andrews, J.A. (1993). Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III--R disorders in high school students. *Journal of Abnormal Psychology, 102*, 133-144.

Linehan, M.M.. (1993). *Cognitive-behavior therapy of borderline personality disorder*. New York: Guilford.

Linehan, M.M., & Dimeff, L.A. (1997). *Dialectical Behavior Therapy For Substance Abuse Treatment Manual*. Seattle, WA.: University Of Washington.

Linehan, M.M., Dimeff, L.A., Reynolds, S.K., Comtois, K.A., Welch, S.S., Heagerty, P., & Kivlahan, D.R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug & Alcohol Dependence, 67*, 13-26.

Linehan, M.M., Schmidt, H. 3rd, Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug dependence. *American Journal on Addictions, 8*, 279-92.

Managed Care Initiative Panel on Co-occurring Disorders (1998). *Co-occurring* Psychiatric and Substance Disorder in Managed Care Systems: Standards of *Care, Practice Guidelines, Workforce Competencies, and Training Curricula*. Rockville, MD: Center for Mental Health Services.

McLellan, AT, Luborsky, L, Woody, GE, O'Brien, CP, & Druley, K. (1983). Predicting response to alcohol and drug abuse treatments. *Archives of General Psychiatry, 40*, 620-625.

Meichenbaum, D. (1994). *A Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with PTSD*. Waterloo, ON: Institute Press.

Meichenbaum, D., & Cameron, R. (1983). Stress Inoculation Training: Toward a General Paradigm for Training Coping Skills. In J. M. Meichenbaum D (Ed.), *Stress Reduction and Prevention* (pp. 115-157). New York: Plenum Press.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services, 52*, 597-9.

Moggi, F., Ouimette, P.C., Moos, R.H., & Finney, J.W. (1999). Effectiveness of substance abuse treatment for dual diagnosis patients: A model of treatment factors associated with one-year outcomes. *Journal of Studies on Alcohol, 60*, 856-866.

Mueser, K.T., & Fox, L. (2002). A Family Intervention Program For Dual Disorders. *Community Mental Health Journal, 38*, 253-270.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated Treatment For Dual Disorders: A Guide To Effective Practice.* New York: Guilford.

Mueser, K.T., Sengupta, A., Schooler, N.R., Bellack, A.S., Xie, H., Glick, I.D., & Keith, S.J. (2001). Family treatment and medication dosage reduction in schizophrenia: effects on patient social functioning, family attitudes, and burden. *Journal of Consulting & Clinical Psychology, 69*, 3-12.

Najavits, L.M., Weiss, R.D., Shaw, S.R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions*, 6, 273-283.

Najavits, L.M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford.

Najavits, L.M. (2003). Seeking Safety: A New Psychotherapy for Posttraumatic Stress Disorder and Substance Use Disorder. In Ouimette, P.C., & Brown, P.J (Eds.) *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*. (pp. 147-169) Washington, DC: American Psychological Association.

Najavits, L.M., Gallop, R.J., Weiss, R.D. (2003). Seeking Safety therapy for adolescent girls with PTSD and substance abuse: A randomized controlled trial. *Manuscript submitted for publication.*

Najavits, L.M., Gastfriend, D.R., Barber, J.P., Reif, S., Muenz, L. R., Blaine, J., Frank, A., Crits-Christoph, P., Thase, M., & Weiss, R. D. (1998). Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *American Journal of Psychiatry, 155,* 214-219.

Najavits, L.M., Weiss, R.D., & Shaw, S.R. (1998) "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

Osher, F.C., Drake, R.E., Noordsy,.D.L., Teague, G.B., Hurlbut, S.C., Biesanz, J.C., & Beaudett, M.S. (1994). Correlates and outcomes of alcohol use disorder among rural outpatients with schizophrenia. *Journal of Clinical Psychiatry, 55*, 109-13.

Ouimette, P.C., Ahrens, C., Moos, R.H., & Finney, J.W. (1997). Posttraumatic stress disorder in substance abuse patients: Relationships to 1-year posttreatment outcomes. *Psychology of Addictive Behaviors, 11*, 34-47.

Ouimette, P.C., Ahrens, C., Moos, R.H., & Finney, J.W. (1998). During treatment changes in substance abuse patients with posttraumatic stress disorder: The influence of specific interventions and program environments. *Journal of Substance Abuse Treatment, 15,* 555-564.

Ouimette, P.C., Finney, J.W., & Moos, R.H. (1997). Twelve step and cognitive- behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology, 65*, 230-240.

Ouimette, P.C., Finney, J.W. & Moos, R.H. (1999). Two-year posttreatment course and coping of patients with substance abuse and posttraumatic stress disorder. *Psychology of Addictive Behaviors, 13*, 105-114.

Ouimette, P.C., Gima, K., Moos, R.H., & Finney, J.W. (1999). A comparative evaluation of substance abuse treatment: IV. The effect of comorbid psychiatric diagnoses on amount of treatment, aftercare, and 1-year outcomes. *Alcoholism: Clinical and Experimental Research, 23*, 552-557.

Ouimette, P.C., Humphreys, K., Moos, R.H., Finney, J.W., Cronkite, R., & Federman, B. (2001). Self-help participation and functioning among substance use disorder patients with PTSD. *Journal of Substance Abuse Treatment, 20*, 25-32.

Ouimette, P.C., Moos, R., & Finney, J. W. (1998) Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. *Journal of Studies on Alcohol, 59*, 513-522.

Ouimette, P. C., Moos, R. H., & Finney, J. W. (2003). PTSD treatment and five year remission among patients with substance use and posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 71*, 410-414.

Perconte, S.T., & Griger, M.L. (1991). Comparison of successful, unsuccessful, and relapsed Vietnam veterans treated for posttraumatic stress disorder. *Journal of Nervous & Mental Disease, 179,* 558-562.

Pickrel, S. G., & Henggeler, S. W. (1996). Multisystemic therapy for adolescent substance abuse and dependence. *Child and Adolescent Psychiatric Clinics of North America. 5*, 201-211.

Piette, J.D., Baisden, K.L., & Moos, R.H. (1999). *Health Services for VA Substance Abuse Patients: Utilization for Fiscal Year 1998*. Palo Alto, CA: Program Evaluation and Resource Center.

Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7-29.

Project MATCH Research Group (1997). Project MATCH secondary a priori hypotheses *Addiction, 92,* 1671-1698.

Randall, C.L., Thomas, S., & Thevos, A.K. (2001). Concurrent alcoholism and social anxiety disorder: A first step toward developing effective treatments. *Alcoholism: clinical and experimental research, 25)*, 210-220.

Randall, J., Halliday-Boykins, C.A., Cunningham, P.B., Henggeler, S.W. (2001). Integrating evidence-based substance abuse treatment into juvenile drug courts: Implications for outcomes. *National Drug Court Institute Review.*

Randall, J., Henggeler, S.W., Cunningham, P.B., Rowland, M.D., & Swenson, C.C. (2001). Adapting multisystemic therapy to treat adolescent substance abuse more effectively. *Cognitive and Behavioral Practice, 8*, 359 - 366.

Randall, J., Henggeler, S.W., Pickrel, S.G., & Brondino, M.J. (1999). Psychiatric comorbidity and the 16-month trajectory of substance abusing and dependent juvenile offenders. *Journal of the American Academy of Child & Adolescent Psychiatry. 38,* 1118-1124.

Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L,L,, Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association, 264,* 2511-2518.

Ross, H.E., Glaser, F.B., & Germanson, T. (1988). The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry, 45*, 1023-31.

Rounsaville, B.J., Anton, S.F., Carroll, K., Budde, D., Prusoff, B.A., & Gawin, F. (1991). Psychiatric diagnoses of treatment-seeking cocaine abusers. *Archives of General Psychiatry, 48*, 43-51.

Rounsaville, B.J., Kosten, T.R., Weissman, M.M., Kleber, H.D. (1986). Prognostic significance of psychopathology in treated opiate addicts: A 25-year follow-up study. *Archives of General Psychiatry, 43,* 739-745.

Stein, L.I., & Santos, A.B. (1998). *Assertive Community Treatment Of Persons With Severe Mental Illness.* New York: W.W. Norton.

Stewart, S.H., Ouimette, P.C., & Brown, P.J. (2002). Gender and the comorbidity of PTSD with Substance Use Disorders. In Kimerling, R., Ouimette, P.C., & Wolfe, J (Eds.) *Gender and PTSD.* (pp. 232-270). New York: Guilford.

Swindle, R.W., Phibbs, C.S., Paradise, M.J., Recine, B.P., & Moos, R.H. (1995). Inpatient treatment for substance abuse patients with psychiatric disorders: A national study of determinants of readmission. *Journal of Substance Abuse, 7,* 79- 97.

Test, M.A. (1992). Training in Community Living. In R.R. Liberman (Ed.). *Handbook of Psychiatric Rehabilitation* (pp. 153-170). Boston: Allyn & Bacon.

Triffleman, E. (2002) Issues in Implementing Posttraumatic Stress Disorder Treatment Outcome Research in Community-based Treatment Programs. In J. L. Sorensen, R. A. Rawson, J. Guydish, & J. E. Zweben (Eds.). *Research to practice, practice to research: Promoting scientific-clinical interchange in drug abuse treatment*.(pg 227-248). Washington, DC:American Psychological Association.

Triffleman, E. (2000). Gender differences in a controlled pilot study of psychosocial treatments in substance dependent patients with posttraumatic stress disorder: Design consideration and outcomes. *Alcoholism Treatment Quarterly, 18*, 113- 126.

Triffleman, E., Carroll, K., & Kellogg, S. (1999). Substance Dependence-Posttraumatic Stress Disorder Treatment: An Integrated Cognitive-Behavioral Approach. *Journal of Substance Abuse Treatment, 17,* 3-14.

Trull, T.J., Sher, K.J., Minks-Brown, C., Durbin, J., & Burr, R. (2000). Borderline personality disorder and substance use disorders: A review and integration. *Clinical Psychology Review, 20*, 235-53.

Schoenwald, S.K., Ward, D.M., Henggeler, S.W., Pickrel, S.G., Patel, H. (1996). Multisystemic therapy treatment of substance abusing or dependent adolescent offenders: Costs of reducing incarceration, inpatient and residential placement. *Journal of Child and Family Studies. 5*, 431-444.

Schoenwald, S.K., Ward, D.M., Henggeler, S.W., & Rowland, M.D. (2000). MST vs. hospitalization for crisis stabilization of youth: Placement outcomes 4 months post-referral. *Mental Health Services Research, 2*, 3-12.

Shaffer, D., Schwab-Stone. M., Fisher, P., Cohen, P., Piacentini, J., Davies, M., Conners, C.K., & Regier, D. (1993). The Diagnostic Interview Schedule for Children— Revised version (DISC--R): I. Preparation, field testing, interrater reliability, and acceptability. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*, 643-650.

U.S. Surgeon General's Report on Mental Health (1999). Sections on multisystemic therapy outcomes.

Verheul, R., van den Brink, W, & Hartgers, C. (1998). Personality disorders predict relapse in alcoholic patients. *Addictive Behaviors, 23*, 869-82 Weiss, R.D., Griffin, M.L., Greenfield, S.F., Najavits, L.M., Wyner, D., Soto, J.A., & Hennen, J.A. (2000). Group therapy for patients with bipolar disorder and substance dependence: Results of a pilot study. *Journal of Clinical Psychiatry, 61*, 361-367.

Weiss, R.D., Najavits, L.M., Greenfield, S.F. (1999). A Relapse Prevention Group For Patients With Bipolar And Substance Use Disorders. *Journal of Substance Abuse Treatment, 16*, 47-54.

Wise, B.K., Cuffe, S. P., & Fischer, T. (2001). Dual diagnosis and successful participation of adolescents in substance abuse treatment. *Journal of Substance Abuse Treatment, 21*, 161-165.

Zlotnick, C., Najavits, L.M. & Rohsenow, D.J. (in press). A Cognitive-Behavioral Treatment for Incarcerated Women with Substance Use Disorder and Posttraumatic Stress Disorder: Findings from a Pilot Study. *Journal of Substance Abuse Treatment.*

Resource Guide

Integrated Treatment for Dual Disorders

Description:

1. **Primary purpose**: This program is a comprehensive set of approaches including assessment, individual, group, and family that can be tailored to the specific needs of individual programs

2. **Target population**: Adults with severe mental illness, most commonly those with psychotic disorders, but may include anxiety disorders such as posttraumatic stress disorder and personality disorders such as borderline personality disorder

Evaluating this practice:

The manual cited below includes measures to evaluate adherence to dual diagnosis treatment principles (Dual Disorder Treatment Fidelity Scale) and multiple assessment instruments/forms that can be used in treatment planning.

Evidence supporting practice:

1. **Peer reviewed research** – see other considerations
   Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford.

2. **Practice implementation:** see other considerations

3. **Other considerations:** This program/book summarizes available knowledge on various treatment programs (e.g., individual, family) that have been researched separately and recommends that programs include each component in a complete dual diagnosis intervention program. Information (evidence and implementation requirements) on available individual interventions that are included as potential components of an overall program is detailed in this section.

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Relevant websites:

Family Intervention for Dual Disorders – FIDD

Description:

1. **Primary purpose**: Designed to teach client's family the information and skills needed to manage the client's dual disorders. Includes both single family (behavioral family therapy) and family group formats. Goals also include decreasing the client's substance use as well as maintaining family involvement and providing social support for families.

2. **Target population:** Adult patients with severe mental illness and substance abuse

Evaluating this practice:

Alcohol use scale, Drug use scale, Substance abuse of treatment scales, see: Mueser, K.T., Drake, R.E., Clark, R.F., McHugo, G.J., Mercer-McFadden, C., & Ackerson, T. (1995). *Toolkit For Evaluating Substance Abuse In Persons With Severe Mental Illness*. Cambridge, Ma: Evaluation Center At HSRI.

Evidence supporting practice:

Mueser, K.T., & Fox, L. (2002). A family intervention program for dual disorders. *Community Mental Health Journal, 38*, 253-270.

Mueser, K.T., Sengupta, A., Schooler, N.R., Bellack, A.S., Xie, H., Glick, I.D., & Keith, S.J. (2001). Family treatment and medication dosage reduction in schizophrenia: Effects on patient social functioning, family attitudes, and burden. *Journal of Consulting & Clinical Psychology, 69*, 3-12.

Schooler, N.R., Keith, S.J., Severe, J.B., Matthews, S.M., Bellack, A.S., Glick, I.D., Hargreaves, W.A., Kane, J.M., Ninan, P.T., Frances, A., Jacobs, M., Lieberman, J.A., Mance, R., Simpson, G.M., & Woerner, M.G. (1997). Relapse and rehospitalization during maintenance treatment of schizophrenia: The effects of dose reduction and family treatment. *Archives of General Psychiatry, 54*, 453-463.

Manuals

Mueser, K.T., & Glynn, S.M. (1999). *Behavioral family therapy for psychiatric disorders* (2nd ed.). Oakland, Ca.: New Harbinger.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford.

Practice implementation:

1. **Staffing requirements –** For multiple family groups –optimal to have two leaders - one with a background in addictions treatment and other with a background in mental health treatment
2. **Training requirements –** typical training is a 1-2 day workshop followed by weekly supervision
3. **Cost of program**
4. **Use of natural funding** - The FIDD program has been implemented at two mental health centers using state funds.

Other considerations:

A randomized controlled trial is underway in Boston, Massachusetts and Los Angeles, California

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Relevant websites:

Behavioral Treatment for Substance Abuse in Schizophrenia (BTSAS)

Description:

1. **Primary purpose:** Five treatment components focus on motivational interviewing, urinanalysis contingency, drug refusal skills, education and coping skills, and problem solving/relapse prevention

2. **Target population:** Adult patients with schizophrenia and substance abuse

Evaluating this practice:

- Addiction Severity Index (McLellan et al., 1990)
- Substance Use Event Scale In Schizophrenia (Bennett, contact information below)
- Quality Of Life Interview (Lehman, 1988)
- Social Functioning Scale (Birchwood et al., 1990)
- Positive And Negative Symptom Scale (Kay et al., 1987)

Evidence supporting practice:

Bennett, M.E., Bellack, A.S. & Gearon, J.S. (2001). Treating substance abuse in schizophrenia: An initial report. *Journal of substance abuse treatment, 20*, 163-175.

Bellack, A.S., & DiClemente, C.C. (1999). Treating substance abuse among patients with schizophrenia. *Psychiatric Services, 50*, 75-80.

Bellack, A.S., & Gearon, J.S. (1998). Substance abuse treatment for people with schizophrenia. *Addictive Behaviors, 23*, 749-766.

Manual

Behavioral Treatment for Substance Abuse and Schizophrenia (contact Dr. Bennett, see below)

Practice implementation:

1. **Staffing requirements –** A range of individuals have been successfully trained in using BTSAS, including social workers, and master's level and doctoral level psychologists.

2. **Training requirements –** Consultation on implementation is available.

3. **Cost of program –** Complete cost data are not available. Materials that are needed for the program include urine drug tests and related materials (gloves, cups), teacher materials (each member of the group gets a binder with handouts), payments for attendance ($2 plus a bus token and a McDonald's coupon), and payments for the urinalysis contingency ($1.50-3.50 per clean urine per patient).

4. **Use of natural funding**

Other considerations:

Currently in year four of a 5-year NIDA funded study.

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Relevant websites:

Integrated Group Therapy (IGT) for Bipolar and Substance Use Disorders

Description:

1. **Primary purpose:** IGT is a relapse prevention therapy; major goals include educating patients about their two illnesses, and helping patients: (1) gain acceptance of their illnesses, (2) offer and receive mutual social support to recover, (3) desire and attain a goal of abstinence, and (4) helping patients comply with medication and other treatments for bipolar disorder.

2. **Target population:** Adult patients with bipolar and substance use disorders.

Evaluating this practice:

- Addiction Severity Index (Mclellan, Kushner et al. 1992)
- Timeline Follow-Back Assessment (Sobell & Sobell, 1992)
- Urine Toxicology Screens
- Breath Alcohol Assessments
- Young Mania Rating Scale (Young et al., 1978)
- Hamilton Rating Scale For Depression (Hamilton, 1960)
- Medication Compliance Interview (Weiss et al., 1998; Jamison et al., 1979)
- Treatment Services Review (Mclellan, Alterman et al., 1992)

Evidence supporting practice:

Weiss, R.D., Najavits, L.M., & Greenfield, S.F. (1999). A relapse prevention group for patients with bipolar and substance use disorders. *Journal of substance abuse treatment*, *16*, 47-54.

Weiss, R.D., Griffin, M.L., Greenfield, S.F., Najavits, L.M., Wyner, D., Soto, J.A., & Hennen, J.A. (2000). Group therapy for patients with bipolar disorder and substance dependence: results of a pilot study. *Journal of clinical psychiatry, 61*, 361-367.

Manual:

Integrated Group Therapy (contact: Dr. Weiss, see below for information).

Practice implementation:

Characteristics of therapists who have conducted the groups included: (1) having master's or doctoral training that included education in psychopathology; and (2) having at least one year of experience conducting therapy in a general psychiatric setting, in a substance abuse treatment clinic and as a group therapist.

Other considerations:

Program currently being evaluated with NIDA funding

Contact information:

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Relevant websites:

http://www.adatp.org/

Motivational Interviewing, Cognitive Behavior Therapy, and Family Intervention

Description:

1. **Primary purpose:** This program integrates routine care with three intervention approaches: motivational interviewing, individual cognitive-behavior therapy, and family or caregiver intervention.

2. **Target population:** Adult patients with schizophrenia/schizoaffective and substance use disorders (and their caregivers)

Evaluating this practice:

- Global assessment of functioning scale (DSM-IV)
- Positive and negative symptom scale (Kay et al., 1987)
- Social functioning scale (Birchwood et al., 1990)
- Drugs attitude inventory (Hogan et al., 1983)
- Timeline follow-back (Sobell & Sobell, 1992)
- Addiction severity index (Mclellan et al., 1980)
- Leeds dependence questionnaire (Rastrick et al., 1994)
- Alcohol and drug use scales (Drake et al., 1996)

Evidence supporting practice:

Barrowclough, C. (2000). Cognitive behavioral interventions for clients with severe mental illness who have a substance misuse problem. *Psychiatric Rehabilitation Skills, 42*, 216-233.

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S.W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry, 158*,1706-1713.

Barrowclough, C. & Tarrier, N. (1992). *Families of schizophrenic patients: A cognitive-behavioral intervention*. London: Chapman & Hall.

Haddock, G., Tarrier, N., Spaulding, W., Yusupoff, L., Kinney, C., & McCarthy, E. (1998). Individual cognitive-behavior therapy in the treatment of hallucinations and delusions: A review. *Clinical Psychology Review, 18,* 821-838.

Practice implementation:

1. **Staffing requirements:** In Barrowclough et al., (2001), each patient was assigned a "family support worker" in addition to their assigned therapist. The support worker provided information, gave advice on benefits, advocated for the patient, provided emotional support and practical help. Therapists in the controlled trial were psychologists and a nurse therapist who had experience in cognitive-behavioral therapy with psychotic patients

2. **Training requirements:** Motivational interviewing, cognitive behavior therapy

3. **Cost of program**

4. **Use of natural funding**

Other considerations:

Contact information:

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Relevant websites:

Assertive Community Treatment for Patients with Co-occurring Severe Mental Illness and Substance Use Disorder

Description:

1. **Primary purpose:** This program uses multidisciplinary teams that directly provide comprehensive services in the patient's natural environment and are available 24 hours per day for a group of patients

2. **Target population:** Adults with severe mental illness, including schizophrenia, schizoaffective, and bipolar disorder and an active substance use disorder

Evaluating this practice:

- Time-line follow-back (Sobell et al., 1980). For more information see http://cps.nova.edu/~gsc/
- Addiction severity index (Mclellan, Luborsky, O'Brien, & Woody, 1980)
- Quality of life interview (Lehman, 1988)
- Expanded brief psychiatric rating scale (Lukoff, Nuechterlein, & Ventura, 1986)
- Service utilization interview (Clark, 1994)
- Toxicology screens

Evidence supporting practice:

Clark, R.E., Teague, G.B., Ricketts, S.K., Bush, P.W., Xie, H., McGuire, T.G., Drake, R.E., McHugo, G.J., Keller, A.M, & Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Services Research, 33*, 1285-1308.

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H., Miles, K., & Ackerson, T.H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: a clinical trial. *American Journal of Orthopsychiatry, 68*, 201-215.

Manuals/training materials:

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: a guide to effective practice.* New York: Guilford.

Stein, L.I., & Santos, A.B. (1998). *Assertive community treatment of persons with severe mental illness.* New York: W.W. Norton.

Practice implementation:

1. **Staffing requirements**
2. **Training requirements**
3. **Cost of program**
4. **Use of natural funding**

Other considerations:

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Concurrent Treatment of PTSD and Cocaine Dependence

Description:

1. **Primary purpose:** Combines cognitive-behavioral exposure treatment for PTSD with coping skills training for substance use disorders. CTPCD is a 16-session individual outpatient therapy. Developed for cocaine dependence, but could serve as a treatment for PTSD comorbid with any alcohol or drug dependence.

2. **Target population:** Adults with PTSD and substance use disorders.

Evaluating this practice:

- Clinician administered PTSD scale (Blake et al., 1995)
- Addiction severity index (Mclellan et al.1990)
- Impact of events scale (Horowitz et al., 1979)
- Mississippi scale for PTSD (Keane et al., 1987)
- Urine and drug screens

Evidence supporting practice:

Brady, K. T., Dansky, B. S., Back, S., Foa, E. B., & Carroll, K. (2001). Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: preliminary findings. *Journal of Substance Abuse Treatment, 21*, 47-54.

Coffey, S. F., Dansky, B. S., & Brady, K. T. (2002). Exposure-based, trauma-focused therapy for substance abusers with PTSD. In: P. Ouimette and P. Brown, (Eds.). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. American Psychological Association, Washington DC.

Coffey, S.F., Schumacher, J., & Brimo, M.L. (in press). Exposure therapy for substance abusers with PTSD: translating research into practice. *Behavior Modification.*

Manuals:

Carroll, K. (1998). *A cognitive-behavioral approach: Treating cocaine addiction. NIDA Therapy Manual for Drug Addiction Monograph Series (vol. 1).* Washington DC: DHHS Pub No 98-4308. (Available at the NIDA website (http://165.112.78.61/TXManuals/CBT/CBT1.html).

Foa, E. & Rothbaum, B. (1997). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York: Guilford.

Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abram, D., Litt, M., & Hester, R. (1994). *Cognitive-Behavioral Coping Skills Therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence. NIAAA Project MATCH Monograph Series (vol. 3).* Washington DC: DHHS Pub No 94-3724. (Available from the NIAAA website for a nominal fee (http://www.niaaa.nih.gov/publications/match.htm).

Practice implementation:

1. **Staffing requirements** –Recommended treatment team includes the patient's individual therapist, group therapy leaders, case managers, and psychiatrist**.**
2. **Training requirements –** Working knowledge of learning theories on which exposure therapy and coping skills therapy are based; training in prolonged exposure treatment for PTSD, coping skills therapy for substance use disorders
3. **Cost of program –** training, audiotapes
4. **Natural funding –** CTPCD has been adapted to a group therapy format for use in a community mental health center for substance abusing women with trauma histories (see Coffey et al., in press).

Other considerations:

Contact information:

Scott F. Coffey, Ph.D.
Department of Psychiatry
University at Buffalo
State University of New York
Buffalo General Hospital
80 Goodrich St.
Buffalo, NY 14203.
scoffey@acsu.buffalo.edu.

Relevant websites:

Assisted Recovery from Trauma and Substances (ARTS)

Description:

1. **Primary purpose:** ARTS (formerly Substance Dependence PTSD Therapy) is a two-phase twice weekly individual 20 week cognitive-behavioral therapy. Phase one focuses on abstinence with psychoeducation about ptsd. Phase two focuses on PTSD symptom treatment and includes prolonged exposure treatment.

2. **Target populations:** Adults with PTSD and substance dependence

Evaluating this practice:

- Clinician administered PTSD scale (Blake et al., 1995)
- Addiction Severity Index (McLellan et al., 1992)
- Urine toxicology

Evidence supporting practice:

Triffleman, E. (2002) Issues in Implementing Posttraumatic Stress Disorder Treatment Outcome Research in Community-based Treatment Programs. In J. L. Sorensen, R. A. Rawson, J. Guydish, & J. E. Zweben (Eds.), *Research to practice, practice to research: Promoting scientific-clinical interchange in drug abuse treatment.* Washington, DC: American Psychological Association. (pg 227-248).

Triffleman, E., Carroll, K., & Kellogg, S. (1999). Substance Dependence-Posttraumatic Stress Disorder Treatment: An integrated cognitive-behavioral approach. *Journal of Substance Abuse Treatment, 17*, 3-14. Training manual available from Dr. Triffleman

Practice implementation:

1. **Staffing requirements –**Dr. Triffleman recommends that experienced mental health or substance abuse clinicians deliver ARTS. Other recommendations include having after-hours on-call evaluation services and referral to psychiatric consultation available; clinicians should have access to supervision to review client progress and transference/countertransference issues; clinicians should know where to refer their patients/clients for other levels of care as needed, such as detoxification services, opiate agonist/antagonist medical maintenance, partial hospitalization and inpatient/rehab services. Clinicians should know how and where to refer for evaluations for medical problems (including OB-GYN) and treatment of HIV and hepatitis B and C. Knowledge of other kinds of social services is useful, such as housing, child care services, shelters, soup kitchens, etc., as appropriate to the socioeconomics of the clientele.

2. **Training requirements –** contact Dr. Triffleman.

3. **Cost of program –** Training manual can be sent for the cost of photocopying and postage, contact Dr. Triffleman.

4. **Use of natural funding**

Other considerations:

Contact information:

Elisa Triffleman, MD
elisa.triffleman@yale.edu

Relevant websites:

Seeking Safety

Description:

1. **Primary purpose**: Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse and may be conducted in individual and group formats. The key principles of Seeking Safety include: Safety as the larger goal, working on PTSD and substance abuse at the same time, a focus on ideals to counteract the loss of ideals from the experience of having PTSD and a substance use disorder, and addressing cognitive, behavioral, interpersonal, and case management areas for client's functioning. In addition, there is a focus on clinician processes such as helping clinicians work with countertransference issues.

2. **Target population:** Adults and adolescents with PTSD and substance use disorders

Evaluating this practice:

- Safety Feedback Questionnaire (Najavits, 2002)
- Trauma Symptom Checklist 40 (Elliot & Briere, 1990)
- Brief Symptom Inventory (Derogatis et al., 1974)
- Addiction Severity Index (McLellan et al., 1992)
- Beliefs about Substance Use (Beck et al., 1993)
- Website – www.seekingsafety.org has downloadable assessment instruments

Evidence supporting practice:

Holdcraft, L.C. & Comtois, K.A. (in press). Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health.*

Najavits L.M. (2003). Seeking Safety: A new psychotherapy for posttraumatic stress disorder and substance use disorder. In P. Ouimette & P. Brown, (Eds.). *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*. Washington, DC: American Psychological Association.

Najavits, L.M., Weiss, R.D., & Shaw, S.R. (1998) "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

Zlotnick, C., Najavits, L.M. & Rohsenow, D.J. (in press). A cognitive-behavioral treatment for incarcerated women with substance use disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment.*

Manual:

Najavits, L.M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford.

Practice implementation:

1. **Staffing requirements –** Seeking safety has been implemented by counselors (e.g., B.A. level, case managers), social workers, as well as masters and doctoral level psychologists.

The seeking safety website has a paper that discusses Dr. Najavits' strategy on how to select therapists to conduct seeking safety – see Najavits, L.M. (2002). *Suggested protocol for selecting and training clinicians in Seeking Safety,* unpublished manuscript, McLean Hospital, Belmont MA.

2. **Training requirements –** DR. Najavits conducts trainings that can be individualized to specific needs of clinics. There is also a list of upcoming trainings on the website. The seeking safety website has three papers that discuss the training of clinicians on seeking safety:
   Najavits, L.M. (2000) Training clinicians to conduct the Seeking Safety treatment for PTSD and substance abuse. *Alcoholism Treatment Quarterly, 18*, 83-98.
   Najavits, L.M. (2002). *Implementing Seeking Safety therapy for PTSD and substance abuse: Clinical guidelines*. Behavioral Health Recovery Management Project (www.bhrm.org)
   Najavits, L.M. (2002). *Suggested protocol for selecting and training clinicians in Seeking Safety,* Unpublished manuscript, McLean Hospital, Belmont MA.

3. **Cost of program-** Cost of training may be obtained by contacting Dr. Najavits. The manual is $35 with discounts for multiple copies.

4. **Use of natural funding –** Seeking Safety has been implemented in a variety of agencies funded at the local and state level.

Other considerations:

Several studies of seeking safety are underway, see website for more details.

Contact information:

Lisa M. Najavits, PhD
McLean Hospital
115 Mill St.
Belmont, MA 02478
info@seekingsafety.org
617-855-2305

Relevant websites:

http://www.seekingsafety.org/

Transcend

Description:

1. **Primary purpose**: Twelve-week partial hospitalization program for Vietnam combat veterans. Program includes six weeks of skill development and six weeks of trauma processing. The program is based on concepts from constructivist, dynamic, cognitive-behavioral, and 12-step paradigms/theories.

2. **Target population:** Vietnam veterans with chronic combat-related PTSD and substance use disorders

Evaluating this practice:

- Clinician Administered PTSD Scale (Blake et al., 1995)
- Addiction Severity Index (McLellan et al., 1992)
- Urine toxicology

Evidence supporting practice:

Donovan, B., Padin-Rivera, E., & Kowaliw, S. (2001). Transcend: Initial outcomes from a posttraumatic stress disorder/substance abuse treatment program. *Journal of Traumatic Stress, 14*, 757-772.

Manuals/other supporting materials:

Donovan. B,. Padin-Rivera, E., & McCormick, R. (1997). *Transcend* Manual: Therapist Guidelines For The Treatment Of Combat-*Related PTSD.* (3rd Ed.) Brecksville, OH: Louis Stokes Cleveland Department of Veterans Affairs Medical Center, Brecksville Division.

Padin-Rivera, E., Donovan. B., & McCormick, R. (1997). *Transcend Manual: A PTSD Workbook.* (3rd Ed.) Brecksville, OH: Louis Stokes Cleveland Department of Veterans Affairs Medical Center, Brecksville Division. There is a brochure available from Dr. Donovan

Practice implementation:

1. **Staffing requirements –** Two staff – a psychologist and a social worker have implemented the program – with medication consultation by a psychiatrist within the VA healthcare system. Clients also participate in occupational therapy.

2. **Training requirements**

3. **Cost of program**

4. **Use of natural funding**

Other considerations:

Participants must complete a primary substance abuse program within six months of starting Transcend.

Contact information:

Beverly Donovan, Ph.D.
VAMC-Building 2 SA
116A (B)
10,000 Brecksville Road
Brecksville, Ohio, 44141
Beverly.Donovan@med.va.gov

Relevant websites:

Dual Focus Schema Therapy

Description:

1. **Primary purpose:** Individual 24 week cognitive-behavioral therapy that integrates relapse prevention with targeted intervention for early maladaptive schemas

2. **Target populations:** Adults with co-occurring personality and substance use disorders

Evaluating this practice:

Treatment outcomes being evaluated in an ongoing study – substance abuse, treatment retention, psychiatric symptoms, working alliance, AIDS risk, methadone clinic outcomes, affective experiences, interpersonal problems, cognitive schemas, and coping styles.

Evidence supporting pratice:

Ball, S.A. (1998) Manualized treatment for substance abusers with personality disorders: Dual focus schema therapy. *Addictive Behaviors, 23*, 883-891.

Training manual:

Ball, S.A. & Young, J.E. (1998). *Dual focus schema therapy: A treatment manual for personality disorder and addiction*.

Practice implementation:

1. **Staffing requirements**
2. **Training requirements**
3. **Cost of program**

4. **Use of natural funding**

Other considerations:

Currently being evaluated through a NIDA grant

Contact information:

Samuel A. Ball
Clinical Research Unit
1 Long Wharf Drive
New Haven, CT 06511

Relevant websites:

Dialectic Behavior Therapy (DBT) for substance abusers with borderline personality disorder

Description:

1. **Primary purpose**: DBT is a cognitive-behavioral therapy for borderline personality disorder adapted to substance abusing clients. DBT synthesizes directive, problem-oriented therapy with supportive therapy (e.g., empathy, acceptance, validation).

2. **Target population**: Adults with borderline personality and substance use disorders

Evaluating this practice:

- Timeline follow-back (Sobell & Sobell, 1986)
- Urine toxicology
- Treatment history interview (Linehan & Heard, 1987)
- Parasuicidal history interview (Linehan et al., 1989, 1990)
- Social history interview (Linehan & Heard, 1994)
- State-trait anger inventory (Spielberger et al., 1988)
- Brief symptom inventory (Derogatis & Melisaratos, 1983)
- Link to instruments developed by Dr. Linehan and colleagues - http://www.brtc.psych.washington.edu/framepublications.htm

Evidence supporting practice:

Linehan, M.M., Dimeff, L.A., Reynolds, S.K., Comtois, K.A., Welch, S.S., Heagerty, P., & Kivlahan, D.R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug & Alcohol Dependence, 67*, 13-26.

Linehan, M.M., Schmidt, H. 3rd, Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions, 8,* 279-92.

Training manual:

Linehan, M.M. (1993). *Cognitive-behavior therapy of borderline personality disorder.* New York: Guilford.

Linehan, M.M. (1993). *Skills training manual for treating borderline personality disorder.* New York: Guilford.

Linehan, M.M. & Dimeff, L.A. (1997). *Dialectical behavior therapy for substance abuse treatment manual.* Seattle, WA.: University of Washington.

Practice implementation:

1. **Staffing requirements –** In Linehan et al. (1999), weekly individual psychotherapy (1 hour) and group skills training sessions (2 hours plus 15 minute wind-down) were provided. In addition, skills coaching phone calls were provided when needed. Therapists met weekly as a team.

2. **Training requirements –** Information on training is available at the website –two day workshops to ten day trainings are available for treatment teams.

3. **Cost of program**

4. **Use of natural funding**

Other considerations:

Contact information:

Marsha M. Linehan, Ph.D.
Director, Behavioral Research & Therapy Clinics
University of Washington
Seattle, Washington
98195-1525
Phone: (206) 685-2037
Fax: (206) 616-1513
linehan@u.washington.edu

Relevant websites:

http://www.brtc.psych.washington.edu/

Seeking Safety for Adolescent Girls

Description:

1. **Primary purpose**: Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. In an adaptation for adolescent girls, individual therapy was used. The key principles of Seeking Safety include: Safety as the larger goal, working on PTSD and substance abuse at the same time, a focus on ideals to counteract the loss of ideals from the experience of having PTSD and a substance use disorder, and addressing cognitive, behavioral, interpersonal, and a focus on clinician processes such as helping clinicians work with countertransference issues. Parents are invited to attend one session.

2. **Target population:** Adolescent girls with PTSD and substance use disorders

Evaluating this practice:

- Clinician Administered PTSD scale – Child and Adolescent version (Nader et al., 1998)
- Personal Experiences Inventory (Winters et al., 1989)
- Trauma Symptom Checklist for Children (Briere, 1996)
- Beliefs about Substance Use (Beck et al., 1993)
- Reasons for Using scale (Jaffe et al., 1989)
- Adolescent Psychopathology Scale (Reynolds, 1998)
- Website – www.seekingsafety.org has downloadable assessment instruments

Evidence supporting practice:

Holdcraft, L.C. & Comtois, K.A. (in press). Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health.*

Najavits L.M. (2003). Seeking Safety: A new psychotherapy for posttraumatic stress disorder and substance use disorder. In P. Ouimette & P. Brown, (Eds.). *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*. Washington, DC: American Psychological Association.

Najavits, L.M., Gallop, R.J., Weiss, R.D. (under review). *Seeking Safety therapy for adolescent girls with PTSD and substance abuse: A randomized controlled trial.*

Najavits, L.M., Weiss, R.D., & Shaw, S.R. (1998) "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

Zlotnick, C., Najavits, L.M. & Rohsenow, D.J. (in press). A cognitive-behavioral treatment for incarcerated women with substance use disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment.*

Manual:

Najavits, L.M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* New York: Guilford.

Practice implementation:

1. **Staffing requirements –** In the version of Seeking Safety delivered to adolescents (see Najavits et al., under review), individual therapy was used and therapists were female psychologists.

2. **Training requirements –** DR. Najavits conducts trainings that can be individualized to specific needs of clinics. There is also a list of upcoming trainings on the website. The seeking safety website has three papers that discuss the training of clinicians on seeking safety:
   Najavits, L.M. (2000) Training clinicians to conduct the Seeking Safety treatment for PTSD and substance abuse. *Alcoholism Treatment Quarterly, 18*, 83-98.
   Najavits, L.M. (2002). *Implementing Seeking Safety therapy for PTSD and substance abuse: Clinical guidelines*. Behavioral Health Recovery Management Project (www.bhrm.org)
   Najavits, L.M. (2002). *Suggested protocol for selecting and training clinicians in Seeking Safety,* Unpublished manuscript, McLean Hospital, Belmont MA.

3. **Cost of program-** Cost of training may be obtained by contacting Dr. Najavits. The manual is $35 with discounts for multiple copies.

4. **Use of natural funding**

Other considerations:

A NIDA funded study is underway that examines seeking safety among adolescent girls.

Contact information:

Lisa M. Najavits, PhD
McLean Hospital
115 Mill St.
Belmont, MA 02478
info@seekingsafety.org
617-855-2305

Relevant websites:

http://www.seekingsafety.org/

Multi-systemic Therapy with Community Reinforcement Plus Vouchers Approach

Description:

1. **Primary purpose**: Multi-systemic therapy focuses on individual, family, peer, school, and social network variables that are linked to serious antisocial behavior in juvenile delinquents, as well as the inter-connections among these variables. Interventions include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavioral therapy. Psychopharmacological treatment is integrated with psychosocial treatment. Recently, MST has been adapted for youth with serious emotional disturbance. MST has also been integrated with an evidence-based treatment for substance use disorders - community reinforcement and vouchers approaches (CRA).

2. **Target populations:** MST targets juvenile offenders with serious antisocial behaviors, who are at high risk of out-of-home placement, and their families. MST also targets adolescents with serious emotional disturbance. MST-CRA targets those adolescents with antisocial behaviors and substance use disorders.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**
   - Criminal Behavior:
     - ✓ Self-Report Delinquency Scale (Elliot et al., 1983)
     - ✓ Seriousness Index (Hanson et al., 1984)
   - Substance use/psychiatric symptoms:
     - ✓ Personal Experiences Inventory (Winters & Henly, 1989)
     - ✓ Brief Symptom Inventory (Derogatis, 1993)
     - ✓ Child Behavior Checklist (Achenbach, 1991)
     - ✓ Young Adult Self-Report (Achenbach, 1991)
     - ✓ Youth Risk Behavior Survey (Kolbe et al., 1993)
     - ✓ Addiction Severity Index (McLellan et al., 1980)
   - Family Relations:
     - ✓ Family Adaptability and Cohesion Evaluation Scales-III (Olson et al., 1985)
     - ✓ Issues Checklist (Robin et al., 1977)
   - Peer Relations:
     - ✓ Peer Conformity Inventory (Berndt, 1979)
     - ✓ Revised Problem Behavior Checklist (Quay & Peterson, 1987)
   - School Functioning:
     - ✓ Child Behavior Checklist – School functioning subscale (Achenbach, 1991)
   - Out-of-Home Placement:
     - ✓ The Monthly Service Utilization Survey (Henggeler et al., 1992)

Evidence supporting practice:

1. **Peer reviewed research:**

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L., & Hall, J. A., Cone, L., & Fucci, B. R. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly, 1*, 40-51.

Henggeler, S.W., Clingempeel, W.G., Brondino, M.J., Pickrel, S.G. (2002). Four-year follow-up of multisystemic therapy with substance-abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 868-874.

Henggeler, S. W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry, 153*, 427-428.

Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C., Sheidow, A.J.,Ward, D.M., Randall, J., Pickrel, S.G., Cunningham, P.B., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 543-551.

Henggeler, S.W., Pickrel, S.G., & Brondino, M.J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*, 171-184.

Randall, J., Halliday-Boykins, C.A., Cunningham, P.B., Henggeler, S.W. (In press). Integrating evidence-based substance abuse treatment into juvenile drug courts: Implications for outcomes. *National Drug Court Institute Review*

Randall, J., Henggeler, S.W., Cunningham, P.B., Rowland, M.D., & Swenson, C.C. (2001). Adapting multisystemic therapy to treat adolescent substance abuse more effectively. *Cognitive and Behavioral Practice, 8*, 359 - 366.

2. **Other supporting documents**

Manual/training materials

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York: Guilford

Henggeler, S.W., Schoenwald, S.K., Rowland, M.D., & Cunningham, P.B. (2002). *Serious Emotional Disturbance in Children and Adolescents: Multisystemic Treatment*. New York: Guilford

MST videos, organizational and supervisory manuals, training materials, slides, and posters are available on the MST website (note: some materials are only available to MST licensed agencies).

Practice implementation:

1. **Staffing requirements –** Master's-level therapists who receive weekly supervision from doctoral level mental health professionals conduct MST. Therapist selection is based on the person's motivation, flexibility, common sense, and "street smarts." Each MST treatment team consists of three to four therapists, with each therapist carrying a caseload of four to six families. Therapist teams consult regularly with each other and with an MST expert. It is "strongly" recommended that MST therapists be full-time employees assigned only to the MST program. In addition, MST therapists must be accessible at times that are convenient to their clients and in times of crisis. Other issues that need to be considered are the use of flex-time/comp-time, policies regarding the use of personal vehicles, and the use of pagers and cellular phones. The MST program must have a 24-hour a day, 7 day a week on-call system. Knowledgeable clinicians must provide coverage for MST clinicians who are on vacation. Detailed description of staffing and implementation issues is included on the website.

2. **Training requirements:** MST Services and the Medical University of South Carolina licenses programs to conduct MST therapy. MST program development services provide a pre-training organizational assessment, an initial 5-day training, weekly MST clinical consultation, quarterly booster training, and quality control through the monitoring of treatment fidelity/adherence. Detailed description of each stage of training can be found on the MST website.

3. **Cost of program:** MST services are provided in community settings (e.g., homes, schools), thus less facility space is needed. Costs include those of the therapists, supervisors and training; therapists require transportation and cell phones.

4. **Use of natural funding:** The MST-CRA program has been implemented with state funding.

Other considerations:

The research group is currently in the 4th year of a NIDA and NIAAA funded randomized MST trial, in which one component is examining integrated MST and CRA.

Contact information:

For information about program development, treatment model dissemination, and training contact:

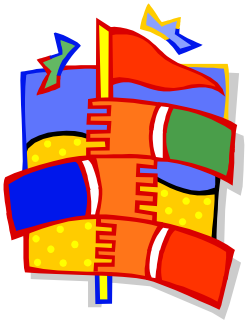
Marshall E. Swenson, MSW, MBA
Manager of Program Development, MST Services
710 J. Dodds Blvd.
Mt. Pleasant, SC 29464
Email: marshall.swenson@mstservices.com
Phone: 843.856-8226
Fax: 843.856.8227

For information about research related issues contact:
Dr. Scott W. Henggeler
Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425-0742
Phone: 843.876.1800
Fax: 843.876.1808

Relevant websites:

http://www.musc.edu/fsrc/index.htm
http://www.mstinstitute.org/
http://www.mstservices.com/

Geriatric



Contributors:

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University of Washington

A Review Of The Literature

OLDER ADULTS[4] IN WASHINGTON STATE

Washington State ranks 7th in the United States in the proportion of its population that is 65+. Also, it has one of the fastest growing populations of older persons in the country with the number of persons 65 years of age and older projected to double by 2025 (US Bureau of the Census, 2000). Between 1995 and 2010, the annual rate of increase can be expected to be between 5.1 to 6.9 percent (US Bureau of the Census). In 2002, older adults accounted for 15 percent of the total population in Washington State. By 2025, the proportion of older adults in the state is estimated to be 20.2 percent (US Bureau of the Census).

As the population ages with the baby boomers, there will be greater attention given to the most common mental disorders of late life, including dementia, depression, anxiety, and substance abuse disorders. While the majority of older adults enjoy healthy and productive lives well into their golden years, about 20 percent of older adults experience symptoms of mental illness that are serious enough to warrant treatment (DSSH, 1999).

THE PREVALENCE[5] OF MENTAL ILLNESS AMONG OLDER ADULTS

Prevalence estimates of mental disorders among older adults vary widely, depending on the definition and procedures used for counting a case (e.g. clinical diagnostic approaches versus screening approaches), differences in setting (community versus inpatient versus health clinic, etc.), and sampling procedures (Gallo & Lobowitz, 1999; Bartels, et al., 2002). In addition, older adults with mental illness often present with a different pattern of symptoms than younger adults which makes detection, diagnosis, and measurement more difficult (DHHS, 1999). Older adults also experience a number of age-related illness conditions (e.g. arthritis, osteoporosis, heart disease, urinary tract infection, high blood pressure) that co-occur with mental illness that further complicates making an accurate diagnosis of mental illness. Indeed, mental disorders of late life often go undetected, undiagnosed, untreated, or mistreated (DHHS, 1999, 2001a).

Depression

Estimates of major depression in community samples of older adults range from .8 to 20 percent (DHHS, 1999). About 15 percent of older adults have been estimated to have significant depressive symptoms that do not meet criteria for a major depression although warrant treatment. Rates of depression increase when special populations of older adults are examined, e.g. nursing home residents (75 percent) and primary care patients, (37 percent).

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[4] In this report, we use the term "older adult" to refer to individuals 60 years of age and older in the population which is consistent with Washington State's cutoff for this age group. However, 55+, 60+, and 65+, are commonly used throughout the literature and will be duly noted when appropriate.

[5] Prevalence refers to the proportion of the population that meets criteria for a disorder within a specified time (Gallo & Lebowitz, 1999).

Depression often co-occurs with substance abuse (DHHS, 1998) and has been found to have a strong link to suicide among older adults (DHHS, 1999; 2001a, 2002).

Indeed, older adults have the highest rates of suicide compared to any other age group. According to the National Strategy for Suicide Prevention (DHHS, 2001b), on average, there is one suicide among persons aged 65 and older every 90 minutes. Moreover, older adults comprise 13% of the population and yet represent 19 percent of all suicide deaths. Older Caucasian men have the highest rates of completed suicide of all individuals 65 years of age and older; 84 percent (DHHS, 2001b). Even though older adults are less likely to attempt suicide, they are more likely to succeed with suicide than any other age group. They use more lethal methods than younger age groups including, firearms (71%), overdose (11%) and suffocation (11%) (DHHS, 2001b).

A number of factors have been found to increase an older person's risk of suicide: depression, alcohol abuse, social isolation, serious health problems, and loss of a spouse through separation or divorce (DHHS, 2001b). A significant number of older adults have recently visited a physician prior to suicide (DHHS, 2001b).

Anxiety Disorders

Anxiety disorders are reported to be the most prevalent mental disorders among older adults (DHHS, 1999). However, they are the least studied and treated of the mental disorders of late life. Community-based studies estimate that between five (Gallo & Lebowitz, 2002) and 11.4 percent of older adults meet criteria for an anxiety disorder (DHHS, 1999). Panic disorder and obsessive-compulsive disorders have been reported as low as .5 percent among older adults, whereas a generalized anxiety disorder has been estimated to range from 1.1 percent to 17.3 percent in community samples (DHHS, 1999). Symptoms of anxiety, e.g. worry, nervous tension, have been found in 17 percent of older men and 21 percent of older women (DHHS, 1999).

Alzheimer's Disease and other Dementia's

Prevalence rates of Alzheimer's disease and other dementia's vary widely. There is evidence that suggests that about half of individuals over the age of 85 have some form of dementia (Gallo & Lebowitz, 1999). Alzheimer's disease, the most prevalent form of dementia, afflicts 8 to 15 percent of individuals over the age of 65 (DHHS, 1999). Hebert et al. (2003), measured the current incidence of Alzheimer's disease among individuals free of the disease at baseline that were residing in three adjacent Chicago neighborhoods to estimate prevalence rates in the US population. Using the 2000 census, they estimate that in 2000, 4.5 million persons were afflicted with Alzheimer's disease in the US population. They go on to predict that by the year 2050, the number will increase to 13.2 million; an approximate 3-fold increase.

Older adults can be successfully treated for mental illness in their later years. A number of recent federal reports (DHHS, 1999, 2001a, 2002) provide a comprehensive review of the efficacy of different types of treatment interventions used with older adults (e.g. pharmacological, psychosocial, electroconvulsive therapy) and will not be presented in this document.

THE NEED FOR SPECIALIZED MENTAL HEALTH SERVICES FOR OLDER ADULTS

The large unmet need for treatment of mental disorders reflects patient barriers … provider barriers… and mental health delivery system barriers (DHHS, 1999, p. 341).

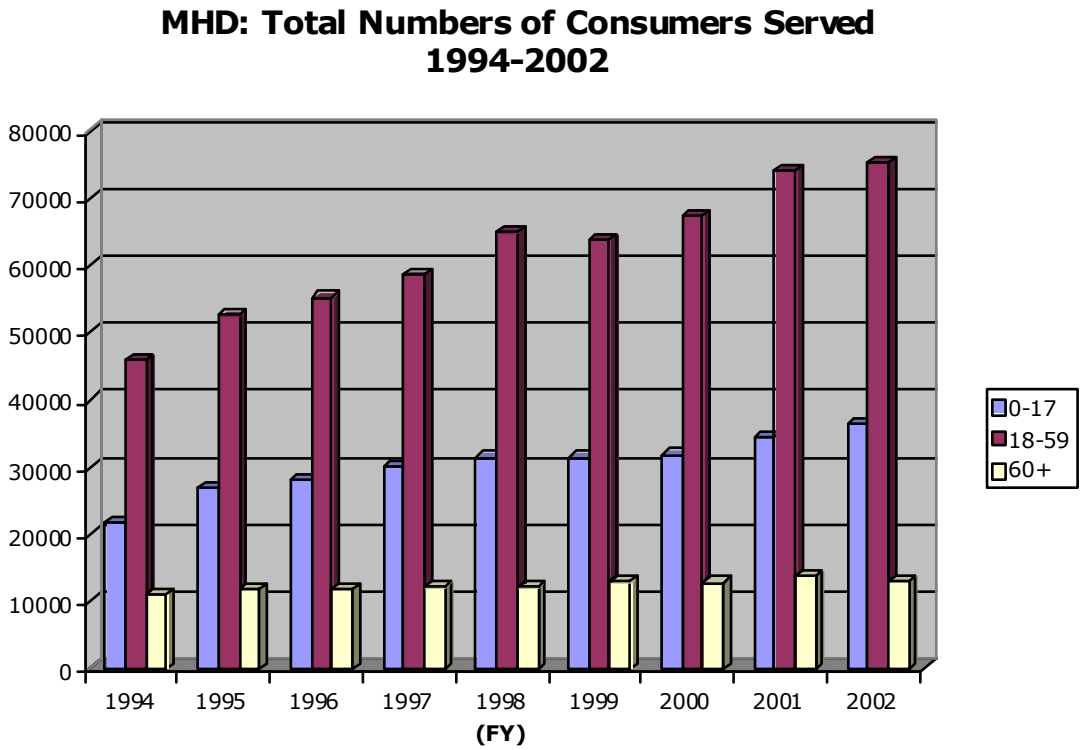
Some older adults experience mental illness for the first time in their later years, yet, relatively few seek help from mental health professionals (DHHS, 1999, Gallo & Lebowitz, 1999). Using prevalence estimates from the Baltimore ECA study, Rabins (1996) concludes that up to 62 percent of older adults have an unmet need for mental health services. Moreover, he suggests that this unmet need increases with advancing age; with the oldest-old exhibiting the greatest unmet need. Best estimates indicate that older adults underutilize mental health treatment more than any other age group (Lebowitz et al., 1997). Persky (1998) reports that older adults make up only 7 percent of all inpatient services, 6 percent of community-based services, and 9 percent of private psychiatric care.

The mental health needs of racial and ethnically diverse older adults are relatively unknown. The President's New Freedom Commission on Mental Health (2003) acknowledges that access, quality and outcomes in mental health care are disproportionately low for members of racial and ethnical minority groups. Culturally competent and appropriate treatments, strategies and models are seriously lacking, especially for older adults (DHHS, 2001a).

There has been a recent effort to develop an evidence base for mental health services for ethnic minority elders through two "Targeted Capacity Expansion" grant programs funded by the Center for Mental Health Services, SAMHSA: "Meeting the Mental Health Needs of Older Adults" and "Reducing Racial and Ethnic Disparities in Mental Health." Together, these grant programs are supporting the development, evaluation and dissemination of six mental health programs focusing on diverse racial and ethnic populations (e.g. Hispanics, Hmongs, Mexican-Americans, Latinos, American Indians, and African Americans).

The magnitude of need for mental health services by older adults is difficult to determine. Over the past ten years, DSHS Mental Health Division has made several attempts to estimate the number of persons, by subgroup, which are in need of mental health services. Several methods or formulas have been used including, prevalence estimates from the Epidemiological Catchment Area Studies, parity with percentage of representation in the population, 95% parity targets ranging from minimum to exemplary, and penetration rates. However, there has been considerable debate over the years concerning what accounts for a fair and equitable formula for estimating need and the resultant number of individuals to be served by the public mental health system.

No matter how need is defined, the number of older adults served from 1994-2002 has stayed about the same despite their steady growth in the population (See below). The number of children and adults (18-59) show steady increases in numbers served during this same time period.



Source. DSHS Mental Health Division, 2003.

CHALLENGES IN PROVIDING MENTAL HEALTH SERVICES TO OLDER ADULTS WITH MENTAL ILLNESS

There are many reasons that older adults with mental illness are under-served and consequently, left untreated. The very nature of the conditions some older adult's experience--memory loss, depression, anxiety and paranoia--can render them incapable of seeking help from mental health and other social service systems. Older adults who need mental health services may simply not know how to access services. Some may seek help from their primary care physicians, many of whom have not been adequately trained in how to recognize and treat mental illness in this population (Bartels, et al., 2002). Many have difficulty navigating service delivery systems that are fragmented and funding mechanisms that are complicated and inadequate (Gatz, 1995). This is especially problematic because illness conditions and care needs of the majority of older adults cross many different systems of care and provider networks.

Individual Factors. There is a negative stigma associated with mental illness among older adults. Many grew up during the Depression era when people with mental illness were sent away to "insane asylums" never to be seen again. There was a sense that one should "pick yourself up by the boot strap and carry on" no matter what was wrong or difficult. Mental illness was not discussed openly and was a great source of shame and personal failure. Still today, many older adults find it difficult and painful to discuss their inner most feelings and symptoms of mental illness.

Moreover, many older adults have strong feelings of pride, stoicism, self-reliance and independence and are reluctant to ask for or accept "charity" or help from others. Older adults may fear that by accepting help, they will lose control over their lives. If someone discovered how poorly they functioned then they might be taken out of their home and placed in a nursing home. In addition, some older adults lack family or a supportive network to access help for them (Pearlin & Skaff, 1995).

Service System Factors. The current mental health system is a complex array of public and private systems of financing and service delivery. The President's New Freedom Commission on Mental Health (2003) concludes that "the mental health system is fragmented and in disarray leading to unnecessary and costly disability…including lack of care for older adults with mental illness" (p. 3). There has been little increase in Federal and State funding for mental health services over the past few years. In fact, mental health services have traditionally been under-funded compared to general health care services (DHHS, 2001a).

Medicaid and Medicare are the principal sources of funding for mental health services yet favor more costly inpatient care over community-based care, acute care versus chronic or preventive care, and time restricted services over the comprehensive care that is needed (Bartels et al., 2002). Older adults are at an added disadvantage because many are not eligible for Medicaid and/or refuse to accept government assistance. Furthermore, Medicare mental health coverage is very limited and covers few community-based mental health services. Within the publicly-funded mental health system, "specialized geriatric programs and clinical case management for older people are inadequate or poorly implemented" (DHHS, 1999, p. 376).

These limitations are typical of state mental health service systems. Washington State's system is no exception. Like many states, Washington State has adopted managed behavioral healthcare. Service providers are challenged with how to serve older adults in this state's capitated managed care environment. Within a capitated budget, the Washington State Mental Health Division specifies which populations are to be a priority for service; however, regional mental health authorities can further refine these definitions to meet their local needs and budgets. Competition for scarce resources is strong and priority populations are the first to receive services with available funding. Because older adults often suffer in silence, especially with late-life mental illnesses, they rarely become a priority for services until a crisis event or hospitalization brings results (Bartels, et al., 2002).

Another service system barrier is the fact that there is a general lack of consensus among mental health, health, aging, and other social service providers concerning *who is responsible for serving whom and under what circumstances*. This is especially true for persons with Alzheimer's disease and other dementias. Indeed, the systems of care designed to meet the needs of older adults are not well coordinated and integrated (Bartels et al., 2002). There is little coordination of care between the public mental health system and primary care even though older adults are more likely to seek help from the latter. Because most primary care physicians or health care providers lack training in geriatric mental health, mental illness often goes undetected and untreated.

Trained Workforce. There is a consensus among geriatric mental health providers that our workforce is ill prepared to provide both the current and future mental health care needs of our older adult population. According to a recent consensus paper by leading authorities in geriatric mental health, "a national crisis in geriatric mental health is emerging (Jeste et al., 1999, p. 848). There is a national shortage of mental health, medical and social service providers who have training and expertise in geriatric mental health care (Abramson & Halpain, 2002; Knight, Teri, Wohlford & Santos, 1995; Bartels et al., 2002, The Presidents New Freedom Commission on Mental Health, 2003).

Halpain and colleagues (1999) examined various sources to provide estimates of our nation's need for professionals that are trained in geriatric mental health. Years for projections ranged from 2000 to 2020. Estimates projected the need for:

- 595,000 RN's, 250,000 LPN's, 500,000+ nurses aides and 19,000 specialized gerontological nurses and practitioners by 2000;
- by 2010, 400-500 academic geriatric psychiatrists, in addition to 4,000-5,000 that are active in clinical care;1,221 physician faculty and 919 non-physician faculty to provide training to medical students; 50,000 to 60,000 full-time social workers; and
- 5,000 full-time doctoral-level clinicians and counseling geropsychologists by 2020.

The importance of this issue is also recognized in service systems beyond mental health. For example, the National Policy Summit on Elder Abuse in 2001 included geriatric mental health services as one of the top ten issues for its Action Agenda:

> Age-appropriate specialized mental health services need to be available and accessible to include aggressive outreach, intensive case management and specialized clinicians to provide acute and ongoing services for victims; dementia-related accurate diagnosis and treatment, capacity assessment and surrogate decision-making; age appropriate substance abuse, medication management and education, and mental health and substance abuse treatment for perpetrators (The National Center on Elder Abuse, 2001).

Also, there is recognition in Washington State government that the need for geriatric mental health specialist training transcends the specialty mental health service arena. DSHS Aging and Disabilities Services Administration has identified the need for specialized geriatric and mental health training for their licensed providers of boarding homes and adult family homes. Operators and managers of facilities that serve persons with mental illness and/or dementia must complete a twenty-hour long training and pass a competency test in order to care for someone with mental illness.

Thus, Washington State is no exception in its need to train a workforce prepared to provide specialized geriatric mental health services. Until recently, the Washington State DSHS Mental Health Division supported the *Geriatric Mental Health Specialist* training certificate program. While no systematic evaluation of the training program was ever carried out, the training increased the capacity of Washington State's mental health workforce to work successfully with older adults with mental illness. Many of these graduates have gone on to

be supervisors of Specialty Older Adult Mental Health Programs within our public mental health system. The last Geriatric Mental Health Training Certificate program was held in 2000 and trained 40 individuals. Professionals in the field of gerontology have noted the absence and point to the growing need for ongoing and comprehensive training.

Advocacy. There is also a paucity of advocacy groups that support geriatric mental health. The National Alliance for the Mentally Ill and their state and local chapters have made great strides in bringing the major issues facing adults with mental illness to the forefront. The American Association of Retired Persons, perhaps the largest senior advocacy group, has primarily focused on the health and economic well-being of older American's. Older adults with mental illness have not been a primary focus of attention due to the many barriers discussed earlier.

A national non-profit advocacy group that recognizes the challenges described above was formed in 1998 and promises to impact national mental health policy. It is called the Older Adult Consumer Mental Health Alliance (OACMHA). This national consumer-based advocacy group focused on the needs of older persons with mental disorders and their families. Its purpose is to improve the quality of life of older persons affected by mental illness, and their family caregivers, by promoting through advocacy and public education, the development of accessible, affordable and age-appropriate mental health services (http://www.oacmha.com/). Targeted for membership are older consumers of public and private mental health services and their family caregivers.

To date, OACMHA has had an impact on raising awareness of the mental health needs of older adults on a national level. Members urged The President's New Freedom Commission on Mental Health to address the mental health issues of older adults separately from the general adult population. Members have also been active in advocating for Representative Patrick Kennedy's "Positive Aging Act." This legislation would improve the accessibility and quality of mental health services for older adults through new authorities and resources within the Substance Abuse and Mental Health Services Administration, DHHS. OACMHA is also working with the National Alliance for the Mentally Ill, the largest advocacy group for persons with mental illness, to increase awareness of mental health issues facing older Americans. It should be no surprise that our own John D. Piacitelli, former Program Manager for Elderly Services, Mental Health Division, DSHS, has been at the helm of this consumer movement. At 73 years of age, Mr. Piacitelli's fight to improve mental health services for older adults continues.

MODELS OF GERIATRIC MENTAL HEALTH PRACTICE

What follows is a discussion of issues that arise when determining best and promising practices. A first step in developing a guide for best and promising practices in geriatric mental health is to define "what is an evidence-based, best or promising practice". Two main tasks involved in arriving at a definition are: 1) to determine what is meant by "geriatric mental health practice" and 2) to establish a set of criteria for what constitutes "evidence" and what constitutes "best" and "promising".

Defining geriatric mental health practice. In addressing the first task, we chose to focus on practice models rather than treatments applied at the individual level. The decision to limit the scope of our review was made for purposes of time and space. How we came to the decision to focus on programs rather than individual treatments is described below.

Secondly, given the current knowledge base for mental health services, we argue that development and implementation of effective geriatric mental health practice models will have the widest impact on the mental health of older adults[6] in Washington State. The most pressing need among mental health services planners is for more information about effective program models.

- **Individual treatments are intertwined with the organization of programs.** In order to clarify what constitutes a mental health strategy or program, we turned to the recent literature on evidence-based mental health services. In its *National Plan of Research to Improve Services for Individuals with Severe Mental Illness*, the National Institute of Mental Health distinguishes two major types of mental health services research: 1) clinical services research in which effectiveness and cost are measured with the individual as the unit of analysis and 2) service systems research in which organization and financing of the service system are the foci. Goldman et al. (2000) state,

  > *"Theoretically, the mental health service system organizes effective treatments into service arrangements of known effectiveness and efficiency. Having completed the assessments of treatments applied at the individual patient or client level (clinical services research), investigators would proceed to establish the effectiveness of various organizational strategies (services system research)."*

  Although that approach sounds sensible, it did not fit with our experience as we reviewed mental health practices. The challenge that we encountered in our review of the literature is that in many cases, it is not possible to clearly distinguish the treatment intervention from the organizational strategy. Goldman et al. (2000) acknowledge this when they state,

  > *"The 'treatment' is embedded in an organization or identified with a particular organizational arrangement, such as in case management, assertive community treatment or residential treatment. For these service interventions, the clinical services research literature serves as an important source of guidance, along with the service systems research literature." (p. 70)*

  We concluded that programs and organization arrangements were closely connected to the individual level interventions and key to their successful implementation.
- **An array of program models is important to geriatric mental health.** We recognized that there is a wide range of organizational and service system structures—many of which transcend specialty mental health—that are potentially effective in improving the mental health of older adults. This array of geriatric mental health program models reflect the many different locations that older adults might access mental health services.

[6] We acknowledge that effective individual clinical interventions are very important. Certainly a well-organized program will be of no benefit to consumers if effective clinical practices are not used.

Locating services "where older adults are comfortable" –in their homes, in primary care clinics, in senior centers, long-term care residences, at adult day centers—is key in many of these models.

In addition, multiple services systems are often included in efforts to take a holistic approach to meeting the health and mental health needs of older persons. For example, these efforts have resulted in a range of models that are designed to integrate physical and mental health services. Service integration is important for this population due to the high prevalence of co-occurring physical illnesses and complexities introduced by physiological changes associated with aging. Therefore, organizations and social and health service settings outside the specialty mental health system often become the places where older adults have their mental health needs met.

Certainly, a public mental health system has a specific role in many of these geriatric mental health practice models. However, distinctions between mental health care, physical care, and social care become blurred as models become more comprehensive and community-based. Thus, the field from which best and promising geriatric mental health practice models are identified is indeterminate, broad, and evolving. This context makes the task of selecting best and promising mental health practice models for older adults more challenging than it would be if the pool of programs were limited to specialty mental health programs.

Existing literature on individual treatments. There is already an available literature on treatments applied at the individual level. The effectiveness of these individual treatments is often intertwined with how programs are organized in the real world of mental health services. We refer the reader to the following recent reports and resources:
Chapter Five of the Mental Health, A Report of the Surgeon General at http://www.surgeongeneral.gov/Library/MentalHealth/home.html;
Administration on Aging's companion report to the Surgeon General's report is entitled, Older Adults and Mental Health: Issues and Opportunities (2001);
Bartels, et al., (2002). Evidence-based practices in geriatric mental health care;
Two journal issues with special sections on geriatric mental health:
Psychiatric Services, (1999), Volume 50 (No. 9), pp. 1157-1208.
Psychiatric Services, (2002), Volume 53 (No. 11), pp. 1389-1431.
Useful web sites (See Appendix 1).

Establishing criteria for best and promising program models. In addressing the second task, we reviewed different methodologies for establishing a designation of "evidence-based", "best", and "promising" practices. We then reviewed geriatric mental health program models and how they matched with selection criteria.

Criteria currently used to evaluate program models. A significant amount of work has been done at the national level to establish criteria for what constitutes "evidence" for evidence-based practices. The Center for Substance Abuse Prevention (CSAP, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration) has created a National Registry of Effective Programs that include effective

substance abuse and mental health programs (NREP, http://modelprograms.samhsa.gov). *The SAMHSA Model Programs* included in the registry have undergone a rigorous multi-step evaluation process to determine the degree of "evidence" available to classify programs in one of three categories: Promising programs, effective programs, and model programs. The registry includes only one practice model that focuses on geriatric mental health. It is included in our resource guide.

The Evaluation Center, Human Services Research Institute, is a SAMHSA funded National Technical Assistance Center that provides useful information and guidance on evidence-based practices in mental health and substance abuse (http://tecathsri.org). Staff can provide technical assistance on moving a program toward an evidence-based practice using evaluation and offer numerous specialty toolkits for model replication (e.g. Assertive Community Treatment, ACT). Many of the toolkits and resource materials are available on-line free. The web site includes several models of therapy that focus on geriatric mental health. However, we do not include them in the resource guide because they are treatment modalities rather than program models and the reader can access them through the website.

A more recent effort to build a knowledge base for evidence-based models and practices in geriatric mental health is currently underway. SAMHSA has funded the National Older Adult and Mental Health Technical Assistance Center at Harvard University (Sue Levkoff, Director, personal communication July 2003). The Center provides technical assistance to nine SAMHSA grantees under the "Targeted Capacity Expansion Programs." They are currently working on plans for providing technical assistance and resources beyond the grantees via a web site.

Washington State criteria. For the purposes of the geriatric mental health resource guide, the Washington State Mental Health Division has provided a relatively broad definition for what constitutes "best" and "promising" practices. Best Practices are defined as strategies and programs which are deemed research-based by scientists and researchers through the National Institute of Mental Health, National Institute for Drug Abuse (NIDA), American Psychological Association or National Association of Social Workers, the National Center for Substance Abuse Prevention (CSAP), National Center for the Advancement of Prevention (NCAP), National Office of Juvenile Justice and Delinquency Prevention (OJJDP), National Department of Education (DOE).

For reasons spelled out below, this definition is problematic—especially if the intent of the resource guide is to establish which models of care are to be supported by the Mental Health Division. Promising Practices are practices in areas where there are few programs that have enough outcome data (or have been sufficiently evaluated) to be deemed a best practice. These programs or strategies have some quantitative data showing positive outcomes over a period, but do not have enough research or replication to support generalized outcomes. For reasons spelled out below, this definition is problematic given the current state of the art in geriatric mental health services—especially if the intent of the resource guide is to establish which models of care are to be supported by the Mental Health Division.

The match of program models with criteria. In our review of programs, we found a modest evidence base. In some cases, there is empirical evidence about the effectiveness of program models, but there is little empirical evidence about the effectiveness of replications. In other cases, there is a relatively strong evidence-base for a component of the intervention (e.g. specific psychiatric medications for specific diagnoses and symptoms), but little evidence about the effectiveness of the program in which the medication intervention is embedded. We suspect that in the many situations in which there is no evidence supporting the effectiveness of a program, it is because they have not yet been studied or evaluated. Given the modest amount of evidence that was found in our review, we suspect that many well-conceptualized and well-implemented programs exist that do not qualify as "evidence-based".

Possible circumstances for unevaluated program models are:

- The intervention is new and innovative and not yet well-documented;
- The organization does not have strong ties to a research institution nor organizational resources to evaluate the practice;
- The complexity of the intervention makes it difficult to evaluate;
- The intervention has not drawn the interest of researchers;
- People who run the program are so busy keeping it afloat they haven't taken time to incorporate a research component;
- The model may not be seen as worthy of study.

A concern is that the above circumstances (with the exception of number 6) could result in an uneven distribution of research evidence across practice model types. This in turn could result in a biased array of practice models classified as "evidence-based", "best", or "promising." A little studied effective practice model would be excluded not based on its inferiority, but, rather, due to its misfortune in not being the subject of an empirical study. While managers of the overlooked program might be criticized for not taking steps to be accountable, realities of the current social service environment also are responsible for this short-coming.

An additional concern is that the "evidence-based" practice movement may be biased against practices that are more difficult to study empirically. Multi-service programs with a mental health component serve as an example. When well-run, these models may significantly increase access to mental health services because mental health services are introduced in a way that is more acceptable to older adult participants than some other models.

WHY WE THINK IT IS PREMATURE TO USE RESTRICTIVE CRITERIA IN SELECTING PROGRAMS FOR A BEST AND PROMISING GERIATRIC MENTAL HEALTH PRACTICE MODELS RESOURCE GUIDE

We conclude that there is not yet a satisfactory research base for geriatric mental health service models, although the body of evidence is growing. We agree with the recommendation of Rosenberg et al. (2001) who suggest that policy makers "hold off on endorsing specific models and instead support studies of comparative effectiveness" (page 1593). Meanwhile, our task is to select promising practices that are good candidates for

effectiveness studies and for receiving support for the development of their evaluation capacity. This recommendation is closely linked to concerns about how the "best" or "promising" practice will affect the service system. In his recent visit to the State of Washington on August 28, 2003, Greg Teague, national expert on outcome measurement and service system research, stressed that mental health systems use the best available current scientific evidence about the effectiveness of mental health practices. He also pointed out that that does not mean we do not fund services that do not yet have evidence. Indeed, evidence-based practices in geriatric mental health care are in their infancy.

What follows are descriptions of twelve models for geriatric mental health services. They range in their comprehensiveness and organizational structures. They are not mutually exclusive, but provide a range of options for communities who want to develop and/or expand their capacity to provide effective geriatric mental health services. Many promising practices were left out due to time constraints. We apologize if your best or promising practice was overlooked; we hope to include it in the next version of these documents. They are:

A. Outreach Models
B. Specialty Community Mental Health Programs
C. In Home Mental Health
D. Caregiver Programs
E. Adult Day Services With Mental Health
F. Comprehensive, Integrated Health/Mental Health/Long Term Care
G. Models for Geriatric Clinical Practice Improvement
H. Multi-Service Programs with Mental Health Component
I. Support/Self Help Groups and Peer Counseling Programs
J. Mental Health in Primary Care
K. Mental Health in Nursing Homes
L. Geriatric Mental Health Services Improvement through Coalitions, Partnerships and Teams

A. Outreach Models

"Outreach is an effort to identify older adults in need of mental health or substance abuse services and to help them get what they need" (DSHS, 2002, p. 29). As mentioned earlier, older adults are not likely to seek help for mental health services from mental health clinics or their primary care physicians (DHHS, 2001a). Outreach includes finding older adults who remain invisible to the systems of care that provide the services that they need; case-finding. Both the mental health and aging systems of care rely on passive case-finding efforts to reach at-risk older adults, that is, they wait to be contacted. The most common strategies, such as television advertisements, Senior Information and Referral services, and public education campaigns, depend on the at-risk population's ability to access services on their own.

Outreach also includes bringing services to older adults who cannot or will not attain services from a more traditional service setting. Providing in-home mental health services is preferable to many older adults who are resistant or unable to travel outside the home. Outreach models are designed to overcome the many individual, provider and system barriers identified previously by reaching out to older adults in need of mental health services in their

own communities and homes. The goal of outreach is to identify vulnerable older adults that do not come to our attention through more traditional avenues and to link them to needed services that help to maintain them safely in their homes.

The Gatekeeper model of case-finding at-risk older adults has been replicated and adapted in many types of communities and systems of care (Jensen, 2002). It is often one component of a larger program of services for older adults. Sometimes the model is adapted to fit a specific target population or setting. Several different outreach models are presented in the guide and highlight the adaptability of the core components of the model.

B. Specialty Community Mental Health Programs

Specialty Community Mental Health Programs for older adults are marked by their dedication and specialty programming to meet the unique needs of older adults with mental health and substance abuse problems. They typically offer an array of mental health, substance abuse and other social services through collaborations and agreements with other community-based service providers. Some programs are part of a larger hospital system, others are special programs within a community mental health center and others are stand-alone programs. They all share a commitment to providing specialized geriatric mental health services by specially trained staff. The Wrap-Around concept that was developed in the field of children's mental health has been adapted to meet the complex needs of older adults (DHHS, 2002). It is a concept that is just beginning to make its way into the geriatric field and holds promise for improved care on the individual level.

In-Home Mental Health Programs are designed to bring services to older adults in their own homes and communities. Most of the programs are targeted to older adults that have difficulties leaving their homes for services due to their psychiatric and/or physical disabilities.

C. Caregiver Programs

Approximately one out of every four households in the United States provides care to a relative or friend aged 50 or older (National Alliance for Care giving, 1997). The average age of informal, unpaid primary caregivers is over 60 years old, almost three quarters are women and one third are juggling care giving with paid employment. Many of these caregivers develop stress-related physical and psychological illnesses. Caregivers of persons with dementia are reported to experience greater strain and have more physical and mental health problems than caregivers for persons without dementia (Ory et al., 1999). Several studies report that caregivers' capacities and health may be as important in the decision to place a loved one in a nursing home as the health condition of the person being care for (McFall & Miller, 1992; Pruchno et al., 1990).

The types of caregiver programs vary. They include education and support, concrete assistance, cognitive, behavioral or psychodynamic therapy, coping skill training, and respite care (Gallagher, 1985).

A general conclusion drawn by Ostwald et al., (1999) from the care giving literature is that two qualities of interventions characterize the most successful caregiver programs: 1) that

they be multi-component (e.g. the programs provides support along with education rather than providing support alone), and 2) that they be designed to address particular caregiver situations or behaviors of the person being cared for (e.g. managing behavioral issues of individuals with dementia) rather than taken a general approach.

D. Adult Day Services with Mental Health

Adult Day Services (ADS) are comprehensive programs that offer a variety of social and health services in a protective setting. According to the Standards for Adult Day Care, "adult day care is a community-based group program designed to meet the needs of functionally impaired adults through an individual plan of care." Typically, transportation is provided to participants who come to the center for several hours a day, two to three times a week. Some participants attend five days a week. Most adult day centers operate five days a week during regular business hours. Services include assessment and care planning, nursing, nutrition programs, recreational activities, a lunch meal, exercises, art, music, and assistance with activities of daily living. Some centers provide physical, speech, and occupational therapy and some are designed to provide care for individuals with special categories of mental illness such as Alzheimer's disease.

ADS have the potential to be beneficial for many older adults with mental illness. The program can offer supervised social interaction and skill building interventions that target behavioral and mood symptoms of Alzheimer's disease and other mental disorders. They also provide respite for informal caregivers. In Washington State, a majority of the ADS programs offer Alzheimer's programs or dementia-specific services. Though ADS programs vary in the extent to which they serve individuals with mental disorders and behavioral issues, the majority of participants in a number of Washington State's programs have a mental disorder. For example, approximately 60% of the Adult Day Health population at Providence ElderPlace Seattle has a mental health diagnosis. The most frequent diagnoses are dementia and depression (personal communication with Ellen Garcia, 2003). ElderHealth Northwest, an ADS provider in Seattle, reports that approximately 37% of its Adult Day Health participants have a mental illness diagnosis and 37% has a diagnosis of Alzheimer's disease (personal communication with Nora Gibson, 2002).

A number of studies report positive outcomes for older adult participants in ADS. Family members have reported improvement in mood, behavior, and sleep (Zarit et al., 1999; Levin et al., 1989, Gottlieb & Johnson, 1995). Zank and Schacke (2002) reported significant positive effects of day care on well-being and dementia symptoms. There is little evidence of improvement in performance in activities of daily living or behavior problems (Wimo et al., 1993). In addition, to date, there has been little study of the relationship between ADS use and nursing home placement. Two studies report that participation in ADS is not related to decreases in admissions to nursing homes (Hedrick et al., 1993; Weissert et al.,1990). More study is needed before conclusions can be made about the effectiveness of ADS in this regard, since it is possible that ADS will be effective in specific circumstances that need to be better understood. For example, several studies have found that caregivers who use adequate amounts of ADS experience lower perceived care burden and less depression (Gottlieb & Johnson, 1995; Wimo et al., 1993; Zarit et. al,

1998). Since caregiver burnout has been shown to be a factor in predicting nursing home placement, an adequate "dose" of ADS respite may associated with reductions in care giver burden and associated nursing home placement. Further study is also suggested because of methodological flaws in many studies of ADS noted by Zarit et al. (1998).

A related issue is how to keep care givers engaged with ADS so that therapeutic levels of respite are achieved. A study of ten ADS demonstration programs found that programs that provided interaction with caregivers had lower discharge rates than programs that provided respite alone (Henry and Capitman,1995).

E. Comprehensive, Integrated Health/Mental Health/Long-term Care Programs

Many older adults with mental illness have co-occurring chronic physical illnesses. In addition, those who are very old are more likely to need assistance with activities of daily living and the support of the long-term care service system than younger populations. Multiple needs require services from multiple providers from different organizations and in various settings. Often older adults with mental illness interact with three service systems: mental health, the aging services network, and primary health care. Unfortunately, the activities of these three social and health service systems are usually poorly coordinated and the experience of the consumer is fragmented. The consequence to the consumers is repetition in information giving, confusion about where to turn for help with specific social and health needs, contradictory instructions for health care, failure to identify important needs, lack of attention to the whole person.

A response to these barriers is comprehensive, integrated care that is provided under the authority of a single organization or administrative authority. Programs of this nature take a variety of forms. Two of the best known programs use capitated financing using Medicare and Medicaid dollars. They are the Social Health Maintenance Organization (SHMO) and the Program for All-Inclusive Care of the Elderly (PACE). Both are federal demonstration projects, though some are becoming established as permanent programs.

F. Models for Geriatric Clinical Practice Improvement

Systems of quality improvement are essential to any geriatric mental health best practice. Since complete and exact replication of the models described in this guide is not the norm, it is recommended that each case of implementation be monitored to see if practices are implemented as intended and client outcomes meet expectations.

"Clinical Practice Improvement" involves detailed recording and analysis of care process factors, patient factors, and outcomes, with assessment of patient condition occurring at multiple points in time (Bartels et al., 2001)" . Ideally, the outcome measure has direct utility in delivering care and the measures become a routine part of clinical and administrative practice. This enables mental health providers to identify the aspects of the process of care that are connected to better or worse outcomes.

Outcomes can be used to improve practice in a number of ways:

- To measure the performance of individual providers;

- To measure the effectiveness of a group or team of providers;
- To compare performance of different procedures for a given diagnosis;
- To compare performance of different provider networks for a given diagnosis;
- To profile providers and identify specific providers who excel and those who could benefit from further training;
- To assess the results of individual clinical treatment to date and improve subsequent care (i.e. the clinician compares a client's condition on the current visit with ratings over time);
- To support formal practice research that addresses specific clinical questions aimed at improving treatments and services, using data from multiple provider networks (Bartels et al., 2001).

A Clinical Practice Improvement model requires "a uniform way to quantify symptoms, behaviors, and functional domains in the medical record so that the Clinical Practice improvement can be conducted in an optimal fashion. This approach also includes a standard approach to rating the specific type of interventions that are provided in psychiatric treatment, allowing for quantification of both process and outcome that can be readily extracted from the chart and analyzed so that effectiveness of practice can be monitored and enhanced" (Bartels et al., 2001, p. 204).

G. Multi-Service Programs with a Mental Health Component

Multi-service centers, nutrition programs, and senior centers have the potential to increase access to mental health and addiction services by older adults who may avoid traditional mental health service providers due to the stigma of having a "mental illness" or an "addiction". Older adults may be more comfortable in these community-based social programs, than they are in the offices of specialty health and mental health centers.

> "After participating in the program for a while, clients often recall how frightened and ashamed they felt when they first came to the center—ostracized by family and neighbors. At the senior center, however, they found a warm welcome, other people who share their experiences, and the help they needed to change their lives." (p. 50, DHHS, 2002).

These social centers offer many opportunities for informal health education and outreach for those at risk of health and mental problems. Since participants are likely to be involved in a number of social activities, there are many opportunities for staff to interact with participants informally and develop relationships. As comfort levels of participants increase, they may be more open to health promotion and health education messages. The many services that go on in any one hour at the centers provide considerable anonymity, a condition that may make the many seniors more likely to accept services.

The two multi-service programs presented in the resource guide are Little Havana, Dade County, Florida, and Kit Clark Senior Services, Boston, Massachusetts. Though they serve thousands of persons per year, their caseload for addiction and mental health services represents a fraction of that number.

H. Support/Self Help Groups and Peer Counseling Programs

Support groups, self-help groups and peer counseling programs provide relatively inexpensive means for older adults to address many mental health needs. They are often used in tandem with formal mental health services. They are especially effective in lowering the risk of serious mental illness for older adults experiencing life transitions, short-term crises and other stressors. Support groups and self-help groups may be more acceptable to older adults than traditional mental health services and they may fill in a gap that exists in the social and health services available to them. They may also prepare participants for professional mental health services that they need.

According to the Administration on Aging, "a support group is comprised of people with a common problem or situation who pool resources, gather information, and offer mutual support, services, or care…Support groups share three basic elements: an intense need expressed by the members; the requirement that members be willing to share personal experiences, and a real or perceived similarity in their suffering." (p. 44, 2001).

Support groups take a variety of forms. They can be open-ended with no set number of sessions or they may be time limited. They may be led by a trained health professional who is paid a fee or they may be "self-help" where the group is led by a volunteer or peer (these groups are usually free). The topic of the group can be general (e.g. bereavement of any type) or specific (e.g. mental illness or Alzheimer's disease).

There is some evidence that support groups can be effective, however intervention conditions among the various studies are not consistent. One study showed improved mental health status for participants in of bereavement self-help groups while those in control groups showed deterioration on most mental health indicators (Lieberman & Videka-Sherman, 1986). Researchers found that level of active involvement in the group was important to outcomes for older adults. Another study of the Widowed Persons Service program, which pairs widows with a widow contact who provides emotional and practical support showed promising results. Although, the study found that most women recovered from bereavement with or without help, those receiving the intervention recovered more quickly (Vachon et. al, 1980).

Peer Counseling programs are comprised of older adults, often volunteers, who share similar experiences or are trained to provide limited mental health support. These programs are designed to be mutually beneficial to the peer counselor and the recipient. Peer counseling often takes place in the "recipients" own home through home visits and telephone reassurance. Peer counselors may provide assistance with shopping, travel and other special activities. Many older adults find sharing their inner most feelings and problems with someone their own age or life experiences more acceptable and beneficial than traditional mental health services (DHHS, 2001a). Peer counseling programs are used in many different systems of care including, Long Term Care Ombudsman, domestic violence, elder abuse, and legal services.

Peer counseling programs are often a component of a larger Older Adult Program or agency, and therefore, have not been the focus of research. Many of these programs start through a

grass-roots process often involving a grateful "recipient" of mental health services whom wants to help others in need. Other peer counseling programs begin as a way to fill a gap in existing services. Most peer counseling programs provide limited descriptive information that focuses on "how to develop a program." Some monitor success through satisfaction surveys, tenure in the program or graduation from the program, or becoming a peer oneself.

The Senior Companion Program is one of the largest peer counseling programs. It is a federally funded program through the National Senior Service Corps (Senior Corps). The program trains individuals that are 55 years of age and older to provide assistance and friendship to homebound elders, generally living alone. This program has been the focus of much research. Some of the findings indicate that, 1) the Senior Companion program has had a positive impact on the agencies, clients and family members/caregivers served by the program, 2) Senior Companions played an important role in expanding the array of independent living services to home-bound elders (RTI, 2003).

The multi-county geriatric peer-counseling program of Skagit Mental Health, Washington (Rogers, LaFollette & Rowe, 1993) began in 1986, to utilize the skills and talents of Senior volunteers who provide home-based supportive services to older adults with mental illness in Skagit, Whatcom, Island and San Juan Counties. Since the program began, staff has assisted many communities throughout Washington State and abroad to develop peer counseling programs with the assistance from their training book, In the Company of their Peers: A geriatric peer counselors training manual (Rogers et al., 1993). An observational study conducted in 1990 (Rogers et al., 1993) revealed that older adults who received peer counseling experienced many different problems or conditions. The most commonly reported were, frequent visits to their doctors (71%), depression (69%), some type of chronic illness (64%), some degree of mental illness (61%), poor eating habits (58%) and conflict with children (36%). The typical contact between the peer counselor and recipient involved companionship, counseling, shared interests, transportation, crisis control and health monitoring to address these and other concerns.

I. Mental Health Services in Primary Care Settings

Models of mental health service in primary care are increasingly recognized as important for older adults with mental health issues. They are a natural point of access to mental health services for most older adults who visit them regularly. Older adults may prefer to access mental health treatment in primary care clinics because they may be more "user-friendly". Primary care clinics may also have less stigma associated with them as compared to specialty mental health services. In addition, primary care may be more convenient than specialty care.

Over half of older adults who receive mental health care receive that care from their primary care provider. Models designed to improve mental health services in primary care settings address the well-documented problem of lack of identification and under-treatment of mental health problems in primary care settings and in the community. Typically, these models involve collaborative arrangements between mental health professionals and the primary care physician, nurse practitioner, or physician's assistant. Some models integrate mental health professionals into the primary care practice, while others have looser affiliations. In all models, mental health professionals assist primary care physicians and their staff by

performing one or more of the following activities: 1) screening, 2) counseling, 3) patient and family education, 4) monitoring compliance with physician advice, and 5) coordination of care. Most models of mental health services in primary care have targeted individuals with depression. There is still some question as to whether this approach can be successful for persons with other major mental disorders such as schizophrenia or Alzheimer's disease.

Models of mental health services in primary care settings fall into three categories: 1) attachment mental health professional, 2) consultation liaison, 3) community mental health teams (Gask et. Al., 1997). The following examples of promising models of mental health services in primary care settings are grouped into these three categories.

Attached mental health professional
A mental health professional, such as a psychiatrist, nurse, clinical psychologist, or social worker, associated with the practice may screen for mental health problems, conduct psychosocial treatment sessions, and monitor compliance with medications. There is comparatively little teamwork in this model in comparison with the other two types.

Consultation-liaison
A psychiatrist or mental health professional serves as the mental health specialist for a primary care practice. The specialist collaborates closely with the primary care staff with regular face-face contact. All older adults in need of mental health services are discussed in face-face meetings of the mental health specialist and primary care team. Some patients are treated by mental health specialists only, while others are referred to the mental health specialist for treatment (Gask et al., 1997). The model is designed to enhance the primary care provider's skills in identification and treatment of milder mental disorders and selectively refer older adults with serious mental illness to the specialist.

Community mental health teams
This model is characterized by psychiatric hospital-based teams that operate within the community. They do geriatric assessments and provide education and consultative services. They refer older adults with mental health care needs to a variety of community resources.

J. Mental Health Services in Nursing Homes

The prevalence of mental illness, especially depression and dementia, is high in nursing homes. It has been estimated that two-thirds of nursing home residents have some mental disorder or illness (DHHS, 1999). In fact, mental disorders are a key risk factor for institutionalization for older adults (DHHS, 1999). However, few residents in need of mental health services receive them (Lombardo, 1994; Bartels, et al., 2002, DHHS, 2001a).

A number of key policies have contributed to the high rates of mental illness in long term care facilities. The deinstitutionalization movement of the 1960's played a major role in the shift of older adult state psychiatric hospital population to nursing homes. Financing incentives favoring in-patient care over out-patient care also contributed to the trend toward reliance on nursing homes as a care setting for older adults with mental illness. Tragically, nursing homes were ill prepared to care for this difficult population. A key report published by the Institute of Medicine (1986) revealed inappropriate and inadequate care in nursing

homes, including the improper use of seclusions and restraints and psychotropic medications. This report was largely responsible for major nursing home reform. As a result, the Nursing Home Reform Act of 1987 (the Omnibus Budget Reconciliation Act of 1987; OBRA) was passed.

The Pre-admission Screening and annual resident review (PASARR) was intended to improve the overall quality of mental health services to nursing home residents. There has been some debate on whether this has in fact occurred (DHHS, 1999; DHHS, 2002; Bazelon Center for Mental Health Law, 1996; DHHS, 2002; Snowden & Roy-Byrne, 1998). There is evidence to suggest that mental health services remain limited in nursing facilities due to the absence of specialized geriatric mental health providers (Bartels, Moak & Dums, 2002), lack of follow-through with PASARR treatment recommendations (Snowden & Roy-Byrne, 1998), and restricted funding for mental health services in this setting (DHHS, 1999).

The American Geriatrics Society and American Association for Geriatric Psychiatry recently convened an expert panel on improving mental health services in nursing homes (in press). They developed a consensus statement to address this issue, which will be presented in an upcoming issue of the American Journal of the Geriatric Society (in press).

Bartels, Moak and Dums (2002) provide an excellent review on models and outcomes of mental health services in nursing homes. They review extrinsic models that refer to services that are provided to nursing homes by a variety of professionals external to the nursing home itself. They identify three common models of mental health service delivery; 1) psychiatrist-centered, 2) nurse-centered, and 3) multidisciplinary team models.

According to Bartels et al. (2002), there are few well-designed controlled intervention and outcome studies of these models in the literature. Most have methodological limitations that make it difficult to reach consensus on their effectiveness. Still, there is some evidence to suggest that the mere provision of mental health services in nursing homes may lead to improved symptoms and functioning, reduce the use of acute services, improve functioning of nursing home staff, and improve physician's prescribing practices.

We know that nursing homes in Washington State utilize all three models for the delivery of mental health services to their residents. However, they have not been evaluated to determine effectiveness on a program-level or individual level. Several models attempt to change the way nursing homes are structured and function in order to improve the overall care of residents. Two that have been replicated throughout the states and abroad, including Washington State, are GENTLECARE and the Eden Alternative. They are included in the resource guide. These models have not undergone rigorous testing for outcomes, but do have some observational evidence to suggest their effectiveness.

Older adults with mental illness also reside in long-term care residential settings other than nursing homes. They include assisted living facilities, boarding homes, and adult family homes. Unfortunately, there is a paucity of literature on promising or evidence-based practices focused on mental health services in residential long term care facilities, (DHHS, 2001, Bartels, et al., 2002). However, the Washington State Dementia Care Project in

Boarding Homes is included in our *Best and Promising Practices in Geriatric Mental Health Resource Guide* as an example of a local practice that holds promise for improving mental health care for a large population of older adults residing in this type of setting.

K. Geriatric Mental Health Services Improvement through Coalitions, Partnerships and Teams

There is increasing interest in improving access, quality, and delivery of geriatric mental health services through better coordination and collaboration of service systems and service provider networks by developing coalitions, partnerships and multidisciplinary teams. The National Coalition on Mental Health and Aging, along with it's partner, the National Council on Aging, spearheaded the movement on the developing many of these mental health and aging coalitions (NCOA, 1999). DHHS (2001) is promoting four strategies to foster collaboration:

1) promote partnerships among mental health, substance abuse, primary care, and aging services at national, state and local levels in order to develop policies and plan programs by developing referral protocols, coordinating care for clients, disseminating research, and sharing best practice information;
2) utilize collaborative relationships among a wide range of organizations, such as housing programs, churches, and hospitals to provide continuity of care and more comprehensive services;
3) expand and improve case management services for older adults with serious and persistent mental disorders; and
4) develop a national demonstration program of local partnerships involving aging, mental health, primary care, substance abuse providers and consumer groups to offer prevention, screening and referral services (p. 62).

Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems (DHHS, 2002) provides a list of the known State-level mental health and aging coalitions, therefore, they are not listed in the resource guide--there are many. Washington State has a newly formed coalition, The Washington State Coalition for Aging, Mental Health and Substance Abuse (WSCAMHSA). A major goal of these coalitions is to improve advocacy, access, quality, and service delivery of mental health, aging, and substance abuse services to older adults. The AARP Foundation has published an experienced-based guide from their study of state and local mental health, aging and substance abuse coalition building efforts (2001). Based on the experience of 52 participants from state and local coalitions, including representatives from Pierce County, Washington's Older Adult Group, the guide provides important issues to consider when building a coalition. Issues include getting started, building the momentum, taking off, surviving and thriving and many lessons learned and successes.

Washington State has several local and regional coalitions dedicated to improving mental health services to older adults; however, the effectiveness of these coalitions has not been formally evaluated. Some include broad representation of mental health and aging service providers, while others represent geriatric mental health providers. A short list of some of these coalitions include: King County Geriatric Coordinators, Pierce County's Older Adult Group, and Spokane County's Task for Mental Health and Aging. As mentioned in the

Outreach section, the counties involved in the Community Action Grant, Gatekeeper program replication were required to develop mental health and aging coalitions to adapt the program to fit their communities. The majority of these coalitions are ongoing and have gone on to further improve and expand older adult mental health, aging and social services (for a complete list of these coalitions, see Jensen, 2002).

References

American Association of Retired Persons (AARP) (2001). Building and maintaining coalitions: For aging, mental health, substance abuse & Primary Care. Washington, DC: AARP.

Abramson, TA & Halpain, M (2002). Providers of mental health services--Now and in the future. *Generations*, *Spring*, 107-110.

American Geriatrics Society and American Association for Geriatric Psychiatry Expert Panel on Quality Mental Health Care in Nursing Homes (in press). Consensus statement on improving the quality of mental health services in US nursing homes: Management of depression and behavioral symptoms associated with dementia. *Journal of the American Geriatric Society*, *51*, 1287-1298.

Bartels, SJ, Dums, AR., Oxman, TE, Schneider, LS, Arean, PA, Alexopoulos, GS & Jeste, DV (2002). Evidence-based practices in geriatric mental health care. *Psychiatric Services*, *53*, 1419-1431.

Bartels, SJ, Miles, KM, Levine, K, Horn, SD, Sharkey, PD, & Joyce, T (1994). Improving psychiatric care of the older patient. In SD Horn & DSP Hopkins (Eds.), *Clinical practice improvement: A new technology for developing cost-effective quality health care.* New York: Faulkner & Gray.

Bartels, SJ, Moak, GS & Dums, AR (2002). Models of mental health services in nursing homes: A review of the literature. *Psychiatric Services*, *53*, 1390-1396.

Bazelon Center for Mental Health Law (1996). *The impact of PASARR*: *Report on a survey of state's implementation of the preadmission screening and annual resident review program to prevent inappropriate admission and retention of people with mental disabilities in nursing homes*. Washington, DC: Judge David L. Bazelon Center for Mental Health Law.

Gallagher, D. (1985). Intervention strategies to assist caregivers of frail elders: Current research status and future research directions. In C. Eisdorfer, M.P. Lawton, & G.L. Gallagher, D., Rose, J., Rivera, P., Lovett, S. Thompason, L.W. (1989). Prevalence of depression in family caregivers. *The Gerontologist, 29*, 449-456.

Gallo, JJ & Lebowitz, BD (1999). The epidemiology of common late-life mental disorders in the community: Themes for the new century. *Psychiatric Services*, *50*, 1158-1165.

Gatz, M (Ed). (1995). *Emerging issues in mental health & aging*. Washington, DC: American Psychological Association.

Goldman, HH, Thelander, S, Westrin, C (2000). Organizing mental health services: An evidence-based approach. *The Journal of Mental Health Policy and Economics 3,* 69-75.

Gottlieb, GB, & Johnson, J (1995). Impact of day care programs on family caregivers of persons with dementia. Guelph, Ontario: Gerontology Research Centre, University of Guelph.

Halpain, MS, Harris, MJ, McClure, FS, & Jeste, DV (1999). Training in geriatric mental health: Needs and strategies. *Psychiatric Services*, *50*, 1205-1208).

Hedrick, SC, Rothman, ML, Chapko, J, Ehreth, J, Diehr, P, Inui, TS, Connis, RT, Gover, PL, & Kelly, JR (1993). Summary and discussion of methods and results of the adult day health care evaluation study. *Medical Care, 31,* SS94-SS103.

Henry, ME & Capitman, JA (1995). Finding satisfaction in adult day care: Analysis of a national demonstration of dementia care and respite services. *Journal of Applied Gerontology, 14,* 302-320.

Herbert, LE, Scherr, PA, Bienias, JL & Evans, DA (2003). Alzheimer's disease in the US population: Prevalence estimates using the 2000 census. *Archives of Neurology*, *60*, 1119-22.

Institute of Medicine (1986). *Improving the quality of care in nursing homes*. Washington, DC: National Academy Press.

Jensen, J.E. (2002). Gatekeeper model of case-finding at-risk older adults: Implementation. Process Evaluation Report. SAMHSA, No. P7953314-01.

Jeste, DV, Alexopoulos, GS, Bartels, SJ, Cummings, JL, Gallo, JJ, Gottlieb, GL, Halpain, M, Palmer, BW, Patterson, TL, Reynolds, CF, & Lebowitz, BD (1999). Consensus statement on the upcoming crisis in geriatric mental health. *Archives in General Psychiatry*, *56*, 848-853.

Knight, BG, Teri, L, Wohlford, P, Santos, J (1995*). Mental health services for older adults: Implications for training and practice in geropsychology*. Washington, DC: American Psychological Association.

Lebowitz, B, Pearson, J, Schneider, L, Reynolds, C, Alexopoulos, G, Bruce, M, Conwell, Y, Katz, I, Meyers, B, Morrison, M. Mossey, J, Niederehe, G, & Parmelee, P (1997). Diagnosis and treatment of depression in later life: Consensus statement update. *Journal of the American Medical Association*, *278,* 1186-1190.

Levin, E, Sinclair, I, & Gorbach, P (1989). Day care. In *Families, services and confusion in old age*. Aldershot: Gower.

Lombardo, NE (1994). *Barriers to mental health services for nursing home residents*. Washington, DC: American Association of Retired Persons.

McFall, S, & Miller, BH (1992). Caregiver burden and nursing home admission of frail elderly persons. *Journals of Gerontology: Social Sciences*, *47,* 73-79.

National Alliance for Caregiving and American Association of Retired Persons (AARP) (1997). *Family caregiving in the U.S.: Findings from a national survey*. Final report. Washington DC: National Alliance for Caregiving and AARP.

National Center on Elder Abuse (2001). *The National Policy Summit on Elder Abuse, Action Agenda: Creating and promoting an elder abuse action agenda*. Washington, DC, December 4-6, 2001, National Center on Elder Abuse.

National Council on Aging (1999). Building state and community mental health and aging coalitions: A how to guide. Washington, DC: National Coalition on Mental Health and Aging.

Ory, M, Hoffman, R, Yee, J, Tennstedt, S, & Schulz, R (1999). Prevalence and impact of caregiving: A detailed comparison between dementia and nondementia caregivers. *The Gerontologist*, *39*, 177-185.

Ostwald, S.K., Hepburn, K.W., Caron, W., Burns, T., & Mantell, R. (1999). Reducing caregiver burden: A randomized psychoeducational intervention for caregivers of persons with dementia. *The Gerontologist*, *39*, 299-309.

Pearlin, LI & Skaff, MM (1995). Stressors and adaptations in late life. In M. Gatz (Ed.). *Mental Health & Aging*, Washington, DC: American Psychological Association.

Persky, T. (1998). Overlooked and underserved: Elders in need of mental health care. *The Journal of the California Alliance for the Mentally Ill*, *9*, 7-9.

Pruchno, R, Michaels, J, & Potashnik, S (1990). Predictors of institutionalization among Alzheimer disease victims with caregiver spouses. *Journals of Gerontology: Social Sciences*, *45*, S259-S266.

Rabins, PV (1996). Barriers to diagnosis and treatment of depression in elderly patients. *American Journal of Geriatric Psychiatry*, *4*, S79-S83.

Research Triangle Park (RTI). (2003). *Final report of the Senior Companion quality of care evaluation*. Prepared for the Corporation for National and Community Service (Contract #97-743-1008).

Rogers, BP, LaFollette, JG & Rowe, W. (1993). *In the company of their peers: A geriatric peer counseling training manual*. Mt. Vernon, WA: Nookachamps Publications, Inc.

Rosenberg, S.D., Mueser, K.T., Friedman, J.S., et. al.: Developing effective treatments for posttraumatic disorders among people with severe mental illness. *Psychiatric Services*, *52*, 1453-1461.

Snowden, M & Roy-Byrne, P (1998). Mental illness and nursing home reform: OBRA-87 ten years later. *Psychiatric Services*, *4*, 229-233.

The President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America*. (Available from Parklawn Building, 5600 Fishers Lane, Suite 13C-26, Rockville, MD, 20857). *www.mentalhealthcommission.gov/*

US Bureau of the Census (2000). Population Division, Population Electronic Product #45.

US Department of Health and Human Services (1998). *Substance abuse among older adults: Treatment improvement protocol* (TIP) Series, *26*, (DHHS Publication No. (SMA) 98-3179). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

US Department of Health and Human Services (1999). *Mental Health: A report of the Surgeon General. Rockville*, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

US Department of Health and Human Services (2001b). *National strategy for suicide prevention.* A collaborative effort of SAMHSA, CDC, NIH, HRSA, IHS. *www.mentalhealth.org/suicideprevention/elderly*

US Department of Health and Human Services (2001a). *Older Adults and Mental Health, Issues and Opportunities.* Rockville, MD: US Department of Health and Human Services, Administration on Aging.

US Department of Health and Human Services (2002a). *Promoting older adult health: Aging network partnerships to address medication, alcohol, and mental health problems*.

(DHHS Publication No.(SMA) 02-2628). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

US Department of Health and Human Services (2002b). *Screening for mental illness in nursing facility appliations: Understanding federal requirements*. (DHHS Publication No.(SMA) 01-3543). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vachon, ML, Lyall, WA, Rogers, J, Freedman-Letofsky, K, & Freeman, SJ (1980). A controlled study of self-help intervention for widows. *American Journal of Psychiatry, 137,* 1380-1384.

Weissert, WG, Elton, JM, Bold, EJ, Zelman, WN, Motrin, E, & Mangum, AB (1990). *Adult day care. Findings from a National Survey*. Baltimore, MD: The Johns Hopkins University Press.

Wimo, A., Mattson, B., Adolescent, R., Eriksson, T., & Neligh, A. (1993). Dementia day care and its effects on symptoms and institutionalization-a controlled Swedish study. *Scandinavian Journal of Primary Health Care*, *11*, 117-123.

Zank, S & Schacke, C (2002). Evaluation of geriatric day care units: effects on patients and caregivers. *Journal of Gerontology: Psychological Sciences, 57*, P348-357.

Zarit, S, Gauge, J, & Jarrett, S (1999). Useful services for families: Research findings and directions. *International Journal of Geriatric Psychiatry*. *14*, 165-181.

Zarit, SH, Stephens, MAP, Townsend, A & Greene, R (1998). Stress reduction for family caregivers: Effects of adult day care use. *Journal of Gerontological, Social Science*, *53B*, S267-S277.

2003 Evidence Based Practices in Geriatric Mental Health

Websites and Resources with information about evidence-based individual geriatric mental health treatment. Thank you to Dr. Sue Levkoff and the National Older Adult and Mental Health Technical Assistance Center at Harvard University for sharing this compilation.

Name	Organization	Website
Macarthur Initiative Depression Toolkit	The Macarthur Foundation Initiative on Depression and Primary Care	http://www.depression-primarycare.org/toolkit2.html
Management of Depression	Intermountain Health Care (IHC)	http://www.ihc.com/documents/61/cpmdepression.pdf
Practice Guideline for the Treatment of Major Depression	American Psychiatric Association (APA)	http://www.psych.org/clin_res/Depression2e.book.cfm
What are the general guidelines for treatment of depression?	Well-Connected	http://www.well-connected.com/report.cgi/doc08treatguidelines.html
Depression in Primary Care (Detection and Diagnosis)	Agency for Healthcare Research and Quality (AHRQ)	http://hstat2.nlm.nih.gov/hq/Hquest/screen/HquestHome/s/63364 then search for keywords
Depression in Primary Care (Treatment)	Agency for Healthcare Research and Quality (AHRQ)	http://hstat2.nlm.nih.gov/hq/Hquest/screen/HquestHome/s/63364 then search for keywords
Clinical Practice Guideline for Management of Major Depressive Disorder in Adults	Veterans' Affairs/ Department of Defense	http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm
Treatment of Depression: Newer Pharmaco-therapies	Agency for Healthcare Research and Quality (AHRQ)	http://www.ahrq.gov/clinic/epcsums/deprsumm.htm
Late-life depression How to identify its symptoms and provide effective treatment	Geriatrics, 2002: 57, 18-35	http://www.geri.com/geriatrics/data/articlestandard/geriatrics/072002/9472/article.pdf

Choosing Appropriate Treatment for Geriatric Depression	Article: Clinical Geriatrics 2001, 9(5), 30-46	http://www.mmhc.com/cg/articles/CG0105/lavretsky.html
Screening for Dementia: Cerebral Dysfunctioning in the Elderly	M. Allan Cooperstein, on the ExpertLaw.com Website	http://www.expertlaw.com/library/attyarticles/dementia.html
Substance Abuse Among Older Adults	USDHHS, SAMHSA, National Clearinghouse for Alcohol and Drug Information (NCADI)	http://www.health.org/govpubs/BKD250/
Dementia	American Medical Directors Association (AMDA)	http://www.guideline.gov/FRAMESETS/guideline_fs.asp?guideline=1031&sSearch_string=
Practice Guidelines for the Treatment of Major Depression	American Psychological Association (APA)	http://www.psych.org/clinres/depression2e.book.cfm
Screening for Dementia	USDHHS, Office of Disease Prevention and Health Promotion, U.S. Preventive Services Task Force	http://cpmcnet.columbia.edu/texts/gcps/gcps0058.html
Practice Guideline for the Treatment of Patients with Schizophrenia	American Psychiatric Association (APA)	http://www.psych.org/clin_res/pg_schizo.cfm
Guidelines for Assessing and Treating Anxiety Disorders	New Zealand Guideline Group	http://www.nzgg.org.nz/library/gl_complete/anxiety/Anxiety_guideline.pdf
Substance Use Disorders	Veteran's Administration/ Department of Defense	http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm
Guidelines for the Support and Management of People with Dementia	New Zealand Guideline Group (NZGG)	http://www.nzgg.org.nz/library/gl_complete/dementia/index.cfm#contents

Resource Guide

The Gatekeeper Model of Case-Finding

A Best Practice

Description:

The Gatekeeper model was created in 1978 by Raymond Raschko, MSW at Elder Services, Spokane Mental Health, Spokane, Washington. It is a community-wide system of proactive case finding to identify at-risk older adults who remain invisible to the service delivery systems created to serve them. Gatekeepers are non-traditional referral sources that come into contact with older adults through their everyday work activities. Gatekeepers are employees of corporations, businesses and community organizations who come into contact with older adults through their everyday work activities. They are trained to look out for signs and symptoms that might indicate an older person needs assistance. Gatekeepers are: Postal Service workers, meter readers, police and sheriff department personnel, bank tellers, cable television installers, resident apartment managers, restaurant employees, residential property appraisers from the county assessor's office, telephone company employees, code enforcement workers, emergency medical response teams of fire departments and ambulance company personnel and many others.

The Gatekeeper model has 3 core program elements: 1) Gatekeeper Recruitment and Training, 2) The Referral System, and 3) The Community Response System.

Gatekeeper Recruitment and Training Over the years, Mr. Raschko, along with the Clinical Director at Elder Services, were primarily responsible for recruitment and training of Gatekeepers in Spokane. It is important to target corporations, businesses and community organizations whose work force has the greatest opportunities for interacting with older adults in the community. Some of the strategies used to recruit potential Gatekeepers include: "cold calls", face-to-face contacts, letters introducing the model and inviting participation, and public media announcements. Experience has shown that persistence is key; telephone calls and face-to-face contacts are the most effective recruitment strategies. Successful recruitment of Gatekeepers usually becomes easier as the program gains visibility in the community. Training issues are presented below.

The Referral System. Communities must have a formalized referral system in place before Gatekeeper recruitment and training begins. Procedures for incoming Gatekeeper referrals must be designated and agreed upon by the community. Daytime, after-hours and weekend telephone numbers must be determined. Telephone screeners must be educated about the

Gatekeeper model, prepared to accept Gatekeeper referrals, and be able to respond appropriately.

In Spokane, when a Gatekeeper identifies an older adult believed to need assistance, they telephone the Senior Information and Assistance (Senior I & A) program at Elder Services. Traditional referral sources (e.g. family, physicians, other agencies) make referrals through the same mechanism. Trained telephone screeners/outreach workers are available 24 hours a day to receive Gatekeeper referrals.

The Response System. Communities must have relevant mental health and other health and social services to offer older adults referred to the program. The community must decide who will respond (e.g. clinical case manager, social worker, nurse, a nurse and geriatric mental health specialist team) once a referral is taken, how the referral response will take place (e.g. home visit, telephone contact, referral to the appropriate agency), and under what conditions (e.g. immediate response, crisis response, refused first contact—return visit). Once contact is made with the older adult, a comprehensive in-home assessment is completed to evaluate the individual's overall needs. Along with input from the older adult, a treatment plan is developed to address their needs. Services are provided from any number of agencies (e.g. mental health case management, chore services, meal service, health services), therefore, prior agreement and coordination with agencies that serve older adults is critical for the successful delivery of appropriate and quality services.

When a Gatekeeper referral is received at Elder Services, a Senior I & A telephone screener/outreach worker reviews the information and determines the next steps. In some situations, the referral information suggests a simple telephone referral to another community agency, for example, when the referral information indicates a higher functioning older adult needs transportation services. The Senior I & A worker will telephone the older adult, provide information about transportation services, and offer information about other senior services. In other cases, the clinical case manager and nurse will make an in-home visit to complete a comprehensive assessment.

After the initial assessment is complete, a clinical case manager is assigned to manage and coordinate the individual's care. A treatment plan is developed, along with input from the older adult and any other collateral supports (e.g. family members, friends, neighbors, and physician). A variety of services available through Elder Services (e.g. Caregiver respite, in-home pharmacy services), as well as other community services are utilized to provide individualized and tailored care. Elder Services has formal contracts with a number of community agencies that provide the ancillary services necessary to maintain the older adult safely and independently in their own home (e.g. Adult Day Health, minor home repair, legal assistance).

1. **Primary purpose:** To identify, refer and treat older adult residents in need of mental health services who reside in urban public housing developments.

2. **Target populations:** The target population is community-dwelling adults over the age of 60 experiencing any, or all, of the following signs or symptoms of distress: a serious and

persistent mental illness, emotional or behavioral problems, suicide risk, poor health, social isolation, abuse or neglect, substance abuse problems, and reluctance or inability to seek help on their own behalf or the absence of someone to seek help for them.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Qualitative evaluation: recognized as one of eight "exemplary" practices in the delivery of outreach services to older adults by the Western Interstate Commission for Higher Education, a national organization based in Boulder, Colorado.

Evidence supporting practice:

1. **Peer-reviewed research**: The Spokane Gatekeeper program was evaluated in 1994 by researchers from the Washington Institute for Mental Illness Research & Training. The program has been replicated throughout Washington State and beyond. Two reports highlighting the replication of the project in 10 rural areas in Washington State are cited below.

   Florio, E. R., Dyck, D. G., Rockwood, T. H., Hendryx, M. S., Jensen, J. E. & Raschko, R., Dyck, D. (1996). A model gatekeeper program to find the at-risk elderly: Client characteristics and service needs. *Journal of Case Management, 5*, 106-114.

   Florio, E. R., Hendryx, M. S., Jensen, J. E., Rockwood, T. H., Raschko, R. & Dyck, D. G. (1997). A comparison of suicidal and non-suicidal elders referred to a community mental health center program. *Suicide and Life Threatening Behavior, 27*, 182-193.

   Florio, E. R., Jensen, J. E., Hendryx, M. S., Raschko, R. & Mathieson, K. (1998). One year outcomes of older adults referred for aging and mental health services by community gatekeepers. *Journal of Case Management, 7*, 1-10.

   Jensen, J.E. & Florio, E. R. (1999). Gatekeeper model of case-finding at-risk older adults: Coalition building & community consensus to adopt the model. Process Evaluation Report. SAMHSA, No. P7953314-01.

   Jensen, J.E. (2002). Gatekeeper model of case-finding at-risk older adults: Implementation. Process Evaluation Report. SAMHSA, No. P7953314-01.

2. **Other supporting documents:** A training manual was developed by Mr. Raschko to train Gatekeepers (Raschko & Coleman, 1991, manual is available upon request). An ABC World News Tonight video highlighting the program in 1991 is also available. A number of guides to assist communities to adopt the model are available as well as example materials from other Gatekeeper models across the United States.

Practice implementation:

1. **Staffing requirements:** A program coordinator is key to the success and sustainability of the program. The coordinator should have a geriatric mental health background and/or medical background. A multidisciplinary team should be available to address the various needs of older adults referred. Elder Services' Gatekeeper program has geriatric clinical case managers, nurses, gero-pharmacist, and psychiatrist. They also have formal contracts with other health and social service agencies (e.g. adult day health, respite care, transportation, physician services) to provide comprehensive services.

2. **Training requirements:** The Gatekeeper training sessions, which are held at the workplace, last on average, one hour. The training sessions are kept flexible to accommodate the varied work schedules and time demands of the work force. The training should be adapted to accommodate cultural and language differences. Annual or more frequent re-training is suggested for companies or organizations that experience recurrent turnover of staff.

3. **Cost of Program:** The cost of the program will vary considerably based on the scope of the program and the population base. At a minimum, programs should have a .50 FTE program coordinator, an outreach worker, and geriatric specialists to provide and monitor the care of older adults referred.

4. **Use of Natural Funding:** Programs have utilized multiple funding sources including, federal block grant dollars, Older American's Act dollars, Medicaid for services, discretionary funds.

Other considerations:

Replications: The Gatekeeper program has been replicated in many counties in Washington State: Grant, Adams, Chelan-Douglas, Lincoln, Kittitas, Okanogan, Garfield, Asotin, Whatcom, Jefferson, Grays Harbor, Lewis, Pierce, Thurston-Mason, and Clark. Other known sites of replication can be found in Arizona, Florida, Hawaii, Illinois, Maryland, Michigan, New Hampshire, Oklahoma, Oregon, Pennsylvania, Wisconsin, Wyoming, Australia, and British Columbia.

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Relevant websites:

Psychogeriatric Assessment and Treatment in City Housing (PATCH)

Best Practice

Description:

Psychogeriatric Assessment and Treatment in City Housing is an outreach program that utilizes the Gatekeeper case finding strategy and a mobile treatment component, that is based on the Assertive Community Treatment model, to target older adult residents of public housing in need of mental health care. The program began as an NIMH demonstration project in six Baltimore high-rise public housing developments in 1986. The program has been so successful that it now operates in every public housing site in Baltimore, Maryland.

The model has three components: 1) A psychiatric nurse provides education and training to public housing employees (e.g. custodians, maintenance workers, managers) that come into contact with residents. They learn how to recognize changes in a residents behaviors that may indicate signs or symptoms of mental illness. The one-hour training addresses: normal versus abnormal aging, mood disorders, schizophrenia, substance abuse, dementia and death and dying issues. If staff become concerned about a resident then they refer the older resident to the psychiatric nurse for follow-through, 2) The mobile treatment nurse approaches the resident in their home and asks for their participation in a series of tests to assess their mental health status and service needs, 3) if mental health services are needed, a psychiatrist makes a home visit with the nurse and together they develop an ongoing treatment plan (e.g. psychotherapy, medications, service linkages). The nurse continues care with case management and advocacy as needed.

1. **Primary purpose:** To identify, refer and treat older adult residents in need of mental health services who reside in urban public housing developments. A major goal is to link 75% of those in need of care to the geriatric outpatient clinic or other community-based services.

2. **Target populations:** Targets urban public housing residents, sixty-years of age and older. The public housing developments are culturally and ethnically diverse.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Several published instruments are used to assess pre-post mental health status and outcomes: CAGE questionaire (alcohol use/misuse/abuse screeing), ADL/IADL checklist, Montgomery-Asbery Depression Scale (detects change in mood and depressive symptoms), Brief Psychiatric Rating Scale (BPRS; measures psychiatric symptoms and behavioral disorders), Mini Mental Status Exam.

2. **Qualitative evaluation:** Recognized as one of eight "exemplary" practices in the delivery of outreach services to older adults by the Western Interstate Commission for Higher Education, a national organization based in Boulder, Colorado.

Evidence supporting practice:

1. **Peer reviewed research:** Dr. Rabins and colleagues from Johns Hopkins, Center for Research on Services for Mental Illness and Johns Hopkins Hospital have a been involved in a large and onging investigation of PATCH (Evaluation of Psychogeriatric Outreach in City Housing: EPOCH). They have published a large body of research that show the effectiveness of PATCH in identifying and treating older adult residents of public housing in Baltimore. Their investigations also focus on specific issues facing older adults including, suicide, social isolation, and access to healthcare.

   During the first ten months of PATCH, 9.5 percent of older adult residents of four housing units were referred for assessment (Roca et al., 1990). Of those evaluated, 89 percent met criteria for at least one DSM-III-R diagnosis; the majority were previously undiagnosed. Dementia, depressive syndromes, schizophrenia and delusional disorders, and alcohol abuse or dependence were the most common diagnoses. In one study, Rabins and colleagues found that 26 months post referral to PATCH, older adults had significantly lower psychiatric symptoms (lower MADRS and BPRS scores) than a nontreatment comparison group (Rabins et al., 2000). Rabins et al. (2002) also found that 3.2% of African American older adult residents reported suicide ideation. Both depression and anxiety were found to be risk factors for passive suicidal ideation for this group. They found social support and religiousity to be protective factors for suicide ideation.

   Roca, RP, Storer, DJ, Robbins, BM, Tlasek, ME, & Rabins, PV. (1990). Psychogeriatric assessment and treatment in urban public housing. *Hospital & Community Psychiatry, 41,* 916-920.

   Rabins, B. V., Black, B., German, P. et al. (1996). The prevalence of psychiatric disorder in elderly residents of public housing. *Journal of Gerontology: Med Sci, 51A*, 319-324.

   Rabins, PV, Black, BS, Roca, R, German, P. McGuire, M, Robbins, B, Rye, R, Brant, L. (2000). Effectiveness of a nurse-based outreach program for identifying and treating psychiatric illness in the elderly. *JAMA, 283,* 2802-2809.

   Robbins, B, Rye, R, German, P, Tlasek-Wolfson, M, Penrod, J, Rabins, PV, and Black, BS. (2000). The psychogeriatric assessment and treatment in City Housing (PATCH) program for elders with mental illness in public housing: Getting through the crack in the door. *Archives of Psychiatric Nursing, 14,* 163-172.

   Cook, JM, Pearson, JL, Thompson, R, Smith Black, B, Rabins, PV. (2002). Suicidality in Older African Americans: Findings from the EPOCH study. *American Journal of Geriatric Psychiatry, 10*, 437-446.

2. **Other supporting documents:**

   Katz, I. R. & Coyne, J. C. (2000). The public mental health model for mental health care for the elderly. *JAMA, 283*, 2844-2845.

Practice implementation:

1. **Staffing requirements:** Nurse with geriatric mental health training, psychiatrist for consultation and home-visits.

2. **Training requirements:** Eight week educational program.

3. **Cost of Program:** Support staff costs are approximately $100,000 per year.

4. **Use of Natural Funding:** Funding comes primarily from the State Department of Mental Hygiene.

Other considerations:

Contact information:

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Relevant Websites:

www.jhsp.edu/SMI/Research/summaries/patch/html

Rural Elderly Outreach Project (REOP)

Description:

Rural Elderly Outreach Project (REOP) is an assertive outreach model designed to strengthen self-reliance of rural Virginians in caring for older adults, heighten awareness of aging and mental health issues, and to address cultural, ethnic, geographic diversity. It incorporates the Gatekeeper case-finding strategy and utilizes an integrated multiple disciplinary team to develop the individuals care plan. The primary team is made up of psychogeriatric and psychiatric nurses. A social worker, psychiatrist, and gerontologist provide consulation during team meetings.

Upon referral, a nurse and/or psychiatrist will make a home-visit if needed to make a comprehensive assessment. Case management and individualized care is provided in the home as needed.

1. **Primary purpose:** To identify, refer and treat older adult residents in need of mental health services who reside in rural areas of Virginia.

2. **Target populations:** Targets rural residents, sixty-years of age and older in need of mental health services.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:**

3. **Monitoring:** Sixty-three older adults were served the first year of the project. The primary diagnosis of those referred were, dementia (24%), depression (17%), comorbid dementia-depression (10%), and physical illness precipitating psychosocial crisis (25%).

Evidence supporting practice:

1. **Peer reviewed research:**

   Abraham, I.L, Buckwalter, K.C., Snustad, D.G., Smullen, D.E., Thompson-Heisterman, A.A, Neese, J.B. & Smith, M. (1993). Psychogeriatric outreach to rural families: The Iowa and Virginia Models. *International Psychogeriatrics, 5*, 203-211.

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:** Multidisciplinary team comprised of nurse with geriatric mental health training, psychiatrist, social worker and gerontologist.

2. **Training requirements:**

3. **Cost of Program:** $1015 direct cost per patient/year.

4. **Use of Natural Funding:** Kellogg Foundation

Other considerations:

Contact information:

Ivo Abraham, RN, PhD
Principal Investigator

Relevant websites:

Iowa's Elderly Outreach Project (IOP)

Description:

Mental Health of Rural Elderly Outreach Project (EOP) is a replication of the Gatekeeper model in rural Iowa (1986). This project was one of the first to formally replicate the model in a rural area. It was designed to identify older adults in need of services and to initiate and coordinate referrals to medical and social service agencies. They provide training to the formal network of service providers in the elderly case management network as well as nontraditional referral sources--Gatekeepers.

Upon referral a nurse makes a home visit or other acceptable site to conduct a comprehensive evaluation. All assessments are reviewed by a multidiciplinary team (three nurses, general medical practictioner, 2 psychaitric CNS's, social worker and psychiatrist) at a weekly meeting and a care plan is developed. Clients, family members and other providers are often involved in the care plan as well.

1. **Primary purpose:** Identify older adult in need of care and link them to services.

2. **Target populations:** Older adults 60 years of age and older who reside in rural Iowa.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:**

3. **Monitoring:** Number of referrals and outcomes are tracked.

Evidence supporting practice:

1. **Peer reviewed research:** Over 800 older adults have been referred to the program in 5 years. Of those referred, 50 percent needed and accepted referrals, 25 percent needed services but refused, and 25% didn't need additional services. In the first two years of the program, 420 older adults were identified, 412 in-home assessments were completed, 232 unserved older adults were enrolled, 67 older adults received aftercare services, and 215 referrals were made.

Abraham, I.L, Buckwalter, K.C., Snustad, D.G., Smullen, D.E., Thompson-Heisterman, A.A, Neese, J.B. & Smith, M. (1993). Psychogeriatric outreach to rural families: The Iowa and Virginia Models. *International Psychogeriatrics, 5*, 203-211.

Buckwalter, K.C., McLeran, H., Mitchell, S. & Andrews, P.H. (1988). Responding to mental health needs of the elderly in rural areas: A collaborative geriatric education center model. *Gerontology & Geriatrics Education, 8,* 69-80.

Buckwalter, K.C., Smith, M., Zevenbergen, P. & Russell, D. (1991). Mental health services of the rural elderly outreach program. *The Gerontologist, 31*, 408-412.

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:** Multidisciplinary team comprised of nurse with geriatric mental health training, psychiatrist, social worker and gerontologist.

2. **Training requirements:**

3. **Cost of Program:** $622 direct cost per patient/year.

4. **Use of Natural Funding:** 3-Year funded project: NIMH, AoA and Iowa DHS.

Other considerations:

Contact information:

Kathleen C. Buckwalter, RN, PhD
Principle Investigator

Relevant websites:

Geriatric Regional Assessment Team (GRAT) Evergreen Healthcare

Description:

The Geriatric Regional Assessment Team is a specialized crisis intervention and stabilization service for older adults in King County, Washington. The service is provided by a multidisciplinary team with geriatric specialization. The team offers in-home medical, psychosocial, and functional assessments for adults 60 years of age and older. Specific services include a comprehensive psychiatric, medical, social and functional assessment, crisis intervention and stabilization, prompt referral and linkage to mental health, aging, substance abuse, and health care providers, consulation, care planning, and education of professionals, families, and other care providers, and guardianship evaluations on a fee-for-services basis.

Once an older adult is referred to the GRAT, a comprehensive assessment is completed and the team members educate the older adult, and any family or supports about the diagnosis and medications. Assessment tools used include the Geriatric Depression Scale and the Folstein Mini Mental State Exam. They also refer the individual to appropriate agencies and

support groups depending on their need. The agency that receives the referral develops a more comprehensive long-term treatment plan. The GRAT team remains involved with the older adult and the agency until the crisis is stabilized. The GRAT team makes the majority of their referrals to the Aging and Disability Services Case Management program (Area Agency on Aging), medical clinics, the Alzheimer's Association, Adult Protective Services, in-home mental health services (Evergreen) and physicians.

1. **Primary purpose:** Provide crisis response and stabilization services to older adults in need of mental health services.

2. **Target populations:** The target population is adults 60 years of age and older who are: King County residents, in crisis, probability of mental illness, not enrolled in the King County public mental health system, and not residing in a nursing facility. Also, at least one of the following criteria must be met: physically and/or medically compromised; physically disabled, lacking family/friends able and willing to provide support necessary to ensure health and safety, refusing necessary health, mental health, and/or social services, at risk of involuntary psychiatric hospitalization, and in need of an assessment for differential diagnosis. Serves a diverse population of ethnic minorities including Asians (3%), African Americans (9%), Hispanic (5%), and Native American (0.5%). They are also serving the newly emerging Eastern Europeans immigrants including Russians.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:** Formal state and national reviews of the program are outstanding.
3. **Monitoring:** Quality assurance case reviews are conducted quarterly and outcomes are service related. Case reviews are held on an ongoing basis and staff particpate in quarterly reviews. The state and county also conduct annual quality reviews.

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** Information sheet about the program is available.

Practice implementation:

1. **Staffing requirements:** The multidisciplinary team is comprised of a registered nurse, geriatric mental health specialists, an occupational therapist, and a psychiartrist.

2. **Training requirements:** Team members develop cultural competence by participating in annual cultural sensitivity training.

3. **Cost of Program:**

4. **Use of Natural Funding:** Services are funded by King County Mental Health (RSN).

Other considerations:

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Relevant websites:

Elder Substance Abuse Outreach Program

Description:

The Elder Substance Abuse Outreach Program began as a joint project between Hawthorne Services, a multiservice geropsychiatric organization, and Brattleboro Retreat, an inpatient substance abuse treatment agency. The community-based program started in 1997 and modeled after an assertive outreach program in Connecticut. The program was started to address an unmet need in the community for older adults in need of substance abuse services that were not self-referring to traditional substance abuse programs. Staff believed that specialized services were needed for this population because of the co-occurance of substance abuse and depression and the resulting social isolation that often follows. It is not a crisis program nor does it provide formal in-patient substance abuse treatment or detoxification, rather it collaborates with community-based services that do. The primary role of the program is to identify older adults in need of substance abuse treatment and to then link them to appropriate services.

The program has three facets of treatment: Identificaiton of older adults at-risk; outreach to older adults in their home by an experienced clinician, and weekly substance abuse therapy and peer support group meetings.

Referrals flow from community organizations and Gatekeepers to Hawthorne. Within 24-hours an outreach worker (either the part-time substance abuse counselor or full-time social worker with substance abuse expertise) makes an initial contact to the older adult's home. It

is customary to make numerous home visits before the older adult accepts the need for intervention. An initial assessment is conducted using the MAST-G for substance abuse screening, as well as a depression screen.

If substance abuse is an issue then weekly therapy and psycho-educational groups with peers is recommended. The sessions focus on physical and psychological consequences of addiction. The emphasis is on understanding, resource linkage, and social connections rather than abstinence. The goal of these groups is to move the older person along toward recognizing the substance abuse problem and to link them to more formal services.

Peers are an important component of the program. Older adult volunteers are trained to support participants with emotional problems or depression that often co-occur with substance abuse. They are trained and meet monthly with clinical staff for support.

1. **Primary purpose:** To provide whatever substance abuse and mental health services are needed to keep older adults active and at home as long as possible and to provide care to those who would otherwise be underserved.

2. **Target populations:** The target population is adults 60 years of age and older who have a substance abuse problem. Chicopee is primarily Caucasian and African American, however, there is a growing Hispanic population.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:** Participant satisfaction surveys have been completed although no data is available.

3. **Monitoring:** The program is licensed and monitored by the Department of Mental Health.

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** Highlighted in *Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems*, DHHS, 2002.

Practice implementation:

1. **Staffing requirements:** A certified alcohol and substance abuse counselor is need for the success of the program. A part-time substance abuse outreach counselor (a social worker with substance abuse credentials) and full-time social worker with substance abuse expertise staff the program. A substance abuse counselor that speaks Spanish is available to work with the Hispanic older adults when needed.

2. **Training requirements:** Expertise in substance abuse among older adults. Program staff conduct ongoing training to their gatekeepers and other community groups on the prevention, detection, and treatment of alcoholism and depression among the older adult population. Staff also provide consulation to agencies and service providers who seek information and advice on issues of substance abuse and aging.

3. **Cost of Program:**

4. **Use of Natural Funding:** Sources of funding include Brattleboro, direct fund-raising events, grants from the area agencies, and the Center for Community Recovery Innovations (public housing).

Other considerations:

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Relevant websites:

Center for Older Adults and Their Families

Description:

The Center for Older Adults and Their Families is the geriatric speciality service of the Gouverneur Diagnostic and Treatment Center's Department of Behavioral Health, Gouverneur Hospital. The hospital is part of the larger New York City Health and Hospitals Corporation and is affiliated with New York University's Bellevue Medical Center.

The program components include: an older adult outreach team that make initial home visits for assessment and engagement, a clinic program that offers assessment, evaluation, therapy, and case management, a day treatment program with a comprehensive array of services plus activities in a therapeutic milieu, and psychiatric consultation for the nursing facility.

The outreach component relies on staff visiting homes, including public housing, senior centers, and other facilities, to increase awareness of mental health services through education and consultation. The focus is on reducing the stigma associated with mental health and services. Referrals come from primary care physicians, in-patient psychiatric facilities, and from friends and family members.

Once an older adult is referred to the program a comprehensive mental health and substance abuse assessment is completed by a multidisciplinary team. The psychosocial assessment evaluates current and past biological, psychological, and social functioning. The CAGE is used to assess substance abuse for the older adults. If available, families are encouraged to take part in the assessment process as well with special focus on their family roles and dynamics. A cultural assessment focuses on immigration status and cultural beliefs and practices.

The team develops a family-centered treatment plan based on the assessment and the individuals biological, psychological, social and family functioning. The Center provides mental health services in-home, on-site and in a Senior Center. On-site services include day treatment; a 5-hours/day program in a therapeutic environment. Individual psychotherapy sessions are available to those not appropriate or comfortable with day treatment. Services offered in the Senior Center (Grand Coalition of Seniors at Grand Street) are provided by an on-site staff member. This staff conducts assessments and provides assessments and counseling. Services are offered in many languages (English, Spanish, Mandarin, Cantonese, Portuguese, and Slovak) and in many ways to reflect the cultural diversity. For example, the weekly staff and client day treatment meetings are conducted in three languages which are rotated throughout the period. This has increased meeting participation.

Upon successful treatment older adults are linked to other community-based programs and services. The Center has close ties to many community agencies and advocacy groups through written agreements, including the Inter-Agency Council of the New York City Department of Aging and the Manhattan Geriatrics Committee.

1. **Primary purpose:** To provide comprehensive geriatric mental health services for older adults and their families.

2. **Target populations:** Program targets adults 55 years of age and older in need of mental health services and their families who reside in urban Manhattan. The target population is very diverse and includes Caucasians, Hispanics, African Americans and well as more recent immigrant populations from Asia, Russia, Latin America and Europe. Cultural competence is a primary feature of this program.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** The Center is just starting to use the Brief Symptom Inventory at pretreatment and at 6 month followups. No data is currently available however.

2. **Qualitative evaluation:** Satisfaction surveys indicate that participants overwhelmingly (85%) report that treatment helped them. Seventy-five percent of participants report that the psychotherapy services helped them.

3. **Monitoring:** The program is licenced, certified and monitored by the State and reviewed by the New York City Department of Mental Health.

Evidence supporting practice:

1. **Peer reviewed research:** A number of articles highlight various aspects of the program.

Sullivan, M. A. (1991). The homeless older woman in context: alienation, cutoff and reconnection. *Journal of Women and Aging, 3*.

Sullivan, M.A. (Winter, 1997-1998). Look back and wonder: Developing family oriented mental health programs for the elderly. *AFTA Newsletter (American Family Therapy Academy), 70,* 23-28.

Wong, G. (1993). The cross cultural group: A multilingual, multicultural group. Pride Institute *Journal of Long Term Human Health Care, 12*.

2. **Other supporting documents:** Descriptive brochures, the family evaluation (Genogram), the cultural assessment, the substance abuse evaluation and the treatment plan review are available upon request.

Practice implementation:

1. **Staffing requirements:** The multidisciplinary team is made up of a half-time psychiatrist, social workers, psychologists, and nurses.
2. **Training requirements:** Staff has extensive training in geriatric mental health, health and disabilities.
3. **Cost of Program:**
4. **Use of Natural Funding:** Medicare/Medicaid will cover 100% of the cost of care. Private insurance will cover part or all of the cost of care in most situations. A sliding fee scale is utlized for individuals without any insurance coverage.

Other considerations:

Contact information:

Gouverneur Dept. of Behavioral Health
Center for Older Adults and Their Families
Edgar Velasquez, MD
227 Madison St., #397
New York, NY 10002
(212) 238-7384

Relevant websites:

Older Adult Outreach and Education Service

Description:

The Older Adult Outreach and Education Service offers inpatient and outpatient substance abuse and mental health treatment, counseling and assertive outreach with a special focus on older adults with a primary substance abuse problem. Chelsea Community Hospital operates the Outreach program as well as a substance abuse outpatient treatment program, Older Adult Recovery Center. The University of Michigan Turner Geriatric Clinic and Neighborhood Senior Services, a non-profit social services agency, work closely with the two programs to provide seemless and comprehensive community-based services to Ann Arbor's Seniors.

The Geriatric Clinic, the neighborhood services agency, and other aging service providers make referrals to the Older Adult Outreach and Education Service program to meet with older adults in their homes. Other referrals come from family members, physicians, home care aides, or other health care workers, the legal system and other social service agencies. Outreach services are available for older adults who cannot seek services on their own or who are unwilling to accept services. A social worker from the Neighborhood Senior Services links older adults to appropriate resources and/or services.

The hospital also offers inpatient, outpatient, day treatment, family therapy, peer counseling and group psycho-educational services about substance abuse and addiction. The Turner Geriatric Clinic provides comprehensive geriatric health, health promotion, learning programs, and community resource information. The Neighborhood Senior Services offers an array of supportive services, including, home-chore assistance, transportation, volunteer services, and resource advocacy (case management and entitlement assistance).

1. **Primary purpose:** To identify, refer and treat older adult residents in need of substance abuse and mental health services who reside in Ann Arbor, Michigan.

2. **Target populations:** Targets older adults with substance abuse problems.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:**

3. **Monitoring:** Primarily service-related. Numbers of older adults receiving new services indicate success. Data are reported in quarterly reports, including demographic data on race, ethnicity, gender, age, income, disability status, and locale. The State agency is responsible for monitoring and evaluating the program.

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:** The Older Adult Outreach and Education Service has a half-time staff person with substance abuse expertise.

2. **Training requirements:** Staff provide substance abuse training to it's many community partners. It is important to have a training fully versed in substance abuse prevention and treatment among older adults, as well as mental health and other health and social issue.

3. **Cost of Program:**

4. **Use of Natural Funding:** Federal block grant dollars from the State fund the outreach component. Medicare, Medicaid, private insurance and some State funding pay for treatment services.

Other considerations:

Contact information:

Jeff Smith
Older Adult Outreach and Education Service
Chelsea Community Hospital
955 West Eisenhower Circle, Suite H
Ann Arbor, MI 48103
(734) 665-5070
E-mail: jsmith@cch.org

Relevant websites:

Elders Wrap-Around Team

Description:

This project is an expansion of existing geriatric mental health services at Riverbend Community Mental Health, Elder Services. Riverbend Elder Services has grown since it's inception in 1993. It has a staff of 11 that provides psychosocial and psychiatric assessment and evaluation; counseling for groups, individuals, couples, and families, medication assessment and monitoring; case management; education and workshops; information and referral to community resources; outreach; and consumer advocacy. The Elders Wrap-Aound Team provides coordination of a wide range of services that are needed by the target population. The Wrap-Around Team includes representatives from 12 core agencies who meet for two hours each month to discuss specific cases and service issues. Providers from 40 other agencies are invited to the table when a case warrants additional expertise. The older adult and family members or supportive others are also encouraged to attend the meetings.

The Wrap-Around concept centers around an older adults strengths, needs, and preferences. The goal is to maintain the older adult in their own home and community safely and independently as long as feasible. Team services include community education, training of team members and the agency network on mental health and aging issues, screening for depression, memory loss, anxiety and substance abuse. Referrals originate from the agencies involved as well as physicians, hospitals, first responders, families and an older adult themselves. Treatment plans are developed by the older adult and the team. It may involve agency specific treatment (mental health services) or an array of community-based services (e.g. chore services, home-delivered meals, pharmacy).

1. **Primary purpose:** To improve the linkages among community agencies and to develop collaborative relationships to provide greater access, coordination and quality services to older aduls and their families.

2. **Target populations:** The target population is adults age 60 and older that have service needs in at least 3 different life domains.

Evaluating this practice:

The program is currently being evaluated.

1. **Outcome measures used to evaluate practice:** Unknown.

2. **Qualitative evaluation:** Descriptive data available indicates that hospital admissions have declined and the length of stays have decreased. The number of agencies that have joined the team have increased significantly since the beginning of the program. This has also resulted in more referrals to the participating Wrap-Around Team agencies. After the first year and a half, the program served 18 consumers and their families.

3. **Monitoring:** The program is monitored by the program staff and agency.

Evidence supporting practice:

1. **Peer reviewed research:** Unknown.

2. **Other supporting documents:** The program is included in this report as a promising practice. US Department of Health and Human Services (2002). Promoting older adult health: Aging network partnerships to address medication, alcohol, and mental health problems. (DHHS Publication No.(SMA) 02-2628). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Practice implementation:

1. **Staffing requirements:** Staff recommend that a program coordinator (at least half time) is dedicated to the program. The coordinator is responsible for program design and maintence, recruiting agencies, and leading team meetings.

2. **Training requirements:** Education and training opportunties are offerered through presentations and workshops and target consumers, family members, caregivers, students, professionals and others intererested in improving services to older adults. Training focuses on the physical, emotional and social aspects of aging and service delivery.

3. **Cost of Program:** The cost of a coordinator position, staff time for meetings and collaboration. Other costs are minimal. Cost will vary by scope and program.

4. **Use of Natural Funding:** The State funds the coordinator position. Services are billed by each agency involved in service provision; typically services are reimbursed through Medicaid, Medicare and other in-kind contributions, flexible funding and small grants.

Other considerations:

Elders Wrap-Around was recognized for its leadership by the National Council for Community Behavioral Health Care for Special Programs, in 2000.

Contact information:

Jeanne Duford
Elders Community Coordinator
Riverbend Community Mental Health
PO Box 2032
Concord, NH 03302-2032
603-228-2101

Relevant websites:

www.riverbendcmhc.org

The In-Home Mental Health Program

Description:

The In-Home Mental Health Program provides mental health services to older adults in their own homes, adult family homes, assisted living facilities and nursing homes. A multidisciplinary staff provides the following services: assessment and diagnosis, individual therapy, assessment and medication evaluation by an ARNP/Psychiatrist, medication management by psychosocial nurses, social work-case management services, coordination of mental health and medical care, transition to outpatient mental health services, consultation to assisted living facilities, adult family homes and nursing homes, and telephone crisis services 24 hours a day.

Older adults are eligible for in-home services if they meet the following criteria: experience signs and/or symptoms of depression, a thought disorder, dementia, mania or anxiety/panic disorder; are home bound due to a psychiatric or medical condition; and agree to receiving services. Referrals to the program can originate from any source. Program staff recommend that the mental health services be discussed with the potential client prior to referral.

1. **Primary purpose:** To provide a coordinated and comprehensive array of mental health and health services to home bound older adults.

2. **Target populations:** Older adults whose mental and/or physical illnesses or disabilities prohibit them from utilizing traditional outpatient mental health services in King and Snohomish County, Washington.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:**

3. **Monitoring:**

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** Information sheet about the program is available.

Practice implementation:

1. **Staffing requirements:** Masters prepared therapists, social workers, psychosocial nurses, ARNPs and psychiatrists.

2. **Training requirements:** Staff has extensive training in geriatric mental health, health and disabilities.

3. **Cost of Program:**

4. **Use of natural funding:** Medicare/Medicaid will cover 100% of the cost of care. Private insurance will cover part or all of the cost of care in most situations. A sliding fee scale is utlized for individuals without any insurance coverage.

Other considerations:

Contact information:

In-Home Mental Health
2414 SW Andover Street, D-120
Seattle, WA 98106
(206) 923-6300

Relevant websites:

www.evergreenhealthcare.org

Family Caregiver Counseling Service– Evergreen Healthcare, King County

Description:

This is a specialized outreach therapy service provided by the Geriatric Regional Assessment Team that consists of a registered nurse, geriatric mental health specialists, an on-call occupational therapist, and a psychiatrist. The team works collaboratively to provide 1) one to five in-home sessions of brief counseling for caregivers who meet the criteria for eligibility; 2) referral to community services, including support groups and respite care; 3) education and support on specific emotional issues experienced by the caregiver. Counseling, education, and support focuses on problem solving, self-care, stress management, and positive change.

1. **Primary purpose:** .to provide counseling to family caregivers who need counseling secondary to their caregiver role and are unable or unwilling to go to a community counselor.

2. **Target populations:** Adults in King County who are the informal/unpaid primary caregiver of an individual 60 years of age or older or any adult, age 60 or older, who is the informal/unpaid primary caregiver of an individual (under the age of 19 or over the

age of 60) who has mental retardation and related development disabilities; individual with the greatest social and economic need; not residing in a nursing home.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: .

2. **Qualitative evaluation**: .

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:** a registered nurse, geriatric mental health specialists, an on-call occupational therapist, and a psychiatrist.

2. **Training requirements:**

3. **Cost of program:** Unknown

4. **Use of natural funding:** Seattle-King County Aging and Disability Services through a national Family Caregiver Support Grant.

Other considerations:

There is no fee for eligible caregivers but only a limited number of caregivers can be served.

Contact information:

Relevant websites:

www.evergreenhealthcare.org

Resources for Enhancing Alzheimer's Caregiver Health (REACH)

Description:

REACH is a unique, multisite research program sponsored by the national Institute on Aging and the National Institute on Nursing Research. It is occurring at six sites: Boston,

Birmingham, Memphis, Miami, Palo Alto, and Philadelphia. Interventions include: 1) individual information and support strategies, 2) group support and family systems therapy, 3) psychoeducational and skill-[based training approaches, 4) home-based environmental interventions, and 5) enhanced technology support systems Schulz et. al, 2003). The goal of all the interventions is to change the nature of specific stressors such as problem behavior of the care recipient, their appraisal, and the caregiver response to the stressors.

1. **Primary purpose:** to carry out social and behavioral research on interventions designed to enhance family caregiving for Alzheimer's disease (AD) and related disorders; to test the effectiveness of multiple different interventions and to evaluate the pooled effect of REACH interventions overall.

2. **Target populations:** family caregivers of persons with AD at the mild or moderate level of impairment.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: caregiver burden, caregiver depression.

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:** Schulz, R., Burgio, L., Burns, R., Eisdorfer, C., Gallagher-Thompson, D., Gitlin, L.N., & Mahone, D.F. (2003) Resources for Enhanding Alzheimer's Caregiver Health (REACH): Overview, site-specific outcomes, and future directions. *The Gerontologist, 43(4),* 514-520.

2. **Other supporting documents:** Training manuals, detailed treatment manuals, certification procedures

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Richard Schulz, PhD
University of Pittsburgh
121 University Place
Pittsburgh, PA 15260
schulz@pitt.edu

Relevant websites:

http://www.edc.gsph.pitt.edu/reach/

Senior Services Caregiver Outreach and Support Program–Seattle/King County

Description:

Caregiver advocates help caregivers identify community resources, select the best options, and assist in securing needed services. Advocates make home visits and give workplace or community presentations on caregiver resources, long distance caregiving, paying for care, and legal issues for caregivers. Additional sources of support include 1) the program's Online Journal where caregivers can read and write daily accounts by other caregivers about their daily experiences via the internet and 2) a caregiver message board.

1. **Primary purpose:** to provide support for unpaid family caregivers by helping them identify community resources, select the best options and assist in securing needed services for themselves and the person they care for

2. **Target populations:** Anyone caring for a person 60 years old or older or any person 60 years old or older caring for a child under the age of 19.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Caregivers utilize community support services. Caregivers report that support services helped them be a better caregiver

2. **Qualitative evaluation**: Anonymous written survey. Review of case records.

Evidence supporting practice:

1. **Peer reviewed research**:

2. **Other supporting documents:** Brochures, caregiver kits, on-line database of community resources, website, monthly reports are generated from client records maintained in a Microsoft Access database

Practice implementation:

1. **Staffing requirements:** 3 FTE Caregiver Specialists, 1.3 FTE Information and Assistance Advocates and .2 FTE Data Manager.

2. **Training requirements:** All Caregiver Advocates have at a minimum a relevant bachelor's degree, 5 years of experience and are Certified Information and Referral Specialists, Ageing Emphasis. All participate in continuing education and in-service training.

3. **Cost of program:** The cost of the program in 2003 will be approximately $250,000.

4. **Use of natural funding:** funded through a National Family Caregiver Support Program Grant allocated through Aging and Disability Services, the local Area Agency on Aging.

Other considerations:

Contact information:

Eileen Murphy, Associate Director
Senior Services I&A Project
2208 2nd Avenue, Suite 100
Seattle, WA 98121
(206)727-6235
Eileenm@seniorservices.org

Relevant websites:

http://www.seniorservices.org/caregiver/caregiver.htm

The SHARE Model (Specialized Help for Alzheimer's in a Residential Environment)

Description:

Though this model is housed in a residential care setting, the practice is adaptable to a free-standing adult day Center where transportation is provided. The model was developed to address the needs of individuals with moderate dementia. The program runs on weekdays, 6 hours per day. The approximately 50 participants experienced discrete structured activity periods for welcoming/orientation, therapeutic activities, socialization, toileting, lunch, and snacks. The program provides nursing, social work, therapeutic recreation, dietary services, and rehabilitation services. Therapeutic activities include cognitive and sensory stimulation, exercise and movement programs, music and rhythm, and reminiscence.

1. **Primary purpose:** "to encourage association, recall, and reminiscence; provide a vehicle for thought and communication; promote socialization and a sense of purpose and belonging; reinforce appropriate behavior; maximize and maintain ADL skills; and facilitate environmental awareness and reality orientation in the patients." (Grower et. al., 1994)

2. **Target populations:** individuals with moderate dementia who are able to engage in the program and do not require frequent one-on-one interventions for aberrant behavior.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**

2. **Qualitative evaluation** showed that participants, staff, and families were satisfied with the program, that the program encouraged recall, humor, familiarity, and affection; the program offered respite to the usual caregivers.

Evidence supporting practice:

1. **Peer reviewed research:** Grower, R. & Frazier, C. (1990). Applying a community based day program to a nursing home setting. Paper presented at the Northeastern Gerontological Society Conference, New Haven, CT.

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:** a program coordinator supervises daily operations and clinical aspects of the program; nursing aides provide direct care; adjunct staff.

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding**:

Other considerations:

Contact information:

Morningside House
1000 Pelham Parkway
Bronx, New York 10461
718-409-8200

Relevant websites:

www.aginginamerica.org

On Lok Senior Services Program Day Health Center

Description:

The On Lok Senior Health Services Day Health Center is located in San Francisco, California. It is one component of a comprehensive a consolidated model similar to the Program for All-Inclusive Care for the Elderly described in another section of this guide.

A multidisciplinary team serves as a case manager for each patient; the team includes physicians, nurse practitioners, nurses, social workers, recreation/occupation therapists, home health aides, dieticians, and drivers. The program transports some clients to adult day care daily. Nutritionally balanced hot ethnic meals and nutritious snacks are served during each session. Social and health care services include monitoring health status, assistance with medications, personal care, health education, physical therapy, occupational therapy, speech therapy, group exercises, assistance with obtaining therapy equipment, dietary consultation, psychosocial assessments, individual and family counseling, support groups, and recreation.

1. **Primary purpose**: to help the frail elderly and disabled adults maintain or restore their health so that they can remain in the community with their families as long as possible

2. **Target populations**: must be 55 years old or older and living in San Francisco; experiencing ongoing medical problems, memory loss, and/or need daily help with bathing, walking, eating or dressing; and, may be considering a nursing home but prefer to remain at home

Evaluating this practice:

1. **Outcome measures used to evaluate practice** rate of hospital use, length of hospital stays

2. **Qualitative evaluation**

Evidence supporting practice:

1. **Peer reviewed research**: Bodenheimer, MD, Thomas; "Long-Term Care for Frail Elderly People — The On Lok Model," *The New England Journal of Medicine*, October 21, 1999, pp. 1324-1328. Robinson, G.K. (1990b). The psychiatric component of long-term care models. In B.S. Fogel, G.L. Gottlieb, & A. Furino (Eds.), *Mental health policy for older Americans: Protecting minds at risk (pp. 157-178).* Washington, DC: American Psychiatric Press. O'Malley, Kate and Sara Brooks; "Caring the On Lok Way," *Geriatric Nursing*, March/April 1990, pp. 64-66.

2. **Other supporting documents:** In a 1993 study, savings to Medicare were estimated to be 14 percent to 39 percent when compared to fee-for-service. PACE also has a lower average number of hospital days than does the general Medicare population. This rate is notable primarily because the general Medicare population includes people who are well and those who are sick - unlike PACE, which includes only the very ill and frail, and a majority of patients who have many serious illnesses.

   On Lok gained "organization of the year" honors in the Public Health Heros program, University of California, Berkeley, for its contribution to promoting the health of older adults.

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:
www.onlok.org

Relevant websites:
info@onlok.org <info@onlok.org>

Kaiser Permanente Social Health Maintenance Organization

Description:
This S/HMO plan offers the full range of medical benefits that are offered by standard HMO's plus chronic care/ extended care services. The organization received extra Medicare capitation to expand long-term care services. Enrollees are charged higher premiums that make them eligible for an expanded array of long-term care benefits that go beyond the usual Medicare long-term care benefit. The expanded part of services is usually community-based. A dollar limit on long-term care services is set along with strong oversight by a case manager.

Strengths of this model, according to Dowd et. al. (1999) are that it combines "the authorization and provision of both acute care services and long-term care under one organizational model allowing for better coordination between service providers and a broader scope of control for the organization as a whole." (p.11) Also it places "the organization at risk for the cost of acute and long-term services covered by the plan." This creates a strong financial incentive "to ensure that care is provided in the least costly environment that is able to meet the member's needs." (p.11)

1. **Primary purpose:** to integrate medical, social and long term care services and long term care services within a capitated managed care framework and to keep functionally impaired older adults living at home as long as possible.

2. **Target populations:** individuals over 65 years of age and is enrolled in Medicare Part A and Part B who live in the Kaiser Permanente S/HMO service area and qualify for nursing home certification. Criteria may include "needing daily ongoing assistance from another person with one of the following activities of daily living: walking or transferring indoors, eating, managing medications, controlling difficult or dangerous behavior, controlling bowels or bladder, or the need for protection and supervision because of confusion or frailty (Official U.S. Government Site for People with Medicare, 2003)". Not for those with end-stage renal disease or for those who reside in an institutional setting.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation**

Evidence supporting practice:

1. **Peer reviewed research:** S/HMOs are in their infancy. They are evolving and under investigation. We feature Portland's Kaiser Permanente because it includes behavioral factors in its assessment for service eligibility and because it is in a family of managed care interventions to "keep an eye on", given their comprehensive nature. Evaluation of cost savings for a similar program in Minneapolis run by the same parent company, showed increased spending for the S/HMO as compared to a traditional HMO. Possible explanations offered by Dowd et. al. (1999) are that S/HMO membership led to increased salience of medical problems for enrollees receiving the extended care benefit, the transportation benefit may have improved access to physicians and clinics, and changes in practice patterns. Indeed, Dowd argues that higher expenditures do not imply that the S/HMO failed to provide services valued by the members. A qualitative study of the termination of the S/HMO in Minnesota found that at risk elderly were receiving fewer home care services, their family caregivers reported increased burden and stress, and they had more out-of-pocket expenses (Fisher et. al., 1998).

   Dowd, B., Hillson, S., VonSternberg, T., Fischer, L.R. (1999). S/HMO versus TEFRA HMO enrollees: analysis of expenditures. *Health Care Financing Review, 20(4)*, 7-23.

   Enguidanos, S.M., Gibbs, N.E., Simmons, W.J., Savoni, K.J., Jamison, P.M., Hackstaff, L., Griffin, A.M., Cherin, D.A. Kaiser Permanente community partner's project: Improving geriatric care management practices. *Journal of the American Geriatric Society, 51(5),* 710-714.

2. **Other supporting documents:** In 1996, the Health Care Financing Administration evaluated the 4 "first generation" S/HMO demonstration projects, one of which was the Kaiser Permanente S/HMO. Evidence that S/HMOs were less costly than fee-for-service were mixed. No improvements in mortality or active life expectancy were demonstrated; however, frail S/HMO enrollees were more satisfied than their fee-for-service comparisons with costs and benefits of care (Vladeck, 1996).

   Vladeck, B.C. Testimony on Long Term Care Options: PACE and S/HMO. Before the House Ways and Means, Subcommittee on Health, April 18, 1996.

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Only a minority of the enrollees are poor and in need of long-term care; Kaiser Permanente, Portland, Oregon includes needing assistance in controlling difficult or dangerous behavior as one of the criteria

Contact information:

Relevant websites:

http://www.dhs.cahwnet.gov/director/OLTC/html/shmo.htm
http://www.hhs.gov/asl/testify/t9604181.html

Program for All-Inclusive Care of the Elderly (PACE): Providence ElderPlace

Description:

PACE is a partnership between the federal government and the private sector. It uses a coordinated set of services that include both medical and social care services delivered at a day health center. It is characterized by interdisciplinary teamwork and has an onsite staff physician. Many programs purchase a variety of in-home services. It provides a full range of medical, social, and long-term care services. PACE programs receive a monthly capitated payment from Medicare and Medicaid for eligible enrollees. PACE is intended to replicate the exemplary On Lok program in San Francisco's Chinatown. Providence ElderPlace is a PACE site in Seattle. Mental Health services are provided largely through a geriatric psychiatric nurse practitioner who conducts a bi-monthly clinic at the center. THE ARPN is also available to do home visits. This is under contract with Evergreen Mental Health. In addition, Providence ElderPlace Seattle uses Asian Counseling and Referral Services, a community mental health provider, when there are language issues. In addition, they have a contract with Community Psychiatric Clinic for substance abuse assessment and supportive services. The physician is available to monitor medications and the PACE social worker is responsible for assuring a safe placement in the community. They frequently do this through arrangement with Adult Family Homes who specialize in mental health.

1. **Primary purpose:** to manage the care of enrollees with minimal reliance on either hospitals or nursing homes.

2. **Target populations:** Medicaid clients 55 years of age and older residing in the community at the time of enrollment whose needs for long-term care are deemed to be at the nursing home level; however, Medicaid eligibility is not a requirement to enroll in the program. While not targeted specifically to adults with mental illnesses, many PACE clients have psychiatric disorders. Approximately 60 % of ElderPlace Seattle has a mental health diagnosis.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: rate of hospital use, length of hospital stays

2. **Qualitative evaluation** In 1993, the Community Health Accreditation Program (CHAP) reviewed five PACE sites and found the quality and coordination of enrollee care to be exceptional

Evidence supporting practice:

1. **Peer reviewed research:** PACE has been difficult to evaluate. There is some evaluation evidence suggesting that PACE resulted in reductions in hospital and nursing use while maintaining positive health outcomes and satisfaction. Kuntz and Shannon (1996) reported reduced number of hospitalizations, lengths of hospital stays, and nursing home admissions for enrolled individuals. Wieland et. al. (2000) found that hospital bed-days per 1000 PACE participants per year were comparable with the general Medicare (fee-for service) population despite the greater morbidity and disability for PACE participants.

Gorshe, N. (1993). An effective, efficient elder care program. Providence ElderPlace focuses on maintaining the continuum of care. *Health Programming, 74(3),* 57-59.

Mui, A.C. (2001). The Program of All-Inclusive Care for the Elderly (PACE): an innovative long-term care model in the United States. *Journal of Aging and Social Policy, 13(203),* 53-67.

Rich, M.L. (1999). The PACE model: description and impressions of a capitated model of long-term care for the elderly. *Care Management Journal, 1,* 62-70.

Branch, L.G., Coulam, R.F., Zimmerman, Y.A. (1995). The PACE evaluation: initial findings. *Gerontologist, 35(3),* 349-359.

Wieland, D., Lamb, V.L., Sutton, S.R., Boland, R., Clark, M., Friedman, S., Brummel-Smith, K., Eleazer, G.P. (2000). Hospitalization in the Program of All-Inclusive Care for the Elderly (PACE): rates concomitants, and predictors. *Journal of the American Geriatric Society, 48(11)*, 1373-1380.

2. **Other supporting documents**: In 1997, the Health Care Financing Administration retained Abt Associates, Inc. to evaluate PACE. They reported PACE enrollment to be associated with improved health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life's problems. To obtain PACE reports, contact Dawn Hoppe, Abt Associates, Inc., 55 Wheeler St., Cambridge, MA 02138-11568. Phone (617)520-2967.

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:** Pools Medicare and Medicaid dollars. In order for a state to participate in the PACE program, the State Medicaid agency must add PACE to the State Medicaid Plan as an optional benefit

Other considerations:

Contact information:

National PACE Association
1255 Post Street, Suite 1027,
San Francisco, CA 94109
Phone: (415)/749-2680

Relevant websites:

http://www.chausa.org/LONGTERM/LTPACE.ASP
http://www.onlok.org/stats.html
http://www.dhs.cahwnet.gov/director/OLTC/html/onlok.htm

Outcomes-Based Treatment Plan (OBTP)

Description:

The OBTP is an integrated outcomes-based treatment planning instrument that is completed by the clinician, a patient-administered treatment outcomes questionnaire, and a set of aggregate service system quality and performance indicators. The following domains are measured:

- physical functioning
- personal care skills
- community living skills
- travel and safety
- treatment self-management

- interpersonal relationships
- leisure and community activities
- problem behaviors
- depressive symptoms
- psychotic symptoms
- negative symptoms
- substance abuse
- cognitive functioning
- general health status
- vocational
- support system risk
- residential status

Validated measures with good inter-rater and construct validity from the existing literature are used for each domain. When an older adult receives a rating on a domain, a checklist menu for treatment planning relevant to that rating is provided. A treatment planning schedule allows the clinician to document the planned treatment and the completed treatment interventions for each domain.

The extensive clinician assessment is augmented by a brief inventory of the client's health and mental health status completed by the client or the family care giver. In addition, in each of 11 domains, the patient or family care giver rates whether they perceive that the treatment has had a beneficial effect.

1. **Primary purpose:** "to assess outcomes for community-based services (excluding institutional settings such as nursing homes and hospitals) for people age ." (Grower et. al., 1994)

2. **Target populations:** Older adults with mental illness.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: improvement in practice behavior of clinicians (breadth and comprehensiveness of their assessments, range and specificity of treatments and services provided; increased measurement of progress using quantifiable anchored measures); improvement in mental health status; grater perceived benefit from mental health services by consumers.

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:** Bartels, S.J., Miles, K.M., & Dums, A.R. (2001) Improving the quality of care for older adults with mental disorders: the outcomes-based treatment planning system of the NH-Dartmouth Psychiatric Research Center. *Policy Brief of the Home Care Research Initiative, Center for Home Care Policy and Research, Visiting Nurse Service of New York: New York.*

2. **Other supporting documents:** http://www.vnsny.org/brief11.pdf; Bartels, S.J., Miles, K.M., Levine, K., Horn S., Sharkey, P. (199&). Improving psychiatric care of the older patient. In SD Horn (Ed.), *Clinical Practice Improvement Methodology: Effective Evaluation and Management of Health Care Delivery,* New York: Faulker and Gray, pp. 193-217.

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

OBTP has been implemented state-wide in New Hampshire's Community Mental Health Centers and pilots are now occurring in Maine and Pennsylvania.

Contact information:

Stephen J. Bartels, M.D., M.S.,
NH-Dartmouth Psychiatric Research Center
2 Whipple Place Suite 202
Lebanon, NH 03766
(603)448-0126
800-540-0126

Relevant websites:

http://abstract.confex.com/ipa/11congress/techprogram/session_1933.htm
www.vnsny.org/hcri

Comprehensive Assessment Reporting Evaluation (CARE)

Description:

The Comprehensive Assessment Reporting Evaluation (CARE) project is a system to enable consistent, accurate, and efficient client assessments and plans for adult Medicaid clients in need of long-term care. It is used to assess and develop service plans for clients who receive

long-term care services; to accurately measure needs and allocate resources based on medical, cognitive, behavioral and personal care needs. A staged process of implementing CARE is currently underway. Once CARE is implemented in a region, all new clients will be assessed in CARE. All existing clients will receive a CARE assessment at the time of their annual reassessment, or sooner if there is a significant change in condition.

1. **Primary purpose:** to ensure correct eligibility determinations are made for corresponding benefits; establish a standard and consistent case management process that will ensure accurate assessments and client care plans; provide a formal assessment of risk indicators to reduce liability and protect vulnerable adults.

2. **Target populations:** adult Medicaid clients in need of long-term care

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: A system for assuring quality of assessments is in place (Quality Assurance and Improvement Program, Chapter 23, Long-term Care Manual, Washington State Aging and Disabilities Services Administration).

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** Project Oversight Report, April, 2003: http://www.wa.gov/dis/isb/041003DSHSCARE.pdf)

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

ADSA has contracted with Deloitte Consulting for the development of the CARE system on a deliverables-based, fixed-price basis for $2.965 million. Deloitte spent five years designing, developing, testing, and implementing a Comprehensive Assessment system for the State of Oregon. Since ADSA's business requirements match those of Oregon, the development of CARE is based upon a transfer of Oregon's design. Starling Consulting Inc. has been contracted to be conduct the external Quality Assurance.

Contact information:

Relevant websites:

http://www.aasa.dshs.wa.gov/professional/care/
http://www.wa.gov/dis/isb/041003DSHSCARE.pdf

Little Havana Health Program

Description:

Little Havana offers a comprehensive array of 70 services to more than 63,000 people each year through 21 multiservice community centers. The centers provide preventive social, health, nutrition, and mental health services (DHHS, 2002). The health program offers health promotion, disease prevention, health education, mental health services and primary health care. Types of settings in which health services are delivered are varied. Health care for older adults occurs in senior centers, congregate meal sites, adult day health centers, and a primary clinic. Cultural competence and sensitivity are seen as key to the success of the program.
A comprehensive health and social assessment is completed for all participants in the Little Havana Health Program. The assessment includes targeted mental health questions that identify individuals for whom the program. Trained caseworkers score the assessment and identify participants at risk for depression or other mental health problems. Those identified as having a potential need for mental health services are seen by a clinical social worker. This mental health professional works with the client to develop a tailored mental health service plan, directs caseworker contacts with clients' families and follow-up referrals to the primary clinic. The primary care clinic provides counseling offered by retired professional volunteers. It also plays a key role in monitoring medications. Consultation is also provided by a volunteer psychiatrist. Some clients receive services at a nearby community mental health center.

Some clients are encouraged to participate in therapeutic activities offered at Little Havana senior centers and adult day health centers. Staff at these centers includes peer counselors trained by the clinical social worker. One of the adult day health care centers offers respite services for participants with Alzheimer's disease.

Since the many service settings cover a broad geographical area and participants need to leave home to use the services, transportation for all who need it is very important. In addition, the broad array of services must be highly integrated in order to successfully meet the needs of participants. The organizational structure and the service plan development process links the services and centers formally with the Little Havana organization. A formal linkage agreement between Little Havana and Miami Behavior Health, an outpatient mental health provider, assures that there is follow-up on referrals between the two agencies.

Informal relationships are also important. For example, the local mental health association has provided speakers for education programs and small group discussions.

1. **Primary purpose:** To meet the health and mental health needs of disadvantaged elders.

2. **Target populations:** Population at risk for isolation due to socioeconomic and language limitations.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Participants are observed for changes in their physical and mental status. Local Area agency on aging monitors Little Havana's services and issues reports on their performance as providers of services funded under the Older Americans Act.

2. **Qualitative evaluation**: Recognized as one of eight "exemplary" practices in the delivery of mental health services to older adults by the Western Interstate Commission for Higher Education, a national organization based in Boulder, Colorado.

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** It was selected as one of 15 promising practices by the National Council on the Aging. These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health.

Practice implementation:

1. **Staffing requirements:** on site clinical professional, retired professionals, a corps of trained volunteers, information system for tracking client assessments, service, planning, monitoring, and follow-up.

2. **Training requirements:**

3. **Cost of program:** $8.7 million to provide services to 63,000 people each year

4. **Use of natural funding:** 70% federal government grant, 13% state grant, 6 % local grant, 11% United Way

Other considerations:

Retired professionals in Florida are allowed to practice without liability insurance as long as they do not charge for their services.

Contact information:

Ariela Rodriguez, Ph.D., L.C.S.W.
Director, Health and Social Services
Little Havana Activities and Nutrition Centers of Dade County, Inc.
700 SW 8th Street.
Miami, FL 33130
(305)858-0887

Relevant websites:

Kit Clark Senior Services

Description:

Kit Clark is a multipurpose elder services agency providing a full spectrum of services to seniors in Boston. Thus, mental health services is one component of a program that provides nutrition programs, meals, home repair, housing programs, exercise, health education, adult day services, primary health care, and social opportunities. Kit Clark offers outpatient treatment programs for older adults with addictions or mental illness. Three clinics address these issues: 1) Geriatric Mental Health Clinic, 2) Alcohol and Substance Abuse Services for Older Adults, and 3) Gambling Treatment for Older Adults. Its addiction and mental health programs are strongly connected to senior centers where individual participants can come in for individual or group treatment sessions as well as socialize and have a meal. Referrals for mental health and addiction programs come from 35 programs offered throughout Boston by Kit Clark Senior Services. Outreach workers, direct care staff, and administrators from the network are trained to recognize substance abuse and mental health issues, discuss them with older adults, and make referrals. Kit Clark also created a network among the area agency on aging, home care corporations, clergy, hospitals and others (DHHS, 2002). Thus, referrals come from external service providers such as case managers, senior housing, managers, home health care nurses, discharge planners, and primary care physicians.

A comprehensive health and social needs assessment, the Senior Health Education and Access Assessment, is conducted. If a possible problem with addiction or mental health is indicated, a more detailed assessment occurs. A treatment plan is arrived at by the senior and a team comprised of clinical social workers, a psychiatrist, and a nurse. Besides individual and group treatment sessions at Kit Clark centers, services are also provided in home for older adults unable to come to the center.

1. **Primary purpose:** to enable older adults to maintain themselves with dignity in the community; to decrease social isolation and loneliness among seniors.

2. **Target populations:** low-income, multi-ethnic seniors.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: concurrent medical problems are addressed; environmental stressors are addressed; whether global assessment of function improves or maintains.

2. **Qualitative evaluation**: Kit Clark has been featured in several documentaries and training videos produced by AARP and the Hazeldon Foundation, Dartmouht-Hitchcock Medical Center. It has been featured in the New York Times, Boston Herald, and Boston Globe.

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** It was selected as one of 15 promising practices by the National Council on the Aging. These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health.

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:** A curriculum has been developed entitled Passing It On, A Handbook for People Who Care About Elders.

3. **Cost of program:**

4. **Use of natural funding:** insurance reimbursement through Medicare and Medicaid; Massachusetts Department of Public Health Bureau of Substance Abuse Services, grant money.

Other considerations:

Only a minority of the enrollees are poor and in need of long-term care.

Contact information:

Georgia Neill, Kit Clark Senior Services
1500 Dorchester Ave.
Dorchester, MA 02122
(607_825-5000
gneill@fdnh.org

Relevant websites:

Over 60 Health Center

Description:

This program describes itself as offering, "one-stop shopping" for a range of health-related services including health promotion, disease prevention, screening, diagnosis, and treatment for health, mental health, and substance abuse problems. It's consumer-directed approach to mental health services is characterized by "age-specific treatment; treatment for depression that addresses loneliness and loss; inclusion of family and caregiver involvement when appropriate; treatment provided in a manner and at a pace that is comfortable for older adults; emphasis on staff training and conducting education in working with older adults; and a strong emphasis on working with other community-based services for elders." (Promoting Healthy Aging, pp. 54-55)

Consumers are referred by community organizations and private physicians. Also, a number of health education programs that Over 60 offers in Senior Centers may draw Senior Center participants to the clinic. Primary care physicians at the center are all trained to recognize mental health problems. Informal screenings for mental health problems are a routine part of patient visits Primary care and mental health services are provided on site. Consumers can self-refer for mental health services and primary care physicians make referrals when their mental health screening indicates mental health issues. A social work intake process occurs with each referral. The primary care physicians and the mental health clinical staff share the responsibility for treatment planning. Mental health services include assessments, individual and group counseling, medication management, and Alzheimer's disease diagnoses.

1. **Primary purpose:** to combine primary care and mental health services so consumers do not have to travel to receive treatment.

2. **Target populations:** low income older adults

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: quality of life, health and functional status, knowledge, attitude, and behavior,

2. **Qualitative evaluation**: has received special recognition from the American Society on Aging

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:** Over 60 have received special recognition from the America Society on Aging, Sisters of St. Joseph of Orange and others. It was selected as one of 15 promising practices by the National Council on the Aging. These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health. It was selected as one of 15 promising practices by the National Council on the Aging.

These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health.

Practice implementation:

1. **Staffing requirements:** physicians, nurse practitioners, physician assistants, psychiatrist, social workers, geriatric ally-trained clinical psychologists, substance abuse counselors

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:** Medicare and Medicaid for social work services.

Other considerations:

Contact information:

Marty Lynch, Ph.D.
Lifelong Medical Care
P.O. Box 11247
Berkeley, CA 94712-2247
(510)704-6010
martyl@lifelongmedical.org

Relevant websites:

www.lifelongmedical.org

Community Contacts for the Widowed

Description:

Widows were paired with a widow contact that provided emotional support and practical assistance. The program employs peers who receive training in helping their clients by establishing a one-to-one supportive relationship. These peers, called widow contacts, also arrange group sessions and conduct community education on behalf of the program.

1. **Primary purpose:** To help widows in early stages of bereavement ; to relieve stress.

2. **Target populations:** widows

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Goldberg General Health Questionnaire .

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:**

Vachon, M.L., Lyall, W.A., Rogers, J., Freedman-Letofsky, K., & Freeman, S.J. (1980). A controlled study of self-help intervention for widows. American Journal of Psychiatry, 137, 1380-1384.

Rogers, J, Vachon, M.L., Sheldon, A., Freeman, S.J. (1980). A self-help program for widows as an independent community service. Hospital and Community Psychiatry, 31(12), 844-847.

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Relevant websites:

Senior Companion Program

A Best Practice

Description:

The Senior Companion Program is a federally funded program through Senior Corp. Senior Corp provides grants to qualified agencies and organizations for the purposes of expanding supportive services to improve the lives of older adults and their families and to enrich the lives of volunteers. There are Senior Companion Programs in every state in the nation, including Washington (Hoquiam, Pasco, Seattle, and Tacoma). In 2001, over 15,500 Senior Companions serve over 61,000 clients annually. Of those they serve, 7,150 have Alzheimer's

disease and almost 5,000 who have emotional problems (www.seniorcorps.org/research/overview).

The Senior Companion Program enlists older volunteers-peers to provide in-home supportive services and assistance with tasks of daily living to home-bound elders. Senior Companions do simple household chores, provide transportation to medical appointments, provide respite care to caregivers, and provide social support and friendship. It is expected that Senior Companions serve at least 9 months, an average of 20 hours /week. They typically serve 2-4 clients on a weekly basis. Senior Companions serve clients in a variety of settings including, an individual's home, nursing facilities, hospices, and other long-term care facilities.

1. **Primary purpose:** To enable low-income persons 60 years of age and older to remain mentally and physically active and to enhance their self-esteem through continued community participation and independent living.

2. **Target populations:** Individuals, 60 years of age and older, who may have emotional, mental health and/or physical limitations and are primarily home bound, in frail health and living alone.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: In the most recent evaluation identified, (RTI, 2003), self-reported open and closed-ended questions were developed for use in the evaluations by RTI (2003). The life domains assessed include: life satisfaction, depressive symptoms, caregiver burden, unmet need for services, health status, functional status, social functioning, and satisfaction with services.

2. **Qualitative evaluation**: Qualitative data was also collected to determine the best and worst things about the Senior Companion Program from the client's perspective and the most difficult aspects of caring for an older person, from the family member's perspective (RTI, 2001).

Evidence supporting practice:

1. **Peer reviewed research:** There are numerous peer-reviewed research articles on the Senior Companion Program (not included here). Two recent evaluations of the Senior Companion Program (RTI, 2003, 2001) were conducted to assess quality of life and quality of care outcomes for clients and families/caregivers served through the population of Senior Companion Program. Major findings include, 1) the Senior Companion program has had a positive impact on the agencies, clients and family members/caregivers served by the program, 2) Senior Companions played an important role in expanding the array of independent living services to home-bound elders, 3) Participants reported more favorable self-reported health, higher self satisfaction, fewer depressive symptoms, higher overall functioning, and fewer unmet needs at a 3 month-follow-up. Also, family members of the recipient of a Senior Companion, reported improved coping with caregiver responsibilities, fewer unmet needs with transportation, higher levels of client activity of daily functioning and satisfied with the Senior Companion. For a more comprehensive review of the findings, please see RTI, 2003.

Lee and Gray (1992) recommend that communities should adapt the program to meet their own geographic and demographic needs. They found that Senior Companion Programs in rural area are more difficult to implement due to fewer available volunteers, fewer family caregiver services and greater unmet need.

Lee, CF & Gray, LC (1992). Respite service to family caregivers by the senior companion program: An urban-rural comparison. *Journal of Applied Gerontology, 11,* 395-406.

2. **Other supporting documents:**

Research Triangle Park (RTI). (2003). Final report of the Senior Companion quality of care evaluation. Prepared for the Corporation for National and Community Service (Contract #97-743-1008).

Research Triangle Park (RTI). (2001). The role and value of Senior Companions in their communities. Prepared for the Corporation for National and Community Service (Contract #97-743-1008).

Alzheimer's Association (1991). Senior Companions, An Action Program: Alzheimer's Care Demonstration Evaluation Report. Chicago, IL: Alzheimer's Disease and Related Disorders Association, Inc.

Practice implementation:

1. **Staffing requirements:** A public agency or private non-profit organization can be responsible for program operation. Program staffing will vary as a function of the size, scope and quality of the program. Senior Companion Programs are typically coordinated by a full-time or part-time program director and/or volunteer coordinator. To be eligible to become a Senior Companion, an individual must be 60 years of age and over with a limited income (150% of poverty). All applicants must undergo a background check and partake in a telephone interview.

2. **Training requirements:** Senior Companions must complete the 40 hours of orientation, of which 20 hours must be pre-service. Four hours of monthly in-service training is also recommended. Training issues covered include, normal aging, Alzheimer's disease, diabetes, and other mental health issues.

3. **Cost of program:** Senior Companions receive a small federal stipend for their participation ($2.65/hour-tax free), and are reimbursed for their transportation, annual physical examination, meals, and accident and liability insurance throughout their service.

4. **Use of natural funding:** Unknown.

Other considerations:

Senior Corps also administers the Foster Grandparent Program and RSVP (Retired Senior Volunteer Programs) programs. Information about program locations and program descriptions can be found on the website below.

Contact information:

Senior Corps Programs (Senior Companions)
1-800-424-8867

Relevant websites:

www.seniorcorps.org

In the Company of their Peers
A Geriatric Peer Counseling Training Manual

Description:

The Skagit Mental Health Geriatric Peer Counseling program was developed by Betty Rogers, Jere LaFollette and Wendy Rowe in 1986. The program has expanded to Whatcom, Island and San Juan Counties. The program uses trained and professionally supported seniors who work on a one-one outreach basis with older adults with mental illness, typically in their own homes (Rogers et al., 1993). Peer counselors complete training and are then matrched with an older adult with mental health needs. A geriatric mental health specialist/case manager or supervisor provides support to the peer counselors through montly meetings.

The program includes, 1) community education to increase awareness of Senior Peer Counseling, 2) recruitment of peer counselors, 3) application process for peer counselors, 4) volunteer screening and the screening interview, and 5) peer counseling training and supervision.

1. **Primary purpose:** To match peer counselors with older adults with mental illness who can benefit from increased contact with a friendly visitor.

2. **Target populations:** Eligible peer volunteers are 55 years of age and older, and interested in working with older adults that have some mental health concerns. The program targets older adults with mental illness who are isolated in the community for peer counseling.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Unknown.

2. **Qualitative evaluation:** A descriptive evaluation was completed in 1990. Findings are included in the training manual (See below). The program was evaluated in 1990 for the previous two years (Rogers, et al., 1993). Some of the findings indicate that older adults who received the peer counseling experienced many different problems or conditions. The most commonly reported were, frequent visits to their doctors (71%), depression (69%), some type of chronic illness (64%), some degree of mental illness (61%), poor eating habits (58%) and conflict with children (36%). The typical contact between the peer counselor and recipient involved companionship, counseling, shared interests, transportation, crisis control and health monitoring to address these and other concerns. Eighty-two percent of peer counselors reported that the program had definitely benefited them personally, including feelings of usefulness, learning new and worthwhile things, and making new friends. The evaluation did not cover benefits to the recipients of the peer counseling.

3. **Monitoring:** Skagit Community Mental Health Services monitors the program through annual audits.

Evidence supporting practice:

1. **Peer reviewed research:** Unknown.

2. **Other supporting documents:**
   Rogers, BP, LaFollette, JG & Rowe, W. (1993). In the company of their peers: A geriatric peer counseling training manual. Mt. Vernon, WA: Nookachamps Publications, Inc.

Practice implementation:

1. **Staffing requirements:** Program staffing will vary as a function of the size, scope and quality of the program. Program should have a full or part-time program coordinator and support staff available to assist with program administration. A large program might also have a volunteer coordinator to assist with recruitment and training of the volunteers.

2. **Training requirements:** Peer counselors complete a training application and partake in a in-person interview. Peer volunteers complete a 50 hour, 8 week training session that is held one day/week from 9am-4pm. Training focuses on the aging process, development of listening skills, and mental health issues. Peers also meet monthly with geriatric mental health specialists for supervision and support.

3. **Cost of Program:** Unknown.

4. **Use of natural funding:** Funding comes primarily from Skagit Mental Health. Grants from the Meyer Memorial Trust.

Other considerations:

Contact information:

Betty Rogers
Skagit Community Mental Health Services
208 W. Kincaid St.
Mount Vernon, WA 98273
360-336-3193

Relevant websites:

The Multi-faceted Primary Care Intervention

Description:

This model uses the attached mental health professional approach to mental health services within primary care. It targets both younger and older adults. Those diagnosed by the primary physician as having major depression and who agreed to antidepressant therapy were given educational materials about symptoms and treatment of depression. A psychologist then provided a highly structured program in the primary setting in 4 to 6 sessions. The sessions were used to teach cognitive-behavioral skills for managing depression and to counsel on medication adherence. A psychiatrist monitored the patient's course of treatment and made appropriate adjustments to the course of treatment.

1. **Primary purpose:** to address lack of access to screening, treatment for depression and non-adherence to antidepressant medication; screen for and treat symptoms of depression,.

2. **Target populations:** adults with minor and major current depression

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: adherence to antidepressant medication, satisfaction with care of depression, depression symptom severity

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:**

Katon, W., Robinson, P., Von Korff, M., Lin, E., Bush, T., Ludman, E., Simon, G., Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry, 53(10),* 924-932.

Katon, W., Rutter, C., Ludman, E., Von Korff, M., Lin, E., Simon, G., Bush, T., Walker, E. Unützer, J. (2001). A randomized trial of relapse prevention of depression in primary care. *Arch Gen Psychiatry.* 2001;58:241-247.

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Department of Psychiatry, University of Washington
wkaton@u.washington.edu

Relevant websites:

http://www.shared-care.ca/katonplenary.shtml

Improving Mood: Promoting Access to Collaborative Treatment (IMPACT)

Description:

This model uses the attached mental health professional approach to mental health services within primary care. Primary care patients have up to 12 months of access to a depression care manager who is supervised by a psychiatrist and primary care liaison. The care manager provides medication support and/or counseling, depression management in collaboration with the primary physician. Interventions include education, care management, support of antidepressant management by the primary care physician or brief psychotherapy for depression.

1. **Primary purpose:** to address the issue of underdiagnosis and undertreatment of mental health problems in primary care settings and in the community

2. **Target populations:** older adults with depression, dysthymic disorder, or both

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: severity of depression symptoms, depression treatments, satisfaction with care, functional impairment, quality of life.

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:**
   Unutzer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, Hoffing M, Della Penna RD, Noel PH, Lin EH, Arean PA, Hegel MT, Tang L, Belin TR, Oishi S, Langston C. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA, 288(22),* 2836-2835.

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Center for Health Services Research,
UCLA Neuropsychiatric Institute,
10920 Wilshire Blvd, Suite 300,
Los Angeles, CA 90024
unutzer@ucla.edu

Relevant websites:

http:/www.hsrcenter.ucla.edu/research/impact.shtml

Prevention of Suicide in Primary Care Elderly – Collaborative Trial (PROSPECT).

Description:

This program uses the consultation liaison approach. Health Specialists and primary care physicians collaborate in identifying depression in older adults, develop targeted and timely treatment recommendations, and encourage compliance with treatment. The intervention also includes education of patients, families, on depression and suicidal ideation. Health Specialists use a formal algorithm when selecting and prescribing anti-depressant medications to older adult patients. Psychotherapy is also used in conjunction with medication in some cases (Bruce & Pearson, 1999). This study is part of a multi-institutional effort funded by NIMH to facilitate the recognition, evaluation, and treatment of elderly patients with depression by introduction of a collaborative depression care manager into practices.

1. **Primary purpose:** to address the issue of underdiagnosis and undertreatment of mental health problems in primary care settings and in the community.

2. **Target populations:** adults with minor and major current depression

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: adherence to antidepressant medication, satisfaction with care of depression, depression symptom severity, prevention of suicide in these at-risk populations.

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:** Reynolds, C.F. (2003). Meeting the Mental Health Needs of Older Adults in Primary Care: How Do We Get the Job Done? *Clinical Psychology: Science and Practice,* 10(1).

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:
ReynoldsCF@msx.upmc.edu.

Relevant websites:
http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm;
http://www.nih.gov/news/WordonHealth/jun2000/story01.htm
http://www.hhs.gov/asl/testify/t030728.html

Integrated Model: Primary Care Research in Substance Abuse and Mental Health for Elders (PRISME)

Description:
The focus of the project is examination of two mental health/substance abuse models providing treatment for older adults with behavioral health problems. In one model the patient will be treated in the primary care setting using a staff integrated approach. In the other model, identified as "the referral model," the patient will be referred to a specialty psychiatric setting. Rigorous scientific methods, including patient level randomization, will be applied to assess the effectiveness of these two models, the differences in financing of services, and the differences in utilization of MH/SA services by older consumers. There are 11 study sites, in which outcomes for older adults randomly assigned to the integrated model are compared to outcomes for those assigned to the referral model. It uses a consumer-oriented approach and emphasizes culturally competent practice interventions.

1. **Primary purpose:** to address the issue of under-diagnosis and under-treatment of mental health problems in primary care settings and in the community

2. **Target populations:** older adults with a range of mental health and substance abuse problems are participating in the study

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: engagement, participation in care, clinic outcomes, prevention, satisfaction, stigma, cultural sensitivity, provider attitudes, and cost outcomes

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:** Other supporting documents (e.g., reports, brochures, tool kit, training manual).

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Coordinating Center: sue_levkoff@hms.harvard.edu

Relevant websites:

http://www.hms.harvard.edu/aging/mhsa/sites.htm
http://www.mhaging.org/info/prisme_nami.html

Geriatric Mental Health Outreach Program

Description:

This program uses the community mental health team approach. Based in a regional psychiatric hospital in Canada, this program works with informal and formal community caregivers, physicians, community agency staff, and long-term care facilities. The program

has an interprofessional consultation home visit team that conducts home and community-based assessments and completes care plans. What may distinguish this outreach programs from some others is that the team provides client-centered case consultations with health care providers who take the referrals. The Specialized Information and Resource Service gives telephone-based consultation to community care professionals as well as making referrals. The Educational Service provides resources for staff skill development of community based service providers. In addition, the program is actively involved in mental and health care system planning and coordination for older adults. It involves and develops community caregivers and local resources (Stolee et. al., 1996).

1. **Primary purpose:** to address the issue of underdiagnosis and undertreatment of mental health problems in primary care settings and in the community

2. **Target populations:** community-dwelling or institutionalized older persons with late-onset psychiatric disorders with age-related changes, and their caregivers; includes those with cognitive impairment, behavioral disturbance, physical/medical problems and depression

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: program monitoring, including a patient database and description of program activities; level of care.

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:** Stolee, P., Kessler, L., Le Clair, J.K. (1996). A community development and outreach program in geriatric mental health: four years' experience. *Journal of the American Geriatric Society, 44(3)*, 314-320.

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Renfrew County Geriatric Mental Health Outreach Program
600 Cecelia St.

Pembroke, ON K8A 7Z3
(613) 735-6500 or 1-877-260-0535
Fax: (613) 735-4638
Email: gmh@marianhill.ca

Relevant websites:
http://www.marianhill.ca/programs/mental-health.htm

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Description:

PEARLS is a community-based treatment program that includes teaching problem solving techniques to relieve symptoms of depression, planning pleasant events, and increasing physical and social activities. Care managers conduct 8 one-hour sessions over 5 months. NWPEC collaborates with community based agencies that provide social support to the elderly. The client's care is coordinated between the social worker, UW researcher, and the client's physician. Participants are recruited through agency-referral and self-referral. The project was evaluated by the Health Promotion Research Center at the University of Washington in a randomized controlled study that compared outcomes for seniors receiving PEARLS versus usual care. Clients in the usual care group received regular treatment for minor depression such as medication, a referral for conventional counseling, or in many case no intervention at all.

1. **Primary purpose:** to reduce minor depression in older adults and to improve overall health and quality of life

2. **Target populations:** physically impaired, socially isolated seniors with minor depression and dysthymic disorder.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:** Schwartz et. al. (2002) Case-Finding Strategies in a Community-Based Depression Treatment Program for Older Adults. *16th National Conference on Chronic Disease Prevention and Control.*

2. **Other supporting documents:** Peer reviewed journal article about to be submitted for publication: "The primary findings are that the intervention was successful at both the 6- and 12-month follow-up" (personal communication Sheryl Schwartz, 2003).

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Sheryl Schwartz, Research Coordinator (206)685-7258
Dick Sugiyama, Director, Case Management Program (206)684-0659

Relevant websites:

http://www.cityofseattle.net/humanservices/ads/Staff-Peers/Pearls.htm

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Preadmission Screening and Resident Review (PASRR)

Description:

The mental health, public health, and aging network systems collaborate on the implementation of PASRR. States differ in who administers the program and how it is implemented. Some States have systems in place to use PASRR Level II screening results to develop treatment plans for mental health. Ultimately, it is the State Medicaid agency that is responsible for the PASRR program.

1. **Primary purpose:** Iimprove the overall quality of mental health services to nursing home residents.

2. **Target populations:** Individuals who are admitted to a nursing home that are suspected of having a mental illness are targeted for the preadmission, Level II screening.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation:**

Evidence supporting practice:

1. **Peer reviewed research:** Snowden, M & Roy-Byrne, P (1998). Mental illness and nursing home reform: OBRA-87 ten years later. Psychiatric Services, 4, 229-233.

2. **Other supporting documents:** Bazelon Center for Mental Health Law (1996). The impact of PASARR: Report on a survey of state's implementation of the preadmission screening and annual resident review program to prevent inappropriate admission and retention of people with mental disabilities in nursing homes. Washington, DC: Judge David L. Bazelon Center for Mental Health Law.

   US Department of Health and Human Services (2002). Screening for mental illness in nursing facility appliations: Understanding federal requirements. (DHHS Publication No.(SMA) 01-3543). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Practice implementation:

Staffing requirements: Independent evaluators that have no relationship with the nursing facilities or the mental health authority conduct the Level II screening.

Training requirements: Professionals with expertise in mental health and aging. Knowledge of the policy and procedures of the PASARR process.
Cost of Program: Cost to the States vary.

Use of natural funding: None.

Other considerations:

For an excellent discussion of the requirments and regulations of PASARR please refer to, Screening for mental illness in nursing facility appliations: Understanding federal requirements (DHHS, 2002). It's an easy to read source and answers the most frequently asked questions about PASARR.

Contact information:

State PASARR Coordinator
Hank Balderrama
Mental Health Division
(360) 902-0820

Relevant websites:

The Eden Alternative™

Description:

The Eden Alternative has gained a lot of attention over the past five years. The Eden Alternative (www.edenalt.com) embraces the philosophy that "we must teach ourselves to see the environments as habitats for human beings rather than facilities for the frail and elderly. We must learn that mother nature has to teach us about the creation of vibrant, vigorous habitats". Coalitions of individuals, organizations and agencies work together to improve nursing home environments. Ten principles guide The Eden Alternative model:

1) The tree plagues of lonliness, helplessness and boredom account for the bulk of suffering among our Elders.
2) An Elder-centered community committs to creating a Human Habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.
3) Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
4) An elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.
5) An elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictible interactions and happenings can take place. This is antidote to boredom.
6) Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
7) Medical treatment should be the servant of genuine human caring, never its master.
8) An elder-centered community honors its elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the elders or into the hands of those closest to them.
9) Creating an elder-centered community is a never-ending process. Human growth must never be separated from human life.
10) Wise leadership is the lifeblood of any struggle against the three plauges. For it, there can be no substitute.

1. **Primary purpose:** To improve the well-being of elders and those who care for them by transforming the communities in which they live and work.

2. **Target populations:** Residents of nursing homes.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:** Unknown.

2. **Qualitative evaluation:** A ten state study of nursing homes that adopted the Eden Alternative (Teitelbaum, 1995), indicate that the program improved the quality of nursing home resident's lives in terms of dignity, independence, freedom of choice, self-image, and a sense of purpose. However, in a recent study, Coleman et al., (2002) found that the Eden site had significantly greater proportions of residents that had fallen in the last 30 days, were experiencing nutritional problems, required skilled nursing and hypnotic prescriptions than the control site. The Eden site also had more new staff hired and more terminations that the control site. The researchers conclude that positive outcomes may take more than a year to observe.

Evidence supporting practice:

1. **Peer reviewed research:**

Coleman, MT, Looney, S, O'Brien, J, Ziegler, C, Pastorino, CA & Turner, C (2002). The Eden Alternative: Findings after 1 year of implementation. The Journals of Gerontology, Biological Sciences and Medical Sciences, 57, M422-M427.

Hamilton, N & Tesh, AS (2002). The North Carolina Eden Coalition: Facilitating environmental transformation. Journal of Gerontological Nursing, 28, 35-40.

2. **Other supporting documents:**

Thomas, W (1994). The Eden alternative: Nature, hope and nursing homes. Sherburne, NY: Thomas.

Teitelbaum, M (1995). Evaluation of long term care survey. Unpublished report under review by the Health Care Financing Administration. Cambridge, MA: Abt Associates.

Practice implementation:

1. **Staffing requirements:** Regional coordinators can provide information and training to interested nursing homes. The goal is to train the entire staff of a facility in the Eden Alternative.

2. **Training requirements:** The 3-4 day "Associate Training" as been developed over the years as a standard training program. It teaches the Ten Principles of the Eden Alternative and gives specific guidelines and suggestions for implementing them in practice. It also helps participants learn about one another to create communities of support.

3. **Cost of Program:** Unknown.

4. **Use of natural funding:** Unknown.

Other considerations:

Contact information:

Vivian Currie, Coordinator
Region XIII
vcurrie@providence.org

Relevant websites:

www.edenalt.com

Gentlecare™ Prosthetic Life Care System

Description:

Moyra Jones is the creator of GENTLECARE. It is a paradigm of care that suggests an alternative system of care that maximizes client function for longer periods, compensates for the dysfunction caused by the disease, and protects the health of family and professional care providers" (Jones, 1999). The model is based on the belief that "appropriate care can be given only when there has been an accurate definition of the deficit a person is experiencing. Only then can the macro-environment be organized into a prosthesis of care designed to compensate for the person's deficts, to support existing or residual funcation and to maximize quality of life" (Jones, 1999, p. 18). It shifts the focus of care to the physical and social environment and away from the behaviors of the individual with dementia. It involves a thorough understanding of Alzheimer's disease and other dementia's, assessment in dementia care, a new approach to programs, nutrition in dementia care, design for living and people and their impact on care.

GENTLECARE uses a system called POWERPOINT PROGRAMS to develop an individualized and tailored daily prosthesis of care for individuals with dementia. They programs focus on: 1) Core activities (ADL's), 2) necessary activities (activities necessary for human health, sleep, relaxation, and privacy), 3) essential activities (those essential for human interaction and communication), and 4) meaningful activities.

GENTLECARE also focuses on changing the physical environment to meet the needs of persons with dementia. Design principles include: safety and security, access and mobility, function and activity, individual control, privacy, comfort and sociality, and flexibility, choices, change, participation, and decision making.

People as prosthesis is the third major element of GENTLECARE. The focus is on the people who are involved in the care of the individual, including family and friends, and the

individual themselves. It includes an understanding of the disease, the family caregiving process, and life stressors associated with caregiving.

1. **Primary purpose:** Utilize the macro-environment to achieve effective dementia care.

2. **Target populations:** Persons with dementia.

Evaluating this practice:

The program has not been formally evaluated, however, the model or model components have been replicated throughout Washington State, the US and abroad.

1. **Outcome measures used to evaluate practice:** The model monitors the following outcomes: level of functioning, participation levels in self-care activities, socialization and communication, non-cognitive and assaultive behaviors, wandering, arguments and altercations, catastrophic behavior, incontinence, family statisfaction and participation in care, volunteer and community involvement, costs of program.

2. **Qualitative evaluation:** Organizations that have adopted the model report, increased client function, reduced catastrophic incidents, decreased staff and family stress, reduced use of psychotropic medications, cost containment, increased community commitment and involvement.

Evidence supporting practice:

1. **Peer reviewed research:** Unknown.

2. **Other supporting documents:**
   Jones, M (1999). GENTLECARE: Changing the experience of Alzheimer's disease in a positive way. Point Roberts, WA: Hartley & Marks Publishers, Inc.

Practice implementation:

1. **Staffing requirements:** It is recommended that the entire staff of a facility completes the GENTLECARE training. The train-the-trainer model is also used.

2. **Training requirements:** The full training consists of 2 days/week for five weeks. Shorter training sessions or workshops are available as well. A standard curriculum has been developed using Jones' (1999) book as a guide.

3. **Cost of Program:** Unknown.

4. **Use of natural funding:** Unknown

Other considerations:

Contact information:

Moyra Jones Resources, Ltd.
8264 Burnlake Drive
Burnaby, British Columbia V5A 3K9
Canada
604-421-1680
e-mail: jonesb@direct.ca

Relevant websites:

www.Gentlecare.com

Dementia Care Project in Boarding Homes

Description:

The State of Washington Department of Social and Health Services contracts with licensed boarding homes who implement specialized dementia care services through a standard set of expectations tied to an enhanced daily rate. This comprehensive program addresses the multiple and complex needs of Medicaid clients with dementia and their caregivers. The care model is both holistic in nature and based upon meeting specific individualized needs. "The resident-centered approach is intended to promote optimum health and quality of life within an environment that accommodates cognitive deficits, maximizes functional abilities, and promotes aging in pace. Standards of care are applied uniformly across sites. They address 1) specialized dementia care assessment and service planning; 2) dementia care activities; 3) staff and staff training; 4) environment; and 5) family involvement.

1. **Primary purpose:** to deliver specialized dementia care services that promote and enhance quality of care.

2. **Target populations:** Medicaid clients with dementia.

Evaluating this practice:

1. **Outcome measures used to evaluate practice:**

2. **Qualitative evaluation**:

Evidence supporting practice:

1. **Peer reviewed research:**

2. **Other supporting documents:**

Practice implementation:

1. **Staffing requirements:**

2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

Other considerations:

Contact information:

Relevant websites:

http://www.aasa.dshs.wa.gov/professional/documents/DementiaStandards.doc