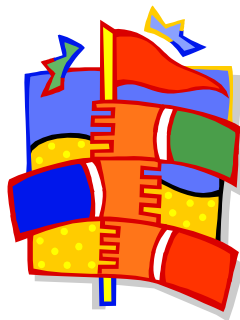


Adult Ethnic Minority



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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 included 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 dysthymia (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 sequelae (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).

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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.

Resource Guide

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 aged 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 percent 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:

Contact information:

Joe Laping, MA, Program Director
Asian American Recovery Services
134 Hillside Boulevard
Daly City, CA 94014
(650) 301-3240
email: jlaping@aars-inc.org

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:

Contact information:

Martha Long, Director
The Village Integrated Service Agency
456 Elm Avenue
Long Beach, CA 90802
(562) 437-6717
village1@pacbell.net

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 Assess 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 care 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 out 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:

Contact information:

1-866-240-3250
stepbd@mailcity.com
Gary Sachs, STEP-BD Principal Investigator
sachsg@aol.com

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:

Contact information:

Ricardo Munoz, PhD
Cognitive-Behavioral Depression Clinic
San Francisco General Hospital
University of California, San Francisco

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