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Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services

MERCER
Government Human Services Consulting
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**Message from Joan Erney**

When the Office of Mental Health and Substance Abuse (OMHSAS) issued the “Call for Change” in November 2005 we challenged all stakeholders to make a commitment to many actions, large and small, that individuals and vested groups could take to begin the process of transforming services in Pennsylvania to be more recovery-oriented. As a result, clear evidence is emerging that progress is being made; there is more training about recovery, increased involvement of individuals experiencing behavioral health issues; greater role and impact of consumer family satisfaction teams and greater emphasis on performance and quality. Communities are coming together with a new energy to transform their local systems.

At the state level, we used the framework of this challenge to consider the actions we could take at the state level that would begin to tackle some of the eleven areas identified in the “Call for Change” that are barriers and challenges to achieving transformation. OMHSAS charged Mercer Government Human Services Consulting (Mercer) to research national best practices and other states strategies that enhance recovery and resiliency (R/R) also considering strategies for specific populations. The preliminary document was presented to the OMHSAS Executive Council and the chairs of the OMHSAS Advisory Committees to begin a dialogue about prioritizing our next set of goals and objectives for the coming years. Mercer used feedback from the Executive Council and Advisory chairs to conduct additional interviews and research to finalize the report.

OMHSAS is pleased to offer, “Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices” for your review and to inform our future discussions together. Chapters 3 and 4 provide a broad national perspective of R/R and evidence based practices for all populations. Chapters 5-7 focus on strategies for specific populations. These ideas begin to help us envision what a service system that fully supports R/R could look like and should look like. I invite you to use this wealth of information to identify and tell us, about the strategies you think are powerful and important as we plan for the next steps we should take in Pennsylvania’s journey of transformation.

Joan D. Erney
Contents

1. Introduction ..................................................................................................................4
   ▪ Background ..............................................................................................................4
   ▪ Purpose of the Paper ...............................................................................................6

2. Methods and Data Sources .....................................................................................9
   ▪ Literature Review .................................................................................................9
   ▪ Interviews .............................................................................................................12

3. Facilitating Recovery and Fostering Resilience in Managed Care .................14
   ▪ Findings from the Literature Review on Intake, Care Management/Utilization Management ...........................................................................................................15
   ▪ Findings from the Expert Interviews on Intake, Care Management, and Utilization Management ...........................................................................................................16
   ▪ Strategies for Intake, Assessment, Care Management, and Utilization Management from other States .................................................................18
   ▪ Findings from the Literature on Provider Network Management ..................18
   ▪ Findings from the Expert Interviews on Provider Networks .........................22
   ▪ Strategies on Network Management from other States ..................................23
   ▪ Findings from the Literature on QM /Performance Measurement ..............24
   ▪ Strategies from other States on Quality Management .....................................25
   ▪ Findings from the Expert Interviews on Quality Management ..................26
   ▪ Strategies for Implementation of R/R through BH-MCOs .............................26
   ▪ Funding Strategies .................................................................................................31
   ▪ Attitudinal/Messaging Strategies .........................................................................31
   ▪ References: Facilitating Recovery and Fostering Resilience in Managed Care ...32

4. Implementation Strategies for Evidence-Based Practices ..............................34
   ▪ Findings from the Literature Review ..................................................................34
   ▪ Findings from the Expert Interviews on Implementing EBPs ............................40
   ▪ Other States’ Strategies .......................................................................................41
   ▪ Funding ..................................................................................................................43
   ▪ Attitudes/Messaging ..............................................................................................43
   ▪ References: Implementation Strategies for Evidence-Based Practices ..........44

5. Reducing Reliance on State Psychiatric Hospitals and Improving Community Integration .................................................................................................................45
   ▪ Findings from the Literature and Expert Interviews on Reducing Reliance on State Hospitals/Increasing Community Integration ........................46
- Service Array to Reduce Reliance on State Hospitalization and Improve Community Integration ................................................................. 47
- Family Psychoeducation ................................................................................................................. 59
- Pennsylvania’s Experience and Results from Interviews with Other States ................ 63
- Strategies Employed During the Closure of Pennsylvania State Hospitals .................. 65
- Strategies that Avoid Unnecessary Hospitalization ................................................................. 66
- Strategies to Enhance “Discharge Readiness” ................................................................. 68
- Strategies to Address the Needs of Older Adults ................................................................. 70
- Strategies to Prevent Criminalization of People with Mental Illness ............................. 71
- Strategies to Increase Community Integration of Transition Age Youth and Adults with Autism Spectrum Disorders ................................................................. 74
- Key Overall Strategies to Reduce Reliance on State Hospitals and Increase Community Integration ................................................................................. 75
- References: Reducing Reliance on State Hospitals and Increasing Community Integration ................................................................................................................. 79

6. Family-Based Services Findings ................................................................................................. 84
- Family Based Evidence Based Practice Models ................................................................. 84
- Cost-Effectiveness of Wraparound Planning ........................................................................ 89
- Optimal Family Based Service Array ................................................................................. 99
- Summary of Interviews ........................................................................................................ 100
- Strategies .............................................................................................................................. 112
- Funding Options ................................................................................................................. 115
- Quality Management ......................................................................................................... 116
- Administrative Requirements ........................................................................................... 116
- Bringing It All Together ..................................................................................................... 118
- References: FBMHS ........................................................................................................ 118

7. Early Childhood Mental Health Consultation ........................................................................ 123
- Key Early Childhood Mental Health Concepts ................................................................. 124
- Research Findings ............................................................................................................. 127
- State Examples of Mental Health Consultation ............................................................... 134
- References: Early Childhood Mental Health Consultation ............................................. 145

8. Summary of Considerations .................................................................................................... 148

Appendix A
- Experts Interviewed by Mercer ......................................................................................... 162

Appendix B
- Interview Guides .................................................................................................................. 168
Introduction

Background

A Call for Change: Toward a Recovery-Oriented Mental Health System for Adults, issued by The Pennsylvania Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS) in November 2005, is the result of over a decade of work to transform Pennsylvania’s mental health system. Yet, as the report suggests, it is “only the beginning” of transforming Pennsylvania’s mental health system (p. 69). The “Call for Change” outlines a vision of a system that enhances each individual’s growth and recovery.

“Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.” (A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults, 2005)

While both adults and children benefit from approaches that foster recovery, transformation of the child-delivery system focuses on building resilience.

“Resilience means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stressors, and to live productive lives.” (New Freedom Commission Report, 2003)

Achieving the vision of recovery and resilience (“R/R”) requires diligence and resolution of systemic challenges and barriers. The “Call for Change” outlined eleven areas that OMHSAS and its stakeholders need to address to overcome current barriers and challenges (p. 54-68):
1. **Power:** Rebalance power so that the expertise and contributions of both the consumer and the provider are mutually respected and have bearing on decisions about treatment.

2. **Relationships:** As the balance of power between consumers and professionals is leveled, role changes occur. Traditional professional/client roles and rules no longer always apply. Professional guilds have begun to work on updating codes of ethics and practice guidelines to address these changes. Yet, for consumers and professionals, this remains largely uncharted territory.

3. **Coordination and Community:** Reduce fragmentation and conflicting care experienced by consumers, their family members, and providers by offering integrated treatment strategies, particularly in the areas of co-occurring disorders and lifespan screening. Schools, primary health care, child welfare, and criminal/juvenile justice are important areas for coordination. Second, emphasize that the role of mental health services is to help individuals meet their personal needs through access to effective mental health treatment and a wide array of community resources.

4. **Peer Support and Consumer-Run Services:** As promising practices, peer services are effective and increase well-being, especially in combination with traditional mental health services. Actions steps to identify standards for peer support services and funding are necessary.

5. **Workforce:** Attitudes that may not engender recovery are enmeshed into standards, policies, and practices. Concepts of recovery are not integrated into academic training and curriculum of most professionals in the mental health field. There is a need to develop recovery-based competencies, especially those that over-arch professional guilds or roles.

6. **Evaluation and Quality Assurance:** To promote R/R principles in evaluation and quality assurance, the fundamental involvement of consumers and family members in the development of instruments and evaluation methods as well as conducting the evaluation is necessary. The potential of the Recovery Oriented System Indicator (ROSI) Measure holds promise.

7. **Medical Necessity and Evidence Based Practices:** Introduction of R/R emphasizes the need to incorporate environmental and often social and spiritual factors into treatment and support. It is also necessary to incorporate R/R concepts into medical necessity guidelines, and to include consumers that actually use services in the design and evaluation of these practices.

8. **Financing:** Explore financing methods such as capitation; managed care financing; separate funding streams for clinical and recovery service bundles; Individual Recovery Accounts for self-directed care; and Personal Assistance Services and Personal Care Services through Medicaid.
9. **Recovery Dialogues between Mental Health and Substance Abuse Services:**
Increase dialogue between mental health and substance abuse systems to further understanding and development of consensus about recovery.

10. **Recovery Education:** Provide education on recovery for consumers, providers, supervisory staff and academicians. Initial and ongoing recovery education should be a part of every academic curriculum for professional training. Provide organizational support for staff to obtain R/R education.

11. **Review of Licensing, Regulations and Policy:** Conduct a review of policies to identify and resolve potential barriers to R/R.

Recognizing that transformation to a system of services that fosters R/R requires a significant philosophical change, OMHSAS charged all stakeholders to look at ways they could impact these eleven areas. OMHSAS requested Mercer Government Human Services Consulting (Mercer) research national best practices and other states’ strategies that enhance R/R to inform the work of the advisory committees and OMHSAS leadership.

**Purpose of the Paper**
OMHSAS charged Mercer with studying the five broad areas:

1. **Facilitating R/R in managed care –** Identifying strategies for adapting managed care tools and practices to incorporate the philosophy of R/R.

2. **Implementing EBPs that enhance recovery and resilience –** Addressing the iterative process of change, promoting readiness to change, incorporating consumer involvement to infuse R/R principles, and offering guidance on how to change.

3. **Reducing reliance on state hospitals and improving community integration for adults, older adults, and people with co-occurring mental illness and substance abuse disorders –** Identifying a minimum service array that enhances R/R and promotes community integration.

4. **Researching evidence-based strategies for Family-Based Mental Health Services (FBMHS) –** Identifying a minimum service array and FBMH strategies that enhances resilience.

5. **Reviewing the emerging practice of Early Childhood Mental Health Consulting –** Researching available outcome literature and interviewing key informants about this service.
The paper identifies national best practices to assist OMHSAS and its stakeholders to validate and expand upon current initiatives to transform the current mental health and drug and alcohol system to one that fosters R/R. The focus of the paper is not to summarize Pennsylvania initiatives, and whenever possible, our aim was to avoid duplication of these efforts. To provide context for our research, Mercer studied the 2006 work products of the Adult, Children, Older Adult, Forensic, and Housing Work Groups, material from Pennsylvania’s Co-Occurring Disorders State Incentive Grant (COSIG) and the DPW Task Force Report on Autism. Findings reported in this paper are geared to facilitate discussion by OMHSAS, consumers and families, and other stakeholders.

**Approach**

Discussion of R/R has to occur in the context of the individualized treatment and support needs of people of all ages and cultures. Thus, this paper also reviews Evidence Based Practices (EBPs) for children/adolescents (Family Based Mental Health Services), adults and older adults, as well as the emerging practice of mental health consultation in child care settings for younger children (ages 0 to 5). The focus of the review was on the intersection of R/R and EBPs, as well as implementation strategies that support both the philosophy of R/R and the evolution of EBPs. The Mercer team searched for EBPs that based their research on diverse populations to identify culturally competent services. In the process, our findings suggest that research on EBPs for children and families tends to be more inclusive of and address more diverse cultures than those for adults.

The review also considered the needs of people that intersect with other systems of care: substance use, criminal and juvenile justice, education, employment, and child welfare. The Mercer team reviewed strategies for reducing reliance on state hospitals, including discharge planning strategies that facilitate R/R and the EBPs associated with increased community integration. The high incidence of co-occurring substance use and mental illness prompted a review of services that assist people with these challenges. Preventing and addressing the criminalization of people with mental illness is discussed. We also focused on special needs for people with Autism Spectrum Disorders by reviewing the DPW Task Force Report to assess synergies with R/R. The Mercer team looked at performance indicators with the goal of identifying uniform indicators that can be used statewide. Finally, our task was to identify a minimum service array that supports the development of an R/R philosophy and the implementation of EBPs.

Mercer conducted a literature review and analyzed materials from other states’ transformation efforts. Consumers, academicians, and researchers, representatives from states and managed care entities, as well as other industry experts were interviewed. The goal of these activities is to identify specific strategies that OMHSAS and HealthChoices can use to infuse R/R principles into managed care and implement a service array that supports R/R and EBPs.
The methodology is described in the Section 2 of this report. Sections 3-7 focus on the findings from the literature review and expert interviews. Section 8 provides a summary table of strategies for review by OMHSAS and its stakeholders.

Mercer would like to extend its appreciation to OMHSAS leadership, the OMHSAS Advisory Committee, and staff for their support of this paper, as well as the opportunity to participate in the Commonwealth’s transformation efforts.
Methods and Data Sources

Literature Review

Mercer conducted an electronic search for studies, articles, and materials between 1995 and May 2006, using the key words for each area of study:

“Resilience,” “recovery,” “evidence-based practices,” “transformation,” “consumer empowerment,” “peer- run and peer-delivered services,” and “recovery and resilience strategies for behavioral health managed care.”

“State hospital discharge planning,” “community tenure,” “psychiatric inpatient hospital alternatives,” and “evidence-based practices.”

“Family based mental health services (FBMHS),” “Multisystemic Therapy,”

“Functional Family Therapy,” “National Wraparound Initiative,” “wraparound,”

“cost,” “cost-effectiveness,” and “evidence-based practices for children/adolescents.”

“Early childhood mental health,” “early childhood mental health consultation,”


“Co-occurring disorders of mental illness and substance use.”

“Youth with mental health needs involved with the juvenile justice system.”

“Adults with mental health needs involved with the criminal justice system.”

“Older adults with mental illness” and “mental health services for elders”

The categories of literature selected for review include:

- DPW/OMHSAS planning documents:
  - A Call for Change: Toward a Recovery-Oriented Mental Health System for Adults
  - Autism Task Force Report
DRAFT Recommendations to Advance Pennsylvania Responses to People with Mental Illness Involved in the Criminal Justice System prepared by the Forensic Advisory Group, OMHSAS

A Plan for Promoting Housing and Recovery-Oriented Services

Housing, OMHSAS

Mental Health and Aging Forums materials, OMHSAS, Adult Advisory Committee

Transforming Children’s Mental Health Services, OMHSAS Children’s Advisory Group materials

Books and publications in peer-reviewed journals that described strategies and barriers to implementing R/R, EBS, and FBMHS and MH Consultation

Consumer organizations/consumer experts/websites

Websites for the purveyors of the dominant, evidence-based child and family programs

Research briefs published by the two federally funded Research and Training Centers for children’s mental health (housed at the University of South Florida and Portland State University), as well as the Georgetown University Center for Child and Human Development website

SAMHSA’s materials on mental health transformation

State and county websites on transformation initiatives and building resilience and fostering recovery

State requests for proposals (RFPs) for managed behavioral health care

Mercer’s resource files on the study topics

We searched numerous websites, including MEDLINE, PSYCHINFO, the Substance Abuse and Mental Health Services Administration (SAMHSA), the National State Mental Health Directors Research (NASMHPD) Institute, the National Center for Mental Health and Juvenile Justice, the GAINS Center (co-occurring disorders and criminal justice involvement), and the archives of Psychiatric Services, Psychiatric Rehabilitation Journal, and Health Affairs. As part of our review, we analyzed the Mental Health Transformation Survey of the States conducted by NASMHPD in July 2005. We reviewed websites of various states’ transformation activities, including the focus and parameters of Federal Transformation State Incentive Grant (TSIG) awards to Texas, New Mexico, Maryland, Connecticut, Ohio, Oklahoma, and Washington. Further, we analyzed recent RFPs for behavioral health managed care programs to assess how different states were approaching R/R, EBP, and FBMHS in their Medicaid managed care initiatives. The national experts also assisted with identifying literature.

Materials were selected based on their relevance to the following areas:

- Practical strategies for public mental health systems and their managed care entities to build resilience and foster recovery, including but not limited to:
  - intake/access, care management and utilization management, including assessment tools and medical records to support R/R;
– provider networks, including array of available services and evidence-based practices (EBPs) that enhance resilience and recovery;
– peer-run services, including strategies to finance and support these initiatives and enlist the traditional providers’ support;
– training on the philosophy and technology of enhancing resilience and recovery;
– integrated systems of care for people with co-occurring disorders;
– methods to identify and finance EBPs that support R/R;
– quality management including outcomes and performance measures for facilitating R/R;
– family-based mental health services (FBMHS) for children and adolescents including Multisystemic Therapy (MST); Functional Family Therapy (FFT); Multidimensional Treatment Foster Care and Wraparound Planning;
– cost-effectiveness of Wraparound Planning in the context of Child and Family Teams;
– early childhood mental health (MH) consultation in child care settings;
– strategies and EBPs that reduce reliance on state hospital and facilitate recovery in the community;
– strategies for developing a minimum service array that should be available throughout the Commonwealth; and,
– performance indicators for statewide managed care implementation that promote R/R.

Barriers that impede the transformation process.

We found a wide array of materials on transformation goals and guidelines, literature on EBPs that support resilience and recovery, and a fairly extensive discussion of barriers. Through review of materials, websites, and interviews, we found that most states are grappling with the overarching issue of how to move their systems to the R/R philosophy and build on the relatively limited availability of EBPs and consumer-run services, as well as the challenge of balancing efforts to develop both.

The Commonwealth’s R/R initiatives already address many of the ideas and strategies that other states employ. The OMHSAS Call for Change paper embodies some of the best materials we reviewed in terms of a conceptual foundation for transformation. Further, action resulting from stakeholder involvement in the “Call for Change” has yielded positive results. Work on Pennsylvania’s 5-year Substance Abuse and Mental Health Services Administration (SAMHSA) Co-Occurring State Incentive Grant (COSIG) resulted in establishing co-occurring disorder competency approval criteria for all licensed facilities and action steps to build core competencies in the treatment of co-occurring disorders. Older adult forums held in Pennsylvania in 2006 focused on the need to address social isolation, depression, and suicide prevention among the elderly and use of peer support. The OMHSAS Children’s Advisory Group prioritized the development of school-based BH services, expanded community-based options for children with high needs in restrictive care settings (such as psychiatric residential treatment facilities), and workforce development needs. The OMHSAS Forensic Work Group report provided useful information on strategies to divert people from criminal justice systems. The
Housing Work Group identified stable housing as an essential component of mental health recovery and underscored the importance of employment, in particular, to help people address their housing needs. Further, the Work Group endorsed supportive housing (permanent affordable housing that is linked to flexible, voluntary supports) as a best practice over more segregated and structured residential programs. For people with Autism Spectrum Disorders, the DPW Task Force Report emphasizes many of the principles of R/R, namely, the importance of peer-led advocacy and individually tailored services provided in integrated community settings.

Literature specific to the role of managed care entities in R/R and FBMHS was limited, but we found strategies that can be extrapolated to BH-MCO operations. The literature did not provide a specific template for an array of R/R services, including consumer-run services or FBMHS. The primary emphasis of the literature was on implementation strategies for EBPs (including FBMHS) and peer specialists, although numerous consumer initiatives are emerging, and FBMHS efforts are well-established in other child/family-serving sectors, particularly juvenile justice. Early childhood MH consultation is an emerging practice, so there is less conclusive research evidence available and little to no literature on its incorporation in managed care settings. There was information available in the literature about state hospital utilization and EBPs that assist with reducing hospital use, including services for people with co-occurring disorders.

Consumer experts provided information on R/R strategies. The expert interviews provided additional information on implementation of R/R in managed care settings, reducing reliance on state hospitals, co-occurring disorders, and FBMHS. Findings from both the literature review and expert interviews suggest that development of EBPs is a complex, iterative process that requires time, resources, and a dedicated focus.

Finally, the literature discusses R/R more as a philosophy than as an EBP, while pointing to research that supports many of the underlying principles of recovery, including hope, choice, control, and self-efficacy. As a result of the developmental status of R/R promotion nationally, the considerations identified in this report emphasize developmental stages, rather than tried and true interventions that OMHSAS and the counties/HealthChoices BH-MCOS can use off the shelf to facilitate R/R and development of EBPs.

**Interviews**

Mercer conducted 39 interviews. We focused on gathering information from other states and national experts to provide information for OMHSAS and its stakeholders to consider in expanding current PA initiatives to transform the BH delivery system and foster R/R. The experts were identified based on the nature of their professional work and/or experience as consumers and/or experts in specialized areas of focus. They included consumer leaders experienced with BH managed care, current and former senior staff of public behavioral health agencies including state hospital administrators, current and former managed care administrators, as well as industry experts on EBPs. We targeted
interviews to two states (New Mexico and Texas) that have SAMHSA Transformation
grants (TSIG) and also contract with behavioral health managed care organizations. For
the state hospital study area, we selected three states for interview (Arizona, Michigan
and Ohio) that have successfully lowered their state hospital utilization, as well as a
northeastern state that has comparable utilization per 1,000 to the Commonwealth
(Massachusetts). Due to high utilization of inpatient psychiatric services by people with
coccurring disorders (COD), we interviewed a former state medical director (New
Mexico) as well as another national expert on COD. We also interviewed a forensic
mental health expert and researcher. After reviewing the DPW Autism Task Force
Report, we interviewed a national autism expert on the status of evidence-based programs
for adults with Autism Spectrum Disorders and the fit of service approaches with the
philosophy or R/R. For the FBMHS study area, interviews were conducted with eight
informants: six experts (researchers and representatives of EBP organizations) and
representatives from three state systems (Connecticut, Hawaii and New Mexico). Eight
additional experts were interviewed for the study area on early childhood MH
consultation, including clinical and system-level experts from five states (Colorado,
Connecticut, Florida, North Carolina, and Vermont). The disciplines of those interviewed
included law, psychiatry, psychology, social work, social science, and management. We
interviewed other experts that were identified during the initial interviews. The length of
the interviews varied from 30 minutes to two hours, including multiple interviews and
follow-up discussions. A list of the experts and a brief summary of their backgrounds is
provided in Appendix A.

For the interviews, we used the interview guides approved by OMHSAS and provided in
Appendix B. The interview questions were developed through a collaborative process
with OMHSAS and national experts. The guide on R/R includes a section for consumer
interviews and one for state officials, managed care organizations, and other industry
experts. The guide on state hospitals focused on discharge planning strategies and EBS
for adults with serious mental illness that are not hospitalized due to forensic reasons. For
the FBMHS and early childhood MH consultation interviews, our focus was on research
findings and implementation of evidence based strategies for child and family based
mental health, including identification of states that are implementing these strategies,
and to understand the lessons learned.
Facilitating Recovery and Fostering Resilience in Managed Care

This section of the report describes the findings from the literature review and interviews, and focuses on practical strategies to implement R/R by key managed care functions, as well as supportive attitudinal change and funding strategies. For ease of review, the findings from the literature are discussed first, followed by findings from the expert interviews, and then examples from other states. Barriers to implementing R/R are also discussed. Mercer offers considerations for strategies to operationalize the findings at the end of the section.

The overarching theme from the literature review and interviews establishes that consumers and their families must shape the design and implementation of R/R principles. If the mental health system should facilitate consumer empowerment and R/R in such a way as to pre-empt consumer choice, e.g., mandating everyone has to have a peer counselor, then the purpose of R/R is defeated. The situation is similar to that of cultural competence, where simply valuing diversity does not translate into expertise on a specific culture or effectiveness in working cross-culturally. In the same way, implementation of R/R requires professionals and administrators to collaborate and learn specific strategies from consumers and their families that will enhance R/R and consumer empowerment.

Forquer and Knight (2001) identified several pros and cons of managed care as an enhancer or inhibitor of recovery. The major enhancer identified includes capitation, which permitted reinvestments of savings to more recovery-based systems of care, including training of providers on R/R precepts and strategies. The inhibitors of managed care were provider resistance to both managed care and the recovery model, unfamiliarity of managed care entities with research on mutual support and rehabilitation, and “traditional views of persons with mental illness as incapable,” attitudes not unique to managed care settings.(Forquer & Knight, 2001, p. 25). The authors further point to self-help and recovery as supportive of positive utilization management strategies, creating
better outcomes and efficiency. The discussion that follows provides additional information on using managed care functions to promote R/R.

Findings from the Literature Review on Intake, Care Management/Utilization Management

As noted in the New Freedom Commission report, “the plan of care will be at the core of the consumer-centered, recovery-oriented mental health system.”

BH-MCOs care management and utilization management processes provide important opportunities to enhance R/R. The oversight of intake, assessment, and treatment planning through care management and utilization management are vehicles that can be used to emphasize self-determination and R/R as shared values among managed care staff, providers, and consumers. The literature references the following strategies:

- Involving consumer and family experts (including clinicians who are consumers) in the review of medical necessity criteria and treatment planning protocols and policies, including broadening “the concept of medical necessity and practice guidelines to include alternative or non-traditional healing and treatment modalities.” Establishing criteria for rehabilitative services, including consumer-run services that address social and human issues that promote recovery, in addition to treatments that address symptom management, are examples of broadening “medical necessity.”
- Instituting initial and ongoing assessment elements/requirements that address both symptom management and R/R values/goals.
- Training of BH-MCO staff by consumers on strategies that enhance self-determination through the intake, assessment, treatment and recovery planning, and care management/utilization management processes.
- Emphasizing the individual’s right to informed consent or choice in collaboration with professionals, as well as requiring appropriate documentation of the collaboration.
- Developing advanced directives that include alternatives to involuntary treatment.

These strategies are echoed in a recent publication on treatment planning for person centered care. According to Adams and Grieder (2005), treatment planning must focus on the following areas:

- Quality of life
- Spiritual fulfillment
- Activity/Accomplishments/Work
- Social opportunity
- Satisfying relationships
- Housing
- Transportation
- Education
- Health/well-being
Furthermore, the process for treatment planning must address the following issues:

- Be developed with the person served and family as a partner
- Be consistent with culture and personal preferences (and family as appropriate)
- Identify the person’s own expectations
- Recognize that participation may vary by:
  - Personal style
  - Age and development
  - Cultural traditions and expectations
  - Severity of needs

Cook (2006) reports that “The Wellness Recovery Action Plan (WRAP),” a consumer self-managed tool developed by Copeland, is emerging as an evidence-based practice and is in various stages of use across all 50 states. There is evidence from well-designed quasi-experimental studies supporting the efficacy of WRAP, and additional studies are underway. If consistent with the interest of the HealthChoices member, use of WRAP plans can be encouraged by the care manager asking the consumer and providers if a WRAP plan was completed and if its contents link to the treatment plan. Further, the BH-MCO can refer consumers for assistance with developing a WRAP plan and/or sponsor training sessions delivered by consumers on WRAPs.

**Findings from the Expert Interviews on Intake, Care Management, and Utilization Management**

Similar to the literature, the experts emphasized the significant shift in values and the training necessary to move BH systems to an R/R footing. They suggested that BH-MCOs may institute methods to assess if services are person-centered and support a recovery vision for each individual while understanding barriers and challenges the person faces. Strategies include:

- Redesigning assessment tools and medical records to support treatment and recovery goals.
- Implementing web-based assessments and care management tools that facilitate use of standard protocols and member involvement to promote R/R during assessment of the individual’s treatment needs and goals.
- Using the assessment and treatment planning process to focus on the person’s strengths rather than deficits, emphasizing past accomplishments, contributions, endurances, opportunities, hopes and dreams, and supports rather than disability.
- Implementing consumer self-management planning tools, such as the Wellness Recovery Action Planning (WRAP).
- Assessing the degree of individualization and recovery orientation in treatment and recovery plans of network providers through utilization review.
- Using utilization management to help network providers manage staff resources by providing the right level of care at the right time, while emphasizing use of consumer-run services, peer support, and least restrictive community resources.
Focusing the most intensive resources on people with mental illness who are ready to participate in their own recovery, as well as offering outreach and peer support services to people with mental illness who are not engaged in treatment and recovery to provide information and education on R/R and service options.

Avoiding the use of coercion/involuntary treatments as a routine part of the treatment planning process. As noted above, using peer-counselors/peer-specialists to engage and educate consumers who are reluctant to access treatment and rehabilitation may be a good use of resources to help people become ready to participate in their recovery, even during acute phases of an illness.

Assessing if the person is able to self-manage his/her care instead of requiring every individual with a mental illness or serious emotional disturbance to have a case manager.

Providing ways for consumers to educate managed care staff and providers on R/R.

Laurie Ashcraft, PhD, of Meta Services, a consumer-run program in Arizona, provided the information in Table 2 below to highlight changes in beliefs that can positively impact the assessment and planning process:

<table>
<thead>
<tr>
<th>Non-Recovery Beliefs</th>
<th>Recovery Beliefs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stability/maintenance is the goal</td>
<td>Recovery is the goal</td>
</tr>
<tr>
<td>Low expectations</td>
<td>Lots of hope; high expectations</td>
</tr>
<tr>
<td>No clearly defined exit</td>
<td>Clear exits and graduates return/share</td>
</tr>
<tr>
<td>People judged by level of motivation</td>
<td>Restoring hope creates new energy</td>
</tr>
<tr>
<td>Provider creates the plan for the person</td>
<td>Each person creates their own plan</td>
</tr>
<tr>
<td>Compliance is valued</td>
<td>Choice and independence are valued</td>
</tr>
<tr>
<td>Coercion used to achieve compliance</td>
<td>Empowerment; people are the experts</td>
</tr>
<tr>
<td>Provider directs the services</td>
<td>Each person chooses their services</td>
</tr>
<tr>
<td>People protected from trial/error learning</td>
<td>People encouraged to take risks</td>
</tr>
<tr>
<td>One-size-fits-all treatment approach</td>
<td>Wide range of options</td>
</tr>
<tr>
<td>Little or no access to information</td>
<td>Education; easy access to information</td>
</tr>
<tr>
<td>People live in “treatment centers”</td>
<td>People choose their own housing</td>
</tr>
<tr>
<td>Employment is too stressful</td>
<td>Everyone can have a meaningful career.</td>
</tr>
<tr>
<td>Medication is the primary tool</td>
<td>Medication is one of several tools</td>
</tr>
<tr>
<td>Emphasis is on treatment</td>
<td>Peer support and self-help are essential</td>
</tr>
</tbody>
</table>

In summary, the experts emphasized methods that incorporate self-direction and choice in the assessment, treatment planning, and utilization management processes.

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1 Interview with Dr. Lori Ashcraft, PhD, Recovery Education Center, Meta Services.
Strategies for Intake, Assessment, Care Management, and Utilization Management from other States

Table 3 below highlights a range of strategies gleaned from other states for promoting use of EBPs and R/R through the intake/assessment/treatment planning process.

### Table 2 – Strategies from Other States

<table>
<thead>
<tr>
<th>State</th>
<th>Strategies for Intake, Assessment, Care Management, Utilization Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>- Screening for co-occurring mental and substance use disorders and link with integrated treatment</td>
</tr>
<tr>
<td></td>
<td>- Providing early mental health screening, assessment, and referral at school mental health programs</td>
</tr>
<tr>
<td></td>
<td>- Developing integrated electronic health record and personal health information system</td>
</tr>
<tr>
<td>CO</td>
<td>- Implementing adults and juvenile justice mental health screening process</td>
</tr>
<tr>
<td></td>
<td>- Promoting early mental health screening, assessment, and referral in child care settings</td>
</tr>
<tr>
<td>FL</td>
<td>- Rewriting case management administrative rules to shift to individually centered recovery- and resiliency-based treatment</td>
</tr>
<tr>
<td>IN</td>
<td>- Launching a mental health and substance abuse early identification and screening program for abused and neglected children</td>
</tr>
<tr>
<td>MD</td>
<td>- Developing standard protocols for assessing mental illness, SED, and monitoring care – building public-academic linkages with major universities</td>
</tr>
<tr>
<td>NM</td>
<td>- Using consumer-run programs and peer specialists to provide outreach and educations services and engage consumers unwilling to participate in the mental health system</td>
</tr>
<tr>
<td>OH</td>
<td>- Training on person-centered planning/assessment planning process and on attitudes and skills</td>
</tr>
<tr>
<td></td>
<td>- Using Ohio outcomes data in treatment planning and incorporating consumer preferences into individual care plans</td>
</tr>
<tr>
<td>TX</td>
<td>- Expanding data infrastructure to facilitate development of individualized plans</td>
</tr>
<tr>
<td>VA</td>
<td>- Establishing REACH – Recovery Education and Creative Healing – with statewide consumer organization to provide access to WRAP training and training certification</td>
</tr>
<tr>
<td>VT</td>
<td>- Providing early mental health screening, assessment, and referral in child care settings</td>
</tr>
</tbody>
</table>

Findings from the Literature on Provider Network Management

Shaping provider and community service networks to match changing need requires knowledge about the demographics, needs, and preferences of the population, currently available and emerging evidence-based practices, and the capacity and quality of the existing network. Significant attention is given to the expectation that managed care contractors will develop networks that have the necessary breadth and depth to provide all
the medically necessary required range of services for their specific populations in a timely manner.

These baseline requirements must be further enhanced by strategies that address R/R, particularly in the areas of offering consumer self-management tools, rehabilitation intervention, support services that promote housing stability, the development or maintenance of social networks and skills, and employment, school performance, or retirement activities. As noted in the OMHSAS Call for Change paper, the Commonwealth has structured its Medicaid services to allow consumers access to expanded rehabilitation services. This is an important step in shaping provider networks to an R/R philosophy. Through this approach, medical necessity is broadened to include a wider range of the types of services and supports that enhance R/R.

Requiring BH-MCOs to develop an annual Provider Network Plan is one strategy for R/R promotion that has its foundation in the Balanced Budget Act (1997, 2002). Although states have considerable leeway in defining the requirements of a Provider Network Plan, typically these Plans describe the enrollee population (numbers, location, racial/ethnic groups [values, beliefs, customs, traditions], and behavioral health care needs); the services being provided; its approach to network development; the reasoning behind the approach; the methods being used to ensure its adequacy (criteria being used and the monitoring processes); the identification of any service gaps, and the outlining of steps being taken to close all service gaps and assure compliance. States can also require the Provider Network Plan to address consumer choice, age-specific services and EBPs, peer support and peer-run services, self-management approaches, provider licensing, and certification requirements (e.g., for case managers, peer specialists, consumer-run services, EBPs) and provider monitoring approaches that support R/R. Network plans must also address age specific needs for children, transitional age youth, adults, and older adults. The development of annual Provider Network Plans should involve significant participation of consumers and family members.

Consumer-Run Services
The mental health consumer movement has begun to influence standards and performance measurement related to the scope and type of services available, as well as the competencies of BH staff and peer counselors most likely to help consumers participate in their treatment and recovery. Consumers are also involved in research initiatives including evaluation of treatment outcomes. The literature reports that initially these efforts were expert-driven, but more recently consumers have become involved in “developing measures to compare treatments, to ensure that outcomes they particularly value, such as the ability to live independently or hold a job, were included”(Tomes, 2006). Further, an evidence base for peer support and WRAP techniques is emerging. Use of peer-support in Illness Management and Recovery is documented as successful (Mueser and Corrigan, 2002). Non-controlled, well-designed quasi-experimental studies suggest that use of WRAP leads to improvements in behavioral or attitudinal change (Cook, 2005).
Double Trouble in Recovery (DTR), mutual aid groups for people with co-occurring mental illness and substance use disorders, is an example of a peer support initiative that has demonstrated positive outcomes. Persons with higher levels of support and participation in dual-recovery mutual aid reported less substance use and mental health distress and higher levels of well-being (Laudet et al., 2000, p. 457).

The clinical benefits of recovery and peer services are clearly supported in the literature. Positive consumer outcomes include, but are not limited to, increased social supports and community participation, improved self-esteem and illness management, access to vocational and other supports, and improved satisfaction with quality of life. One study found that peer services are more effective than traditional services, particularly for individuals who may be alienated from the mental health system, such as those that are homeless. Further, the study notes that peer providers have a positive impact on mental health providers when professionals have the opportunity to see people with mental illness successfully function as a result of peer supports. To be effective, the study suggests that peer support services must have critical ingredients in four areas:

- **Service Elements**: peer support services must include experiential learning and use of natural social support.
- **Peer Characteristics**: peer providers must have experience with mental health service delivery system, be stable and in recovery, and not exhibit current substance abuse or dependency.
- **System Principles**: the mental health system must also provide diversity and accessibility for the types and categories of peer-run services.
- **Choice**: consumers must be allowed to select from various peer support/peer-run services to address their needs.

Fidelity to these ingredients is important to achieve positive outcomes.

While consumers are asking for individualized approaches to their treatment and recovery, other than the general categories of children and adults, age-specific consumer initiatives seem to be somewhat minimal. Older adults and transitional age youth do not receive as much mention in the literature on R/R. The National Consumer-Support Technical Assistance Center, established by the National Association of Mental Health with funds from the US Center for Mental Health Services at SAMHSA, funded one age specific initiative, the Older Adult Consumer Mental Health Alliance (OACMHA).

OACMHA is a consumer advocacy organization that emphasizes the needs of older adults and focuses on advocacy and increasing public awareness of the mental health needs of older adults (including among older adults); expediting the mental health and aging research agenda; and promoting the development and implementation of non-traditional mental health prevention, early intervention, and treatment programs that specifically

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target older adults. A survey of literature on their website indicates that OACMHA focuses on the high suicide rate among older adults, re-institutionalization (from state hospitals to community to nursing homes), the minimal focus on older adults in the New Freedom Commission Report, Medicare services, and the general lack of appropriate and individualized services (The Voice, 2003). While older adult consumer initiatives may exist in other states, we found limited information available on their status.

For transitional age youth, however, a search of the literature suggests that professional sponsored/consumer-moderated focus groups are a key strategy to gain information about their concerns (Research and Training Center on Family Support and Children’s Mental Health). A presentation at the 19th Annual Research Conference, A System of Care for Children’s Mental Health: Expanding the Research Base, discussed the results of focus groups for ninety-nine transition age youth and their family members. Key themes from this presentation address the following areas:

- “The need to recognize youth’s competencies and desire to give back to the community should be recognized.
- “Schools and colleges are seen as especially important in the lives of youth with mental health difficulties, yet a pervasive lack of understanding of mental health issues persists, and needs to be addressed.
- “Stigma cuts across all domains – broad educational efforts are needed for families, professionals, employers, and communities.
- “Successful role models – close in age and experience to youth themselves – can normalize disclosure and provide hope” (Community Integration of Transition Age Youth 2006).
- Individuals of every age are asking for consumer-run services, peer support services, and other mutual aid programs to facilitate their R/R. Network planning and adequacy assessments should consider these factors. Thus, states may want to specify access requirements for consumer-run services that must be addressed in BH-MCO Network Plans.

Provider Concerns

There is debate in the literature among providers and others about the definition of recovery, whether it devalues professionals and treatment, and a host of other concerns. The following quote sums these up well: “recovery is old news; recovery-oriented care is implemented only through the addition of new resources; recovery-oriented care is neither reimbursable nor evidence based; and recovery-oriented care increases providers’ exposure to risk and liability” (Davidson et al., 2006, p. 640).

To counter these beliefs, the literature describes social inclusion and self-determination as the underlying values of recovery. Further, if there is understanding that mental illness is “a condition that many people can learn to live with … choice and self-determination

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3 Several California Counties have also conducted focus groups for Transitional Age Youth, as part of implementation of Proposition 63, the “Millionaires” Tax that provides specialty mental health services funds to counties.
become inevitable rather than optional” (Davidson et al., 2006, p. 643). Research on consumer-run/recovery services, as described earlier in this section, is underway. Comparison of recovery in physical illness to that in mental illness suggests that people will accommodate to their illness or disability and have this be only one dimension of the personhood, while taking advantage of treatment and rehabilitative services. A key concern of how to finance these services is realistic and needs to be addressed.

The literature also describes “well meaning” providers who believe they are already promoting recovery and cautions that while there may be some providers offering recovery, systemic transformation will take time. Providers are asking what they should do differently to be considered a transformed mental health delivery system. Some providers understandably wonder if the push to recovery is a “thinly veiled effort to cut back on services and on expenditures,” expressing the concern that “mental illnesses are highly disabling and require treatment” (Dickerson, 2006, p. 647). Some have concerns that recovery will raise false hope of cure (Torrey and Wiczk, 2000). Yet, experience with implementing R/R has allayed many provider fears. As they move forward in this area, it will be important for the BH-MCO to understand provider concerns underlying resistance to R/R for design of effective training and incentives for fidelity to R/R principles.

Findings from the Expert Interviews on Provider Networks

The interviews in this area focused on strategies to assess and achieve a sufficient and effective network that supports R/R. The experts discussed many of the recommendations referenced in the literature, as well as additional practical strategies to improve network performance. These strategies include:

- Consumer voice in shaping the provider network development strategy. Several states have organized regional consumer leadership organizations to work on various aspects of R/R, including access to services. For example, the Massachusetts Department of Mental Health and the Behavioral Health Partnership (the Medicaid BH carve-out) have established grants to fund consumer-run Recovery Learning Centers (RLCs) throughout the state. The RLCs support consumers to take charge of their own recovery process by providing access to information and referral; a variety of peer support and self-help activities; advocacy and training. The RLCs also provide certification training, testing, continuing education, and support for Peer Specialists that are based in provider agencies and other community based locations. RLCs train and support providers and their agencies to be effective employers of Peer Specialists (Massachusetts Recovery Learning Centers, 2006).
- Design the network to include services that address the phases of change in the recovery process. For example, in the pre-contemplative change phase, peer supports often are the key to helping a person identifying their motivation to participate in treatment and recovery. California and New Mexico have designed peer support programs to work with people who are homeless.
- Provide access to consumer-self management services for co-occurring disorders. For example, New Mexico supports expansion of “Double Trouble in Recovery” mutual support groups.
To address unmet needs, the BH-MCO could offer financial incentives and start up funds for consumer initiatives.

To the extent the BH-MCO participates in research on EBPs, include consumer voice in the design and evaluation of these protocols and services. One expert noted that in Massachusetts, consumers are working with nationally known researchers to include more consumer voice in EBP protocols.

To recruit consumer-owned or run organizations, as well as minority-owned organizations and small firms, be prepared to offer technical assistance or administrative services. These can include a wide range of supports, on an interim basis, such as access to electronic medical records, computers, training on use of information systems, submission of electronic claims, record reviews, and other similar functions. One expert noted that in Massachusetts, there is a move to allow consumer-run organizations to apply for minority business status based on their disabilities. Obtaining this status will allow them to be eligible for loans and other resources that would help them to become independent businesses.

Target a substantial amount of the BH-MCO reinvestment dollars to consumer-owned and delivered services.

Allocate a specified percent of the total BH-MCO service dollars as an initial target for consumer-run initiatives.

Institute electronic medical records or internet based information systems that facilitate inclusion of WRAP plans and other self-management tools, and advanced directives for crisis situations into treatment/recovery plans.

Rethink traditional services that foster dependence, such as use of representative payees that reinforce dependence on the payee to manage money. Substitute training on money management to encourage independence through skill development.

Train providers on motivational interviewing and assessment of readiness to change.

Initiate consumer training and technical assistance for providers to promote hiring of peer specialists to facilitate the acceptance of the specialist by the organization and increase the effectiveness of provider incorporation of peers in the service delivery process.

Provide guidance on how to better integrate the delivery of mental health and substance abuse services for people with co-occurring disorders.

**Strategies on Network Management from other States**

The materials reviewed from other states offered a sample of strategies for promoting R/R and EBPs through the network management process. Table 4 below describes an array of other states’ initiatives.
Table 3 – State Strategies to Facilitate Development of R/R Provider Networks

<table>
<thead>
<tr>
<th>State</th>
<th>Strategies for Network Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZ</td>
<td>The Regional Behavioral Health Authorities (BH Medicaid managed care program) fund consumer-run services, such as META.</td>
</tr>
<tr>
<td>IN</td>
<td>Targeted implementation of Illness Management and Recovery (IMR), an EBP that uses peer specialists.</td>
</tr>
<tr>
<td>CA, OR, WA</td>
<td>Development of specific workgroups to identify needs of Transition Age Youth (TAY). Conducting age-specific consumer focus groups to determine needed services and developing implementation plans for TAY services, including allocation of resources.</td>
</tr>
<tr>
<td>NJ</td>
<td>Consumer Connections trains and supports consumers to fill mental health and human services jobs.</td>
</tr>
<tr>
<td>Portland, OR</td>
<td>Provides access to treatment services, as well as flexible funds for consumers to spend on alternative services of their choice.</td>
</tr>
<tr>
<td>TN</td>
<td>Creating Homes Initiative provides a consumer-directed, accessible housing resource system for Tennesseans diagnosed with mental illness or co-occurring disorders; works to reduce stigma.</td>
</tr>
<tr>
<td>LA, HI, AK</td>
<td>Implementation of COSIG SAMHSA Grant to develop competencies to serve individuals with co-occurring psychiatric and substance use disorders through the development and designation of Co-occurring Disorder Competent Facilities, Co-Occurring Integrated/Enhanced Treatment Facilities, and Credentialed Co-Occurring Disorder Professionals.</td>
</tr>
</tbody>
</table>

Findings from the Literature on QM /Performance Measurement

The literature and strategies on quality management (QM) and performance measurement (PM) related to R/R focus on different types of outcomes, some of which overlap:

- individual’s desired outcomes;
- results of EBPs; and
- BH system reform performance.

For consumer desired outcomes, there is an emerging body of thought on person-centeredness and R/R that challenges current thinking and practice in outcome measurement (Adams, 2006). Each individual becomes their own measure of R/R outcome and success. Yet, administrators and clinicians report that it is difficult to measure individual outcomes for abstract concepts such as hope and self-fulfillment. However, the social sciences offer assistance with measurement scales that can address more conceptual and perceptual beliefs and outcomes that typically have not been used in day-to-day operations of mental health programs. For example, Self Determination Theory (SDT) addresses the conditions that foster (versus undermine) positive human potential (Ryan and Deci, 2000). SDT discusses the importance of motivation and satisfaction of the basic needs for competence, autonomy, and relatedness for a person to achieve a sense of integrity and well-being. There is an emerging body of literature that
reports on outcomes of self-help including improvements in self concept and interpersonal quality of life (Mercer, 2005). The OMHSAS Call for Change paper discusses the recovery domains that are discussed in the literature.

SAMHSA has developed a set of national outcome measures (NOMS) that focus on reduced morbidity, employment/education; crime and criminal justice; stability in housing; social connectedness; access/capacity; retention; perception of care; cost effectiveness; and use of evidence-based practices. The importance of selecting performance measures that reflect consensus among consumers, providers, and the government purchasers of managed care services was emphasized throughout the literature.

**Strategies from other States on Quality Management**

The materials reviewed from other states offered the following strategies for promoting R/R through BH-MCO quality management:

**Table 4 – State Strategies for Infusing Quality Management with an R/R Philosophy**

<table>
<thead>
<tr>
<th>State</th>
<th>Strategies for Quality Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>The Massachusetts Behavioral Health Partnership (BH carve out) offers financial incentives for providers to use a standardized outcome measurement program – Treatment Outcome Package, Behavioral Health Laboratories, Inc. This package includes clinical status outcomes as well as life satisfaction measures.</td>
</tr>
<tr>
<td>DE</td>
<td>Performance-based contracting that provides financial rewards to providers who are able to engage and retain clients in treatment.</td>
</tr>
<tr>
<td>NM</td>
<td>As part of New Mexico’s Interagency Behavioral Health Purchasing Collaborative, seventeen local Collaboratives are being developed to correspond with 13 judicial districts and numerous tribes and pueblos across the state. The Collaboratives will identify needs, help develop a range of resources, and ensure the responsiveness and relevance of BH services and supports to improve the quality of life of those with BH concerns. This approach is in the early stages of development but should be monitored for innovations related to quality management.</td>
</tr>
<tr>
<td>OH</td>
<td>The Solutions to Ohio’s Quality Improvement and Compliance (SOQIC) initiative trains providers to partner with consumers to develop individualized plans of care. The Ohio Advocates for Mental Health train consumers on how to collaborate through person-centered training. Outcome system instruments are completed at intake and regular durations thereafter. This system provides information on individual outcomes and system outcomes. The consumer outcomes data mart provides easy access to information via the web. Domains measure Clinical Status, Quality of Life, Functioning Status, Safety and Health, and Empowerment. To measure outcomes for youth, three parallel forms were developed (Ohio Scales) for completion by each youth client, the youth’s parent or primary caretaker, and the youth’s agency worker. The domains measured include Problem Severity, Functioning, Hopefulness, and Satisfaction.</td>
</tr>
<tr>
<td>TX</td>
<td>For Health plans and purchasers, Texas is instituting measures of quality for coordination of care. Texas is also exploring offering incentives to providers who use electronic medical records to capture data that can be used for quality management.</td>
</tr>
</tbody>
</table>
Findings from the Expert Interviews on Quality Management

The interviews focused on many of the same themes and issues discussed in the network section:

- A consumer-expert suggested that work is needed on incorporating R/R into EBPs. A Massachusetts consumer was reported to be working with a nationally known researcher on improving the R/R focus of ACT teams. Involving consumers in the initial phases of testing and developing EBPs as well as designing R/R fidelity issues was recommended.

- Two experts suggested working with consumers to develop meaningful satisfaction questionnaires that focus on the practical aspects of getting care: wait times, access to psychiatrists and other specialists, after-hours access, and access to someone who speaks one’s own language and having a provider that understands them and works to make treatment a success. Often, satisfaction surveys are very limiting and do not give consumers the opportunity to provide meaningful responses (e.g., Are you satisfied with the care you get? What about the care you would like to get?). In some programs, consumers actually assist their peers with completion of surveys which was thought to be very helpful by the experts.

- Most experts agreed that implementing BH-MCO performance-based contracts and provider Pay-for Performance (P4P) initiatives that include both financial and non-financial incentives, facilitates positive outcomes.

- Many of the experts recommended using consumer quality review teams to assess the degree of permeation of the R/R philosophy in policies and procedures, treatment plans, and staff training programs.

Strategies for Implementation of R/R through BH-MCOs

The following strategies focus on interventions specific to enhancing the R/R orientation of BH-MCOs and stem from the literature review and expert interviews. In general, we recommend for consideration a threefold strategy: targeting counties/BH-MCOs that have demonstrated readiness for R/R implementation, providing technical assistance and financial resources; and establishing competitive procurements for EBP resources for all counties/BH-MCOs.

Service Array for Consumer-Run/Peer Support Services

Mercer strongly recommends that OMHSAS consider establishing a minimum service array for consumer-run services in each county with the input of local consumers and family members and guidance from statewide consumer organizations or consumer-sponsored initiatives. The strategies below are based on our literature review and discussions with experts, including consumers from other states, and can serve as a basis for further discussion with consumers and other stakeholders from the Commonwealth.
Minimum Service Array for Consumer-Run Services:

- Wellness Recovery Action Planning (WRAP)
- Double Trouble in Recovery Groups
- Other condition-specific recovery groups (e.g., Depression, Bi-polar Illness)
- Consumer-run Recovery Learning Centers to provide technical assistance and education on R/R, modeled similarly to the program in Massachusetts
- Peer Support/Peer Specialists (at peer-run and traditional provider organizations) to offer:
  - outreach and education of consumers to engage them in their recovery
  - outreach and education to consumers in the hospital, as part of discharge planning
  - education and support for use of self-management services/toolkits, e.g., depression management, and money management
- Peer Support for older adults to emphasize social connections (e.g., Gateway Program in Philadelphia and Norristown, which services range from weekly phone contact to information and referral, and Compeer, a volunteer friend program).
- Consumer-Run Drop-in Programs, especially those that focus on employment supports
- Consumer Quality Management/Satisfaction Teams

Managed Care Tools/Support

Intake, Assessment, and Treatment/Recovery Plans

The following strategies are offered for consideration to institutionalize self-direction and choice in the assessment and treatment plan process:

- Redesign clinical formats and medical records to support treatment and recovery goals through a systematic review of intake and assessment forms and protocols, and treatment and recovery plans and protocols to assess relevancy to R/R.
- Institute screening protocols to help individuals determine if they have co-occurring disorders of mental illness and substance abuse, as well as forms and protocols to include treatment of co-occurring disorders as a part of the treatment plan.
- Identify key data elements that each BH-MCO must include in their protocols/medical records.
- Involve consumer experts and family members in the review and redesign of records and protocols.
- Consider selecting standardized assessment tools and treatment/R/R plans that are age appropriate (i.e., children, transitional age youth, adults, and older adults).
- Assess the feasibility of implementing web-based tools for standardized assessments that incorporate R/R philosophy to facilitate: 1) assessing the individual’s treatment needs, and 2) developing recovery goals within a strengths-based framework that emphasizes self-determination.
- As part of the BH-MCO treatment planning process, provide the opportunity for individuals to develop crisis plans.
As part of the treatment plan reviews, assess whether the consumer has access to self-management tools such as WRAP. Review the treatment plans to verify consistency with the consumer’s WRAP or other self-management plans.

Systematically introduce access to WRAP and other self-management toolboxes (Copeland 2004) for consumers that would like to use them and provide access to self-managed toolkits for consumers and staff to learn about specific recovery initiatives, e.g., references to Judith Cook’s website at the University of Chicago National Research and Training Center on Psychiatric Disabilities.

Provide access (as part of the assessment and treatment planning process) to self-managed tools, including on-line tools, for such topics as meal planning, money management, housing, smoking cessation, and other health and wellness strategies.

Train access line/member services staff, care managers, and utilization management staff on R/R philosophy and self-help principles and provide them with specific electronic tools that visibly address recovery principles and goals (e.g., use of self-management techniques and consumer-run services).

Require individual housing plans to be incorporated into a consumer’s plan for recovery and monitor the plans on a regular basis for consumer satisfaction and other outcomes (OMHSAS Housing and Recovery Workgroup, 2006).

**Care Management/Utilization Review**

The following strategies are offered for consideration to institutionalize self-direction and choice in the BH-MCO care management and utilization management process:

- Regular training and monitoring of care management and utilization review staff on R/R principles and strategies to facilitate R/R throughout the care management process.
- Review and revise UM guidelines to incorporate R/R philosophy and use of consumer-run, peer support services and other community supports. Include consumer experts and consumers who are also professionals in the review process.
- Routinely assess the degree of individualization and recovery orientation in treatment and recovery plans through utilization review and care management. Develop automated tools/on-line tools that include R/R principles to assist with UM and QM. An example would be a checklist that helps the reviewer determine if key R/R principles are incorporated into the treatment plans, if there is a recovery plan and how these match to the level of care and types of services and supports the person receives. Because implementation of R/R is an iterative process, such tools can assist the BH-MCO to keep R/R principles visible.
- Use utilization management to help network providers manage staff resources by providing the right level of care at the right time, and emphasize use of consumer-run services, peer support and community resources (for example, identify strategies that match consumers to resources that correspond with their recovery stage, e.g., pre-contemplation, contemplation, etc.).
Network Management

The following strategies are offered to identify standards for BH-MCO networks to facilitate development of consumer-run/delivered services and an R/R philosophy:

- Train Network Management staff at the BH-MCOs on R/R principles, as well as consumer-run and delivered services.
- Establish criteria for network contracts with consumer-run programs and for peer support services.
- Require BH-MCOs to develop an annual network plan, in conjunction with consumers, family members, and providers that addresses the following areas:
  - Description of the planning process, implementation goals, and time frames for inclusion/development of consumer-run and delivered services.
  - Identification of peer services that address the phases of change in recovery, e.g., from pre-contemplative to recovery.
  - Development of and access to consumer self-management programs such as WRAP and Double Trouble in Recovery groups.
  - Education for consumers, families, and providers about R/R through EBPs.
  - Plans for financing consumer-run and delivered services and EBPs, including identification of existing resources, reinvestment strategies, and funding constraints that need to be addressed on a statewide and/or federal level.
  - Strategies to include consumers from diverse cultures in planning efforts for R/R, including identification of ethnicities, languages, and race of the member populations.
  - Inventoring existing consumer-run/delivered services and analyzing geo-access to these services.
  - Requirements for training network providers on R/R through consumer-sponsored educational approaches, as well as offering toolkits for providers to use in self-monitoring their R/R philosophy.
  - Certification requirements for consumer-run programs and peer specialists, and EBPs that support R/R.
  - Requirements for developing co-occurring competent facilities, co-occurring integrated facilities, and credentialed co-occurring disorders professionals.
  - Organizational support for the development of consumer run/delivered services, such as administrative and technology support and assistance until the services become self-sufficient.
  - Pay-for-Performance (P4P) strategies that the BH-MCO can use to contract with providers to facilitate development of R/R philosophy and consumer-run services.
  - Training for providers on motivational interviewing and readiness to change.
  - Consumer-delivered training and technical assistance for providers implementing peer specialists to facilitate the acceptance of the peer staff by provider organizations and their effectiveness of incorporation of peers into the service delivery process.
  - Demonstration projects for use of peer supports and consumer-run programs that publicize successes and failures, improved outcomes – lesson learned.
Quality Management/Performance Indicators

The following strategies are offered to establish system-wide performance indicators related to implementation of R/R principles through an OMHSAS sponsored initiative for consumers/families, BHMCOs, providers, and professional organizations:

- Set performance goals and time frames for achieving changes in intake, assessment and treatment planning, in addition to the utilization management initiatives identified above, including maintaining cost effectiveness.
- Set performance goals for achieving network requirements described above, specifically increasing access to consumer-run/directed services and adopting R/R principles.
- Establish consensus on selected performance indicators.
- Incorporate NOM service outcomes as guidelines for uniform performance indicators for statewide implementation, including:
  - Abstaining from drug use and alcohol abuse, decreasing symptoms of mental illness and improving functioning;
  - Getting/keeping a job, staying in school;
  - Decreasing criminal justice involvement;
  - Finding safe and stable living conditions;
  - Improving social connectedness to others in the community;
  - Increasing access to services;
  - Reduced use of psychiatric inpatient beds; and
  - Improving client perception of care.
- Explore feasibility of using the Massachusetts and Ohio performance measurement protocols described in the previous section.
- Modify current QM tools, including on-line tools (e.g., Chart Abstraction Tool in use for annual reviews to monitor treatment planning and utilization management practices that support R/R). Involve consumer experts and consumer clinicians in this activity.
- Expand use of consumer satisfaction teams/quality management teams throughout the counties/BH-MCOs.
- Develop, with input from consumers/families, a statewide consumer satisfaction questionnaire that addresses R/R principles.
- Participate in research and evaluation initiatives to further evidence for use of consumer run/delivered services and involve consumers in the research on EBPs to incorporate the principles of R/R.
- Conduct focused studies to identify progress and barriers in R/R implementation, for example, if treatment plans and medical records are inclusive of consumer self-management tools (such as WRAP) or if there are referrals to consumer-run programs, and whenever not, if there is rationale noted (e.g., the individual does not want to use the tools).
Funding Strategies

**Funding for Consumer-Run Programs and Initiatives that Support R/R:**

- OMHSAS, the counties, and the BH-MCOs should determine a percent of the BH-MCOs administrative fees to be prioritized for R/R development and the percent of funding for the BH-MCOs to include consumer-run/delivered services.
- OMHSAS and the DPW should continue to explore ways to maximize FFP for service components of EBPs and R/R services that are eligible for Medicaid funding, (e.g., peer support) and reserve state general funds for R/R initiatives.
- At the same time, Medicaid administrative dollars can address R/R quality management initiatives.
- OMHSAS, the counties, and the BH-MCO should develop arrangements to provide financial incentives that support the start-up costs of consumer-run programs and provide administrative support to these organizations as they develop, including strategies to designate consumer-run programs as small disadvantaged businesses.

**Attitudinal/Messaging Strategies**

**Messaging** – Strategies to operationalize an R/R philosophy must be a core value and priority of the leadership of the Commonwealth, counties, consumers, BH-MCOs, and providers for people who are Medicaid eligible and those that receive care through state general funds, other federal, county, or local funds. Key messaging strategies to demonstrate and support R/R values include the following:
- The Commonwealth with input from Counties, BH-MCOs, and consumers should review the various R/R metrics and the feasibility of data collection and establish priorities for statewide implementation of key metrics that demonstrate commitment to the principles and philosophy of R/R. These metrics should be reviewed annually and widely publicized.
- Establish Departments of Recovery and Resilience within the BH-MCOs. These departments should have leadership with status equal to other senior managers and enough staff to impact the culture and operations of the organization. When consumers are present and have voice, this can change the dynamics of an organization positively.
- Establish a partnership among The Commonwealth, consumers/advocates, counties, and providers to leverage the power of their voices at Federal levels to move forward legislation that supports R/R initiatives.
- Refer to New York State’s Office of Mental Health as a resource for its framework, messaging tone, expectations, and monitoring of R/R principles and EBPs (described in the following section).
References: Facilitating Recovery and Fostering Resilience in Managed Care

A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults, Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, November 2005.


Community Integration of Transition Age Youth: Voices of Youth and Young Adults, http://www rtc.pdx.edu/pgProjVoices.php, Research and Training Center on Family Support and Children’s Mental Health.


Interview with Dr. Lori Ashcraft, PhD, Recovery Education Center, Meta Services, 2006.


Mercer Government Human Services Consulting. “Fidelity to Evidence-Based Practices (EBP): They only work as promised if you follow the instructions,” 2005.


Ohio Department of Mental Health website, http://www.mh.state.oh.us/oper/outcomes/data.mart.index.html.


Implementation Strategies for Evidence-Based Practices

This section of the report addresses findings from the literature and expert interviews on the overarching principles and strategies for defining and implementing EBPs. It provides the groundwork for later sections of this report on EBPs that reduce reliance on state psychiatric hospitals and have better outcomes for families and children.

Findings from the Literature Review

Evidence-based practices are well known to most in the public mental health system. In the literature, discussion has moved from explorations of the nature and validity of EBPs to address complex but critical issues related to selecting appropriate EBPs and implementing them successfully. Included in these discussions are references to the new concept of “evidence-based cultures” and their importance (Dixon, 2003; Barwick et al., 2005; Rivard et al., 2006).

This summary of selected relevant literature begins with a review of what is meant by evidence-based practice and then touches on specific practices being used in family-based mental health contexts and some issues related to successful implementation, including developing evidence-based cultures.

What Constitutes Evidence?

When used in relation to mental health services, “evidence-based” generally refers to a body of knowledge about service practices and the impact of treatments on mental health conditions and overall functioning, or about the impact of preventive interventions on the course of child and family development.
Multiple definitions and typologies to describe evidence-based strategies exist. Reviewing many of these, it appears that the broadest simplification might yield two levels: interventions that are well established and those that are promising. Well established interventions may be characterized through their support from randomized controlled studies as well as evidence from real-world care settings. Further, well established interventions are sufficiently documented to allow fidelity tracking. Promising interventions are supported by methodologically sound studies in either controlled or routine care settings and are sufficiently documented to allow at least limited fidelity tracking.

Flaum (2003) defines evidence-based practice(s) as “interventions for which there is consistent scientific evidence showing that they improve client outcomes.”

The definition goes on to specify that this body of evidence must include rigorous research studies, specified target populations, specified client outcomes, specific implementation criteria (e.g., treatment manual), and a track record showing that the practice can be implemented in different settings.

The State of Oregon Department of Human Services (2004), through its Office of Mental Health and Addiction Services (OMHAS), has put forth a hierarchy of evidence that is being increasingly adopted due to its practical structure. This hierarchy includes six levels of evidence. The first three levels describe practices that meet sufficient scientific standards to be defined as evidence-based practices.

**Level 1** refers to a prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both scientifically controlled and routine care settings and is sufficiently documented through research to permit the assessment of fidelity. The practice must be supported by scientifically sound randomized controlled studies that have shown consistently positive outcomes. Furthermore, positive outcomes have been achieved in both scientifically controlled and routine care settings.

**Level 2** is similar to Level 1 except that only one setting has been demonstrated (routine care or scientifically controlled).

**Level 3** describes interventions that have been modified or adapted for a population or setting that is different from the one in which it was formally developed and documented. The modification’s effect on outcomes is measured and documented, and based on the results of the outcomes; elements of the service are continually adapted or modified to achieve outcomes similar to those in the original practice. Similarly, the practice is sufficiently documented to provide a framework for replication in a similarly modified setting.

**Level 4** refers to a prevention or treatment service or practice not yet sufficiently documented or replicated through scientifically sound research procedures. These
practices are building evidence through documentation of procedures and outcomes. Often they are specifically designed to fill a gap in the service system but are not yet sufficiently researched for the development of a fidelity tool.

**Level 5** describes a prevention or treatment service based solely on clinical opinion or non-controlled studies without comparison groups. These interventions have not produced a standardized set of procedures or elements that allow for replication of the service. Most often this level of evidence does not include consistently positive measured outcomes.

**Level 6** describes a treatment or prevention service which research evidence points to having demonstrable and consistently poor outcomes for a particular population.

The Oregon hierarchy of evidence may also be expressed in the form of the following matrix.

### Table 5 - Operational Matrix for Levels of Evidence:

<table>
<thead>
<tr>
<th>Level</th>
<th>Transparency</th>
<th>Research</th>
<th>Standardization</th>
<th>Replication</th>
<th>Fidelity Scale</th>
<th>Meaningful Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-Based Practices</td>
<td>I</td>
<td>yes</td>
<td>&gt;=3 studies in peer reviewed journal</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>yes</td>
<td>&gt;=3 studies in peer reviewed journal</td>
<td>yes</td>
<td>yes</td>
<td>Yes or in Development</td>
</tr>
<tr>
<td></td>
<td>III</td>
<td>yes</td>
<td>Based on published research</td>
<td>yes</td>
<td>no</td>
<td>Yes or in Development</td>
</tr>
<tr>
<td>Non Evidence-Based Practices</td>
<td>IV</td>
<td>yes</td>
<td>None</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td></td>
<td>V</td>
<td>no</td>
<td>None</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td></td>
<td>VI</td>
<td>no</td>
<td>Yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

### Key Points in Understanding Evidence-based Practices

While many approaches ranking and labeling EBPs exist, a review of the literature suggests that the following four constructs represent critical features to be examined in determining the extent to which a program may be considered evidence based:

- **Standardization** – An intervention must be standardized so that it can be replicated elsewhere. Standardization typically involves a manual or book that clearly defines the practice and measures to assess if the intervention is being practiced accurately.
- **Replication** – Replication of research findings means that more than one study finds similar positive effects when consumers receive the service.
- **Presence of a Fidelity Scale** – A fidelity scale is used to verify that an intervention is being implemented in a manner consistent with the treatment model.
- **Meaningful Outcomes** – Effective interventions must show that they can help consumers achieve important goals or outcomes related to impairments or risk.
Implementation Issues for EBPs

Introduction of research-based service models and practice guidelines provided by skilled mental health providers offers the opportunity for improving treatment in everyday practice. Yet, the gap between science and practice is wide. Implementation of EBPs is challenging. Stigma, lack of awareness of effective treatment, inadequate supply of evidence based services and trained providers, and benefits/regulations that limit payments for EBPs all impact the use and availability of these services. Further, many of the EBP service models require consumer involvement to evaluate how these models can accommodate an R/R philosophy.

At the service delivery level, implementing EBPs requires an infrastructure – leadership to address barriers and require implementation – technical assistance to learn about service requirements – and measurement of fidelity to EBPs to support appropriate implementation and ongoing operations. Even where EBPs are available, their implementation is too often insufficiently faithful to the original model to achieve desired results. Calling a practice an EBP is not the same as actually implementing an EBP with fidelity, and fidelity to key processes is critical to ensuring positive outcomes. A host of structural and financial barriers hamper the wider dissemination of EBPs:

- Fears that EBPs are too expensive and that much-vaunted “cost-benefits” will not be realized.
- Consumer disinterest in EBPs that have coercive elements.
- Lack of fidelity to EBPs due to costs of certain staff required for the model, e.g., nurses in ACT teams.

To address these issues, we looked at the literature on establishing and evidence-based culture.

Evidence-based Culture

With more widespread implementation of evidence-based practices, there is growing recognition of the need for system or organizational infrastructures that will support the implementation and broad dissemination of evidence-based practices. Such infrastructures should have the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes. Dixon (2003) and Barwick and colleagues (2005) propose that the implementation of EBPs will be more successful in organizations that have an evidence-based culture.

Supportive state, local, and agency infrastructures should have the policy, procedural, and funding mechanisms to sustain EBPs. Dixon (2003) refers to this combination of infrastructure supports and favorable culture/climate as an “evidence-based culture,” and
suggests that the implementation of EBPs will be more successful in organizations that have an evidence-based culture (Rivard, et al., 2006).

An evidence-based culture is characterized by the following elements:

- Involves all levels of the system – state administrators, program managers, clinical supervisors, and clinicians in the implementation process;
- Begins with a thorough understanding of the current treatment system, the interventions that are utilized, and the outcomes being achieved;
- Includes a systematic approach to reviewing available evidence and recommending changes in intervention strategies as appropriate;
- Supports a reimbursement rate commensurate with the level of work required to implement new interventions;
- Provides reimbursement for the training and clinical supervision that are essential to implementation of evidence-based practices;
- Creates and maintains data collection and reporting mechanisms that will document evidence-based practice results;
- Develops and supports policies that facilitate adoption and implementation of evidence-based practices;
- Supports bi-directional communication between researchers and clinicians;
- Promotes an appropriate balance between fidelity and adaptation; and,
- Uses outcome data to drive systems change.

In keeping with this line of thought, members of the National EBP Consortium (Rivard et al., 2006), and all of the individuals interviewed for this document, expressed much concern that the increasingly common approach taken by many states (such as Washington and Oregon) of mandating the use of EBPs does not necessarily lead to improved outcomes and does little to help agencies, provider organizations, and their communities understand how best to select and implement EBPs. In addition, service providers often perceive that the mandated use of EBPs will restrict their ability to serve their clients in flexible, culturally competent ways. In order to make the most of the movement toward evidence-based thinking at the federal, state, and local levels, discussions are increasingly turning towards a systematic process through which communities are supported to select, implement, and sustain effective practices. Such a process would ideally be inclusive, strategic, and driven by the needs and culture of the community and its families.

New York State’s EBP implementation initiative reflects an understanding of the need to work towards an evidence-based culture (Carpinello, et al, 2002). New York has structured implementation in terms of three overarching phases: Phase 1 – Consensus Building; Phase 2 – Enacting; and Phase 3 – Sustaining. These phases are illustrated in the figure directly below. An example of a Phase 1 activity is reflected in the series of focus groups held by the Office of Mental Health in August 2001 to introduce the concept of Evidence-Based Practice to local government leaders, service providers, advocates, and recipients of service. Based on these sessions, cultural and structural changes
necessary for the implementation of Evidence-based Practices were identified. They provided the basis for designing an implementation plan with strategies for change. The Table 7 below comes from Carpinello and colleagues’ (2002) summary of these levels:

<table>
<thead>
<tr>
<th><strong>Implementation Strategies</strong></th>
<th><strong>Phase I: Consensus Building</strong></th>
<th><strong>Phase II: Enacting</strong></th>
<th><strong>Phase III: Sustaining</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Awareness:</strong> Encouragement and collaboration with our stakeholders</td>
<td>Identify and use a network of champions from local government, stakeholders, and advising groups</td>
<td>Using formal consensus-building projects to create a set of evidence-based demonstrations throughout the state (including Drake pilot sites)</td>
<td>Evaluate for widespread replication</td>
</tr>
<tr>
<td><strong>Education:</strong> Introduction and development of new quality initiatives</td>
<td>Produce introductory materials, include national EBP implementation strategies and quality outcome measures</td>
<td>Develop several ‘Centers for Excellence’ for ongoing research and education</td>
<td>Secure permanent funding for ‘Centers for Excellence’ statewide</td>
</tr>
<tr>
<td><strong>Structural and Clinical Improvement:</strong> Incorporation of quality measures into both individual practitioner and provider performance</td>
<td>Develop and test quality outcome measures using network of champions and demonstration sites</td>
<td>Develop fiscal and regulatory changes indicated during development and testing</td>
<td>Create a local level evaluative capacity to monitor performance against outcomes</td>
</tr>
<tr>
<td><strong>Continual Improvement and Support:</strong> Monitoring of quality measures and means for continuous upgrading</td>
<td>Use existing progress report structure to ‘test’ and initial series of performance reviews in selected EBP areas</td>
<td>Use performance data in selected EBP areas to make regulatory and funding decisions</td>
<td>Periodically revisit consensus building stages to identify and promote innovations</td>
</tr>
</tbody>
</table>

**Communities of Practice (COPs) (Barwick et al., 2004).** Closely related to the construct of evidence-based culture, the construct of Communities of Practice has been described as an effective strategy for facilitating readiness to implement practice change and EBPs on a grand scale. Barwick and colleagues summarize it as follows: “COPs are a strategy which can be used to roll-out evidence based practices, share knowledge about their application, and improve their relevance in various settings.”

Community of Practice is a group of people that share knowledge, learn together, and create common practices. An example of the institution of COPs can be found in the Province of Ontario, Canada. Seeking a strategy to quicken knowledge transfer and implementation of EBPs, nine communities of practice are being developed across Ontario to support the province-wide implementation of an intake screening tool and an outcome assessment tool (CAFAS) in 111 children’s mental health organizations located across nine regions. Implications of Communities of Practice include: possibility of quickening the pace at which EBP are transferred to practice settings, improve the relevance of EBP for specific settings and populations, and eventually lead to better outcomes for children and youth.

As described by the authors (Barwick et al., 2004), the strengths of COPs in improving public mental health systems for children and families may include:
- Bringing providers, administrators, and families together in the same forum several times a year,
- Potential for service providers to acquire knowledge from one another about the clinical utility and implementation issues related to these tools and thereby shape system change,
- Opportunity to share preliminary aggregate data as a motivator for implementation,
- Flattening of the communication hierarchy because staff level clinicians attend alongside managers and directors, and
- Each provider that attends and contributes data gets an individualized data report.

Challenges of COPs are also noted:

- Getting everyone to the table;
- Moving from an implementer-led to a group-led process;
- Creating trust and openness required for shared practice in a resource-weak environment; and
- Sharing of preliminary data is only as good as data provided.

Findings from the Expert Interviews on Implementing EBPs

The industry experts echo the strategies in the literature, recognizing that implementation of EBPs is an iterative process, occurs in a culture that promotes readiness to change, and offers guidance on how to change.

- The role of the state in supporting EBPs is a significant factor as to whether providers actually implement these practices. The necessity of providing funding for these services is critical. Training alone is not sufficient to facilitate change.

- The experts suggest the following strategies for financing EBPS: (1) provide start-up funds; (2) assure providers that the State/BH-MCO will continue to pay for EBPs (assuming fidelity and positive outcomes); (3) pay higher rates for EBPs; (4) use Medicaid funds to pay for components of EBPs that are eligible services, e.g., under supported employment, pay for the clinical services and case management through Medicaid and finance the employment components through state general funds; (5) use state plans and waivers to include rehabilitative services; and (6) fund peer-support services through Medicaid per Georgia’s approach.

- Instituting regular monitoring that does not rely on provider self-reporting is an important strategy to measure performance on EBPs, including FBMHS and R/R principles. As a first step, it is critical to require implementation of evidence-based fidelity measures for EBPs. The provider must use the fidelity measures to design the program/service and conduct regular internal audits. The state/county/BH-MCO should conduct or arrange for periodic independent reviews of fidelity at least for

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4 While focusing on Medicaid plans, amendment and waivers, it is important to assess the financing environment at CMS to determine the best course of action.
high-volume providers. Continued financial support of the program/service will be based on fidelity to the model.

- One interviewer suggested using public forums to review EBP outcomes and reported on the director of a managed care program being more concerned about having to report in public about progress on outcomes than having to pay a substantial financial penalty.

- Most experts agreed that using BH-MCO performance-based contracting that uses incentives and penalties and provider Pay-for-performance (P4P) initiatives that use both financial and non-financial incentives are effective tools for implementing EBPs.

- While some states have targeted introduction of specific EBPs and consumer run services, simple mandates to implement these services tend not to be successful.

- Provision of financial incentives, training, and identification of needs as perceived by consumers, families, and providers facilitate implementation of EBPs.

- It is important for leadership to use strategies that create visibility for EBPs:
  - Sponsoring demonstration projects that track outcomes and ROI and then disseminating the results statewide;
  - Setting standards that Counties/BH-MCOs adopt at least one or two EB condition-specific practice guidelines per contract year, including disseminating the guideline, monitoring compliance with the guideline, and building the guideline into care management and utilization management protocols;
  - Developing a “clearinghouse” for statewide activity and resources on EBPs;
  - Providing information to the public on EBPs and their availability within the state;
  - Giving priority for reinvestment funds to providers or consumer organizations that establish new or expand existing programs that are consistent with EBP and R/R; and
  - Tailoring implementation of EBPs so they are culturally competent, and disseminate information on innovations in culturally competent EBPs.

- Services must be organized with quality improvement in mind. This goes beyond initial training and credentialing EB service models or dissemination of EB practice guidelines to include plans to include monitor fidelity, including fidelity studies of EB models, site visits to monitor compliance of high volume providers, and care management audits to monitor incorporation of guidelines into the care management process.

Other States’ Strategies
A fuller discussion of other states’ strategies on specific evidence based practices is included in the sections on reducing reliance on state hospitals and developing family based mental health services. The materials reviewed from other states described briefly
below address methods for promoting EBPs. Some strategies result from legislative mandates or procurement requirements, while others focus on developing a culture of change through partnership with a University or through providing a financial incentive to providers. A combination of these types of strategies may be useful at various times through the development of EBPs. Whatever strategy selected by a state, both the literature and the experts emphasized the need for tools, resources, and an iterative climate that support implementation of EBPs.

Table 7 – State Strategies to Facilitate Development of EBPs

<table>
<thead>
<tr>
<th>State</th>
<th>Strategies for Network Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td>Targeted implementation of specific EBPs – Assertive Community Treatment (ACT), Integrated Dual Disorders Treatment (IDDT), and Illness Management and Recovery (IMR).</td>
</tr>
<tr>
<td>MI</td>
<td>Provided a financial incentive for providers that implemented an EBP.</td>
</tr>
<tr>
<td>RI</td>
<td>Through procurement, required mental health and substance abuse providers to partner and provide integrated treatment.</td>
</tr>
<tr>
<td>SC</td>
<td>Linked with University of South Carolina to oversee EBP and promising practice implementation and track outcomes – EBPs include MST, Family Preservation, ACT.</td>
</tr>
<tr>
<td>WA</td>
<td>Legislative mandate for Regional RSNs to develop EBPs and promising practices by age group: Adults – Illness Management; Children/adolescents – Wrap Around and Dialectic Behavior Therapy; Older adults – Gatekeeper for Older Adults and medication algorithms (MOSES).</td>
</tr>
<tr>
<td>VT</td>
<td>Community Action Group (CAG) funding to implement Integrated Dual Disorder Treatment (IDDT) as a best practice. Implemented Comprehensive Continuous Integrated Systems of Care (CCISC) as a systematic approach to engage agencies in the implementation of core practices of integrated treatment; Combines CCISC outcomes tools and IDDT fidelity tools.</td>
</tr>
</tbody>
</table>

Strategies for Strategies to Implement EBPs

The strategies below focus on overarching strategies to implement EBPs. The remaining sections of this report provide more specific detail.

Tools and Strategies

Establish tools/strategies for implementing and monitoring best practices:

- Establish a website/clearinghouse at the State level on state and national best practices, promising practices and innovations, and fidelity instruments.
- Analyzing claims and encounter data from BH-MCOs to identify overall and provider-specific trends, establish benchmarks, and target areas for focused studies. For example, identifying individuals who have multiple hospitalizations within a 3-month period and providing outreach through ACT.
- Through use of electronic tools, review prescription patterns and formularies to identify opportunities to introduce EBPs. (Several states and MBHOs routinely accept Rx data for their membership and apply clinical algorithms to identify pre-scriber
outliers or problem cases. The clinical algorithms target deviations from practice guidelines on a number of dimensions including medication adherence, inappropriate dosing, duplicate therapy within and across drug classes and/or due to multiple prescribers, inappropriate Rx for pediatric or geriatric populations, multiple doses per day, non-adherence to safety guidelines, Rx switching, contraindications, multiple prescribers, one time fills, drug-disease interaction, etc.).

**Funding**

**Strategies to enhance funding of EBPs and address funding barriers:**

- Target reinvestment dollars to EBPs.
- Develop financing transition plans to support parallel services while EBPs are being implemented, e.g., transition of consumers from Day Treatment to Supported Employment. This is similar to payment strategies developed by the Commonwealth for reallocation of state hospital funds to community services.
- Assess benefit designs and reimbursement methods for EBPs currently in use in the Commonwealth to identify barriers to the use of EBPs, as well as strategies to address them, e.g., if providers were to institute a depression screening guideline, would this be reimbursable under Medicaid or through state funds?
- Pay for service components of EBPs eligible for Medicaid reimbursement and reserve state and local funds for non-Medicaid reimbursable services, e.g., housing subsidies for supported housing.

**Attitudes/Messaging**

**Messaging Strategies for OMHSAS to Implement EBPs:**

- Establishing Communities of Practice (COP) to facilitate readiness to change and create and EBP climate.
- Collaborating with universities within the Commonwealth and elsewhere to establish special initiatives on implementing and monitoring fidelity to EBPs. Include consumers and families in the collaboration to assist researchers with incorporating R/R principles.
- Creating awareness of the importance of implementing EBPs and R/R through ongoing “state of the union” messages that deal with the iterative process of moving the system forward on R/R and EBPs.
References: Implementation Strategies for Evidence-Based Practices


Carpinello, S. et al. (2002). New York State’s Campaign to Implement Evidence-Based Practices for People with Serious Mental Disorders. Psychiatric Services, (53) 2.


[Available online at http://www.scattc.org/pdf_upload/Beacon003.pdf]


Reducing Reliance on State Psychiatric Hospitals and Improving Community Integration

This section of the report summarizes the findings from the literature and expert interviews on reducing reliance on state hospitals and increasing community integration for adults and older adults with serious mental illness who do not receive forensic inpatient services. We focus on organizational structures, services, interventions, and outcome measures shown to enable long-term residents of state hospitals to successfully transition and maintain the locus of their care in the community. Additionally, evidenced-based practices that permit state hospital diversion are explored.

There is also a specific focus on integrated treatment for co-occurring disorders because the frequency of co-occurring disorders is common for people with serious mental illness. Further, the paper summarizes interventions that address the cycle of arrests and incarceration of adults with psychiatric or co-occurring disorders that occur in the absence of effective services and community integration. To provide a context, we describe some of the lessons learned by the Commonwealth on downsizing its state psychiatric hospitals and a comparison of its utilization statistics with other states.

For ease of review, this section of the report begins with a discussion of general findings from the literature and then integrates findings from the literature and the expert interviews related to specific services and strategies that reduce reliance on state hospitals. We also provide a comparison of the 2004 Commonwealth’s state hospital utilization with other states. A description of lessons learned from the Commonwealth’s experience follows. We include a description of an EBP service array that enhances community tenure and reduces reliance on state hospitals. Mercer’s strategies for consideration by OMHSAS and its stakeholders are drawn from a combination of these findings and are included at the end of the section.
Findings from the Literature and Expert Interviews on Reducing Reliance on State Hospitals/Increasing Community Integration

Efforts to downsize or “right size” state psychiatric hospitals since the deinstitutionalization movement in the 1950s and the community mental health movement in the 1960s have been prompted by several factors:

Serious questions about the quality of care offered at state hospitals caused advocates to call for the provision of mental health treatment in non-hospital settings, particularly the institutionalization of individuals who reside at hospitals over the long-term. Institutionalization, defined as excessive dependence on the hospital, was evident in many long term residents.

In the 1999 Olmstead decision, the United States Supreme Court ruled that under the Americans with Disabilities Act (ADA), it is discriminatory for a state to needlessly institutionalize an individual with a disability. This ruling caused states to evaluate the adequacy of existing community resources and put plans into place to develop needed services that support community integration.

- Inpatient care is expensive\(^5\) and states receive little federal relief for these costs due to Medicaid’s Institutes of Mental Disease (IMD) exclusion; there is a financial incentive to provide services in the community.\(^6\)

- Consumer and family member voice has played a key role in moving the locus of behavioral health services from the state hospital to the community.

- The emergence of EBPs and newer medications has contributed to increasing community integration.

- Most recently, the call for implementation of R/R and the national call for transformation of mental health systems confirm the need for community integration for individuals with mental illnesses and/or addictions.

Funding has shifted toward community services. In 1981, sixty-three percent of mental health funding went to hospitals and thirty-three percent to community-based programs. By 2001, only thirty-two percent of funding was for hospital services and sixty-eight percent for community-based services.\(^7\) State psychiatric state hospitals continue to play a role in the behavioral health system of care for many states, but this role has yet to be uniformly defined.

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\(^5\) In 2004, the average expenditure per hospital day was $403.11, and the median expenditure per day was $371.62. Theodore Letterman, Vera Hollen, Robert Shaw, “Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 2002,” NRI, October 2004, p. 24.

\(^6\) Medicaid does not provide coverage for services provided to adults aged 22-64 in an IMD such as psychiatric hospitals and community-based residential facilities of 16 beds or more.

\(^7\) Managed care is credited with precipitating a similar reduction in private psychiatric inpatient beds.
The literature does not report on any definitive research that identifies the optimal number of state hospital beds for a population and states vary widely in the number of beds available. For example, review of state mental health websites indicates that Rhode Island does not have a state psychiatric hospital, only a general hospital with psychiatric beds; while New York has 27 psychiatric state hospitals. Population size, density and the availability of service alternatives are among the factors that impact state hospital beds. However, the literature does describe the EBPs and strategies for reducing hospitalization and increasing community integration.

Service Array to Reduce Reliance on State Hospitalization and Improve Community Integration

In 2001, SAMHSA identifies the following systematic barriers to community integration for people with mental illness:

- Lack of Income Support and Entitlements
- Lack of affordable housing
- Lack of comprehensive and supported employment
- Lack of access to appropriate healthcare
  - Trauma treatment
  - Use of new medications
  - Treatment for co-occurring disorders
  - Lack of access to services (e.g. wait lists, problems keeping appointments, location)
  - Transportation
  - Lack of coordination with physical health care
  - Lack of access in rural areas

The Surgeon General recommends the following services be included in a coordinated, comprehensive community-based system of care:

- Assertive community treatment (ACT)
- Case management
- Psychosocial rehabilitation
- Community alternatives for crisis
- Services for individuals with co-occurring disorders
- Consumer self-help, consumer-run services, and consumer advocacy
- Family self-help and advocacy
- Housing
- Income, education, and employment assistance
- Healthcare
- Integrated service systems
The evidence based service models recommended by SAMHSA include:

- Assertive Community Treatment (ACT)
- Illness Management and Recovery
- Standardized Pharmacological Treatment
- Family Psychoeducation
- Supported Employment
- Integrated Dual Diagnosis Treatment for co-occurring mental illness and substance use disorders (IDDT)

As noted in the earlier section on EBPs, there are both strategies and practices that promote R/R and community integration as well as service models that are noted as EBP. The discussion below focuses on both components.

**Assertive Community Treatment (ACT)**

ACT is an EBP service model that is provided by a team of social work, rehabilitation, counseling, nursing, and psychiatric professionals who deliver case management, assessment, employment and housing assistance, family support and education, substance abuse services, and other supports to individuals with severe mental illness, 24 hours a day, in non-traditional settings. The staff to consumer ratio is small (1 to 10), and the team actively engages individuals in treatment and monitoring.

There is consensus in the literature that ACT is a fundamental element of any behavioral health service delivery system that seeks to reduce hospitalization. Individuals with co-occurring disorders, and those who are homeless, are especially likely to need inpatient care and improve more with ACT than individuals who only receive standard case management when substance abuse is addressed.

ACT is an EBP, but its cost effectiveness has only been consistently demonstrated for high-cost users of service. For this group, ACT is associated with decreased hospitalization rates and improved personal safety, leisure activities, friends, and living situations. ACT is most effective in preventing hospitalization, but is not effective for promoting community integration when employed alone. Improvement in symptoms is not consistently reported, however. For less intensive service users, ACT is not cost-effective. ACT is also experienced by some consumers as intrusive and coercive.

Consistent with these findings, Wisconsin has developed “Comprehensive Community Services” (CSS) using certified county providers. The CSS provider delivers psychosocial rehabilitation services that include a broad range of flexible, consumer-centered, recovery-oriented psychosocial services to individuals who need more than outpatient therapy, but less than Wisconsin’s Community Support Programs (CSPs). (CSPs are based on the Assertive Community Treatment (ACT) model.) The National Alliance on Mental Illness (NAMI) praised Wisconsin’s broad county-based, community services for reducing reliance on state hospitals as evidenced by the absence of waiting lists for beds.
Case Management
Case managers coordinate service delivery and ensure continuity and integration of services. Case managers are essential in identifying the enrollee’s mental health needs, advocating and arranging for the delivery of appropriate services, and monitoring the consumer’s progress. Intensity of case management should match consumer need, however. Collaborative case management, rather than a “brokering model,” is recommended. Several studies have shown that consumer/peer case management is effective in improving outcomes. Research also indicates that case management alone does not reduce hospitalization. Appropriate and effective outpatient and community services must be available for case management to impact inpatient utilization. In fact, case management will increase rates of re-hospitalization without necessary community supports.

Psychosocial Rehabilitation Services
Psychosocial rehabilitation refers to a set of services that aim to restore the individual’s ability to function in the community and not only includes the medical and psychosocial treatment but also include ways to foster social interaction, to promote independent living, and to encourage vocational performance. Psychosocial rehabilitation programs combine pharmacologic treatment, independent living and social skills training, psychological support, housing, vocational rehabilitation, and access to leisure activities. Persons who receive psychiatric rehabilitation services have shorter hospital stays (Bianco and Milstery, 2001, p. 12).

Supported Employment, an EBP that focuses on increasing community and job tenure, is described below.

Supported Employment and Vocational Rehabilitation
Consumers are more satisfied with jobs that match stated preferences and are more optimistic about work chances than family and professionals. Based on her research and the research of others, Cook has identified six principles for vocational rehabilitation for persons with severe mental illness.
- Situational assessment is the best predictor of job potential.
- Clients prefer competitive or supported employment rather than sheltered or unpaid work.
- Rapid placement is better than lengthy prevocational training periods.
- Provision of ongoing vocational support is needed.
- Job development and support must be tailored to the individual’s preferences.
- Planning must include how changes in work status can alter disability income.
The Individual Placement and Support (IPS)

IPS is a model of supported employment found to dramatically increase competitive employment and job tenure among persons with SMI. This model of supported employment focuses on integration of rehabilitation with mental health treatment. Employment specialists are part of the mental health treatment teams with shared decision making. The employment specialist to consumer ratio is 1:25. In addition to mental health treatment, vocational services staff provide all phases of vocational services, including, engagement, assessment, competitive job placement (and finding), and follow-up supports.

Illness Management and Recovery

Mueser and Corrigan et al., in a review of 40 randomized controlled studies, discuss the positive outcomes of Illness Management (IM), a psychoeducational approach for mental illness self-management, whereby professionals provide information and strategies to people with mental illness to help them adhere to treatment, manage their symptoms, and minimize relapses and hospitalization. They discuss the importance of peer support services as an adjunct to Illness Management because peer support focuses on helping people cope more effectively with their mental illness and take care of themselves. Peers are able to share their experiences about lessons learned and coping skills in non-hierarchical relationships, plus provide role models for successful community integration.

Many states report that medication adherence is essential to maintaining an individual in the community. Peer support programs are particularly effective in assisting individuals with developing the motivation to participate in their recovery, including learning about and managing their medications. Behavioral tailoring strategies also help individuals develop a routine for taking medication that fits into their daily habits and included natural prompts to remind them to take the medicine. Approaches that stress motivational strategies to enhance medication adherence has also proven effective.

Consumer self-help and consumer-run services

The clinical benefits of peer services are clearly supported in the literature. Positive outcomes include, but are not limited to, increased social supports and community participation, improved self-esteem and illness management, access to vocational and other supports, and improved satisfaction with quality of life.

“Numerous studies have also shown that participation in self-help groups can significantly help people reduce the need for hospitalization.” For example, persons participating in the Depression and Bipolar Support Alliance described their groups as helping with communicating with their doctor, being motivated to follow instructions, and willing to take medication and cope with side effects. Those attending the group for over a year were less likely to have been hospitalized in the same period.

One study found that peer services were more effective than traditional services, particularly for individuals who may be alienated from the mental health system, such as
those that are homeless. In Schofield’s Bridge to Discharge project, consumers identified consumer-peer partnerships, peer support, and the desire to provide mutual support as critical to success (1991).

Standardized Pharmacological Treatment
The Schizophrenia Patient Outcomes Research Team (PORT) and the Texas Medication Algorithm Project (TMAP) are examples of standardized pharmacological treatment approaches for schizophrenia that addresses use of antipsychotics as well as other medications for side effects and co-existing symptoms. The Star* D Trials (Sequenced Treatment to Relieve Depression) funded by NIMH is another example of a standard approach to pharmacological treatment. Evidence from these treatment algorithms provides practical strategies for managing medications, based on medication trials.

Co-Occurring Psychiatric and Substance Abuse Disorders
SAMHSA reports that up to 65 percent of individuals with a substance abuse disorder also have a history of at least one mental disorder and about 51 percent of those with one or more mental disorders also have a history of at least one substance abuse disorder. Co-occurring disorders (COD) affect 7 to 10 million adults in the U.S. each year. These facts have facilitated the recognition of strategies to address COD and improve evidence-based practice in the management of individuals with COD. If one of the co-occurring disorders goes untreated, both illnesses usually will get worse, and additional complications arise (SAMHSA, 2006). The combination of these disorders can result in poor response to traditional treatments and increases the risk for other serious medical, behavioral, and social problems such as suicide, incarceration, unemployment, homelessness, and serious infections, such as HIV and hepatitis (Drake et al., 2001, SAMHSA 2006).

Both substance abuse disorders and mental disorders have biological, psychological, and social components; thus, treatment must be multifaceted. Yet, service delivery systems are fragmented and give different messages about treatment and recovery, often turning away people with COD. The substance abuse system may tell individuals to return only when their mental illness is treated and the mental health system may turn away people until their substance abuse is treated (Drake et al., 2001).

Drake et al. (2001) report the following barriers to implementing COD programs:
- Federal, state, and local infrastructures generally are organized to respond to single disorders, not co-occurring disorders;
- Mental health and substance abuse service systems often vie for the same limited resources;
- Funding mechanisms do not encourage flexible, creative financing to foster better service for people with COD;
- Lack of clear service models create program barriers;
- Limited availability of training in dual disorder treatment compounds erroneous beliefs held by mental health and substance abuse staff about appropriate assessment protocols and treatment; and
Consumers and families rarely have access to good information about dual disorders and appropriate services.

In an effort to address this serious and pervasive issue, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) developed a framework for addressing COD (2002, 2006). The framework provides a mechanism for addressing symptom severity and level of service system coordination on a continuum from less severe to more severe disorders and from consultation and collaboration to integration, respectively. The conceptual framework, displayed in a matrix format, specifies the level of service coordination needed by those persons in each quadrant. The four quadrants are:

- Low addition/low mental illness severity
- Low addition/high mental illness
- High addiction/low mental illness
- High addiction/high mental illness

The model provides a structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers (CSAT 2006).

NASMHPD and NASADAD released a report in 2002 citing important strategies that should be implemented to address COD, which included:

- Shared vision and established expectations concerning COD;
- Creation of model of integrated services to respond to community level needs with comprehensive service systems to meet the needs of individuals with COD;
- Incorporation of belief that co-occurring symptoms are expected, rather than an exception;
- Staff that are cross-trained in both mental and substance abuse disciplines, working as a multidisciplinary team within their field of expertise;
- Services are individually-oriented with staff engaged at various stages to offer acceptance and facilitate recovery.

The American Association of Community Psychiatrists (2006) suggests the following principles for defining a comprehensive continuous integrated system of care for persons with COD:

- Optimism and Recovery – Process by which a person recovers self-esteem, self-worth, pride, dignity, and meaning through increasing his or her ability to maintain stabilization of the disorders and maximizing functioning;
- Acceptance – Clinical contact that is welcoming, empathetic, hopeful, culturally sensitive, and consumer-centered;
- Accessibility – 24 hour services availability to provide welcoming and competent assessment and intervention for psychiatric and substance symptoms;
- Integration – Integrated conceptual framework for designing comprehensive service system with common language and common methodology and integrated treatment philosophy and approaches;
Continuity – Persons with co-occurring disorders should be regarded as having two or more co-occurring primary disorders, each requiring specific assessment and diagnosis and appropriately intensive treatment;

Comprehensiveness – Comprehensive, integrated continuous service system to address primary care and behavioral health treatment and social service needs;

Individualized Treatment – Effective intervention must be tailored to individual need;

Emphasis on Quality – Systems of care designed in accordance with established national standards;

Responsible System Implementation – Implementation plan which identifies priorities for and obstacles to change with defined objectives and outcomes for change and recommended strategies to overcome obstacles to achieving these objectives.

Best Practices

Early studies of dual diagnosis treatment interventions had disappointing results, most probably attributed to failure to address the complex needs of this population, as well as a lack of outreach and motivational interventions according to Drake et al. (2001). Studies more recently have demonstrated that Integrated Dual Disorder Treatment (IDDT) is successful in retaining individuals who have co-occurring disorders in substance abuse treatment, reducing substance abuse disorders, and reducing symptoms of mental disorders. IDDT involves integrated mental health and substance abuse treatment provided by one team within a single agency. Other key features of IDDT include: 1) stage-wise treatment over time, 2) client collaboration in the development of an individualized treatment plan to address mental health and substance use issues, 3) the use of motivational interviewing and treatment skills, and 4) targeted substance use counseling. The ultimate goal of IDDT is to address mental health and substance use issues so that people are able to live meaningful, satisfying lives. IDDT is discussed in more detail below.

The evidence base continues to grow regarding the effectiveness of interventions that respond to an individual’s stage of recovery and motivation to change. Such interventions focus on building a therapeutic relationship between the client and clinician, as well as services for other needs in the person’s life, including the need for housing and work (SAMHSA, 2006).

In Chapter 4 of the 2002 SAMSHA Report to Congress, the following interventions are discussed:

- Screening/Assessment with a “No wrong door” approach in which assessment occurs wherever an individual with co-occurring disorder presents. Assessments should address a broad range of medical, psychological, and social issues and be found effective in both the substance abuse and the mental health fields;

- Staged Interventions providing a valuable structure to match treatment with the needs of the individual;

- Psychopharmacological Interventions with appropriate consultation from addiction medical specialists;
Motivational Interventions (such as motivational interviewing that aims to tap into what motivates a person to change) identify with techniques matched to the client’s stage of recovery;

Cognitive/Behavioral approaches using strategies to identify and replace an individual’s irrational beliefs that arise from substance abuse or mental illness;

Modified Therapeutic Communities, an approach that focuses on creating structures and activities within residential environments to promote personal integration and recovery, leading to a culture in which individuals can learn from each other and grow from being a part of a community.

Assertive Community Treatment (ACT) adapted from traditional case management, with core components of community based service; assertive engagement and outreach; high intensity services; small case loads; continuous 24 hour responsibility; team approach; multidisciplinary team approach; and close work with community support systems;

Housing and Employment Services;

Consumer Involvement with consumers and recovering persons playing an active role in development and implementation of substance abuse and mental health programming;

Dual Recovery/Self-Help Programs like Double Trouble In Recovery, a 12 step oriented self-help group.

Another best practice approach is Comprehensive Continues Integrated Systems of Care for Individuals with Co-occurring Disorders (CCISC), which we discuss in more detail below.

**Funding**

In 2003, SAMSHA began funding Co-Occurring State Incentive Grants (CO-SIG) to enable States to develop and enhance their service system infrastructure and increase capacity to serve people with COD. Infrastructure enhancement activities may include: network building, aggregated funding planning, integrated management information systems, training, and technical assistance to provider organizations and development of coordinated intake/assessment/placement. The goal of the grant is to ensure the entire system of care develops welcoming, accessible, and comprehensive processes for service delivery in which each facility is, at a minimum, Co-occurring Competent to support the principle of a “no wrong door” approach to accessing quality services. An additional goal is to have all licensed mental health and substance abuse facilities become Co-occurring Disorder Competent over time.

In New Mexico, the COD service enhancement initiative involves a systematic approach to implement welcoming, screening, and improved data collection into contractual requirements for State Regional Care Coordination entities. The State made the commitment to remove data collection barriers and use block grant dollars to support integrated care. “Train the Trainer” groups were also initiated that facilitate training and system improvement on the program level in each region were also initiated. New Mexico
has incorporated Co-occurring Disorder Capable requirements in behavioral health program standards (Minkoff and Cline 2004).

**Findings from Expert Interviews on Co-Occurring Disorders**

Interviews were conducted with two expert researchers and clinicians who are published and well known for their contribution to EBP for management of co-occurring psychiatric and substance abuse disorders. The interviews covered strategies regarding the structure and implementation of programs to address the needs of co-occurring disorders. National experts included Kenneth Minkoff, MD, and Christie Cline, MD, MBA, PC.

The experts reiterated the importance of integrating values through a system-wide architecture to achieve transformation goals. The underlying important principles for R/R and COD are the creation of a welcoming relationship with engagement for people and their families. The values underlying successful management of COD are very similar to those needed for successful implementation of R/R and overall transformation of the MH system. The experts suggested that tools such as the Co-Morbidity Program Audit and Self Survey for Behavioral Health Services (COMPASS) (Minkoff and Cline, 2001) can be used to evaluate readiness of facilities and agencies to address COD, as part of a comprehensive effort to bring about culture change over multiple years. The tool is being updated to accommodate evaluative elements of COD, R/R, and cultural competency principles.

Drs. Minkoff advocates the use of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-occurring Disorders (CCISC) as an architecture or infrastructure to implement EBPs for managing COD. The CCISC model, as described by Drs. Minkoff and Cline is a model for organizing services for individuals with co-occurring psychiatric and substance disorders. It is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. This model is recognized by SAMHSA as a best practice for implementation systems that address treatment of co-occurring disorders.

The emergence of Integrated Dual disorder Treatment (IDDT) fits well with the CCISC model.

**Integrated Dual Disorder Treatment (IDDT)**

Integrated Dual Disorder Treatment (IDDT) is for people who have co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach helps people recover by offering both mental health and substance abuse services at the same time and in one setting. IDDT is a set of evidenced-based approaches for treating CODs, and consists of 14 components each of which has an empirical basis for promoting recovery from COD. SAMHSA’s toolkit on IDDT describes the following primary elements of IDDT:
stage-wise treatment that acknowledges recovery is a process;
- collaborative assessments with the individual that address both the substance use and mental health;
- motivational treatment to inspire hope of recovery;
- incorporation of family psychoeducation and self-help groups; and
- substance abuse treatment.

Fidelity to the 14 components of IDDT summarized in the Table 8 below is clearly tied through research to better clinical outcomes (Drake and Essock et al., 2001).

**Table 8 – IDDT Fidelity Domains**

<table>
<thead>
<tr>
<th>Table 8 - Fidelity Domain</th>
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<tbody>
<tr>
<td><strong>1a. Multidisciplinary Team</strong></td>
<td>Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team.</td>
</tr>
<tr>
<td><strong>1b. Integrated Substance Abuse Specialist</strong></td>
<td>Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT.</td>
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<tr>
<td><strong>2. Stage-Wise Interventions</strong></td>
<td>Treatment is consistent with each client’s stage of recovery.</td>
</tr>
<tr>
<td><strong>3. Access to Comprehensive Dual Disorder Services</strong></td>
<td>Clients have genuine access to five services: residential, supported employment, family psychoeducation, illness management, and ACT/ICM.</td>
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<tr>
<td><strong>4. Time-Unlimited Services</strong></td>
<td>Clients are served long-term, with intensity modified according to need and degree of recovery.</td>
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<tr>
<td><strong>5. Outreach</strong></td>
<td>Program demonstrates consistently well-thought-out strategies and uses outreach whenever appropriate, including housing assistance, medical care, crisis management, and legal aid.</td>
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<tr>
<td><strong>6. Motivational Interventions</strong></td>
<td>Clinicians who treat IDDT clients use strategies such as expressing empathy, avoiding argumentation, rolling with resistance, instilling hope, etc.</td>
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<tr>
<td><strong>7. Substance Abuse Counseling</strong></td>
<td>Clients in action or maintenance stages receive substance abuse counseling, including: 1) Managing use, 2) Relapse prevention, 3) Drug / alcohol refusal skills, 4) Problem-solving skills, 5) Challenging substance abuse beliefs, and 6) Coping skills.</td>
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<tr>
<td><strong>8. Group Dual Disorder Treatment</strong></td>
<td>Dual Disorder clients are offered group treatment specifically designed to address both mental health and substance abuse problems.</td>
</tr>
<tr>
<td><strong>9. Family Psychoeducation on Dual Disorders</strong></td>
<td>Clinicians provide family and significant others education about dual disorders, coping skills training, collaboration with the treatment team, and support.</td>
</tr>
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</table>
Table 8 - Fidelity Domain

10. Participation in Alcohol & Drug Self-Help Groups
Clients in the action stage or maintenance stage attend self-help programs in the community.

11. Pharmacological Treatment
Prescribers for IDDT clients prescribe psychiatric medications despite active substance use, work closely with team/client, focus on increasing adherence, avoid benzodiazepines and other addictive substances, and use clozapine, naltrexone, and disulfiram.

12. Interventions to Promote Health
Clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences, including teaching how to avoid infectious diseases, helping clients avoid high-risk situations and victimization, securing safe housing, and encouraging clients to pursue work, medical care, diet, and exercise.

13. Secondary Interventions for Substance Abuse Treatment Non-Responders
Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions.

Because over 50 percent of people with serious mental illnesses also have a substance use disorder, these services can be very helpful for increasing community integration. The research points out that individuals with COD have poorer outcomes, such as increasing psychiatric symptoms, homelessness, higher risk for relapse, institutionalization, difficulties in managing their lives, lower satisfaction with familial relations, increasing re-hospitalization rates, and greater risk of mortality (Primm, 2002). Thus, treatment of COD is critical to prevention of relapse and readmission, as well as to improve community integration.

Housing Supports
Consumers prefer independent accommodations of their own choosing that they do not have to share with other consumers (Holley, Hodges et al., 1998). They also prefer such settings over group residential treatment facilities (Siegel and Samuels, et al., 2006) (Owen and Jones, et al. 1996). A 1996 study that looked at housing services in Vermont, however, found that most individuals discharged from inpatient services were living in structured housing, while those with the highest needs for support were in structured residential settings. The authors hypothesized that community tolerance for community integration was not supportive of independent living. More recent housing options attempt to address stigma as well as providing a comprehensive range of services that support independence (Dewees and Pulice et al., 1996).

Supported Housing is well documented in the literature as being successful for people with mental illness, including those who are homeless (Hurlburt and Hough et al., 1996) and “even for consumers with characteristics indicating they would have been more likely placed in community residences” (Siegel and Samuels et al., 2006, p. 982). While
supported housing has worked for people with co-occurring disorders, research suggests that younger males with substance abuse issues have a higher level of housing instability (Hurlburt and Hough, et al., 1996, p. 731) (Drake and Wallach et al., 1989). Thus, it may be important to offer more intensive staffing support for people in active stages of substance use or addiction.

South Carolina has developed an array of housing options for individuals with long term or multiple hospitalizations called “Toward Local Care” or TLC. The housing options include:

- Independent Living
- Homeshare (adult foster care): Consumers live in a household with other than natural family members. Homeshare providers are screened, trained and participate in monthly support meetings. Respite services are also available.
- Supervised Apartments: Consumers live alone or with a roommate in an apartment complex with mental health center staff on site.
- Intensive Residential Program: 24-hour program for 6 residents with a one to three staff ratio.
- Transitional Group Living: Short term group living for crisis resolution or transitions.
- Closely Supervised Group Living: Staff on site for part of the day; services at mental health center.

Participants in TLC experienced a ninety-one percent reduction in admissions, a ninety-two percent reduction in days per admission and a statistically significant improvement in perception of quality of life (South Carolina Department of Mental Health).

**Crisis Services**

**Community Alternatives for Crisis Care**

To be effective, crisis services must be easily accessed 24-hours a day. Mobile crisis teams staffed to rapidly respond and compassionately facilitate resolution of crises are a cornerstone of successful crisis resolution in the community. Mobile crisis services must be backed-up with residential crisis services or short-term, acute care hospitalization. Twenty-three hour observation, day services, detoxification, respite care, and intensive in-home services should be part of the continuum. Outpatient therapy and medication management are also essential. Research suggests that when crisis services are provided in non-hospital settings, the likelihood of inpatient admission is reduced. Day hospital combined with crisis respite services has been found to be equally effective as acute hospitalization, but costs less (Sledge, Tebes, et al., 1995).

According to the St. Luke’s Health Initiative (2001), best practice components of comprehensive crisis services include:

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

Access to short-term intensive residential treatment resources for stabilization and hospital diversion.

Access to cultural and linguistic clinicians and translation services to facilitate assessment.

The Saint Luke’s Health Initiative named the Ocotillo Program in Tucson as a best practice model. Ocotillo is a crisis group home providing short-term counseling, psychosocial rehabilitation, nutrition counseling, mobility assistance, and behavior management 24 hours a day. Only thirteen percent of clients who participated with Ocotillo were hospitalized during a two-year evaluation period.

Also in Arizona, META (a peer-run services entity) contracts with the Regional Behavioral Mental Health authority to participate in the operation of urgent care centers designed to provide crisis stabilization and triage care in the context of a recovery-oriented approach to service delivery. The centers offer emergency psychiatric assessment for voluntary and involuntary treatment, 23-hour medical observation, and a few residential crisis beds for which stays range from three to five days. Referrals from family, police, fire, professionals, hospitals, case managers, and self-referrals are accepted. The environment is consumer-centered and non-coercive. Crisis plans and mental health powers of attorney inform service-planning.

Another innovation in crisis management was attempted in urban Detroit. Zeman and Arfken report that emergency room staff developed a focused medication management emergency service to replace the costly full assessments normally completed (2006). Implementation of the program resulted in decreased hospitalization rates and an increase in outpatient service utilization. Despite its success, the program was discontinued because of billing/coding problems.

Family Psychoeducation

This service is also identified in SAMHSA’s Toolkits as an EBP. Family psychoeducation is a method of working in partnership with families to provide information about their family member’s illness, help them develop coping skills, and enlist them in supporting the recovery of their family member. This service involves both educational workshops and problem-solving. Both the American Psychiatric Association and the Agency for Health Care Policy and Research cite family psychoeducation as one of the most effective ways to manage schizophrenia. The research indicates there is a significant reduction in relapse rates (by at least 50% of previous rates) when family intervention, multi-family groups, and medications are used concurrently. ³

³ SAMHSA’s Evidence Based Practices Toolkit on Family Psychoeducation
http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/.
Trauma-Informed and Trauma-Specific Care

Jennings, in a report sponsored by SAMHSA and the National Technical Assistance Center for State Mental Health Planning (NTAC), suggests that the majority of individuals served by public mental health and substance abuse systems have been exposed to trauma (2004). She reports that trauma associated with mental illness is often “interpersonal in nature, intentional, prolonged and repeated, occurs in childhood and adolescence, and may extend over years of a persons life.” The types of trauma include “sudden and traumatic loss, witnessing of violence, severe neglect, sexual abuse or incest, physical abuse, and severe emotional and psychological abuse” (2004, p. 6). Rosenberg et al. report violent victimization is “endemic among clients with severe mental illness,” including early trauma and retraumatization in the mental health system.

Post-traumatic stress disorder (PTSD) is the most common disorder resulting from trauma and is often untreated or treated with under-tested interventions (Jennings, 2001, p. 1453). Jennings’ review of the literature also reports individuals with traumatic experience may have various other diagnoses, including but not limited to borderline personality disorder, schizophrenia, and other psychotic disorders (Jennings, 2001, p. 1453). Data from research collected by Jennings suggests that 90 percent of individuals served by public mental health services have been exposed to (and most have actually experienced) multiple experiences of trauma. Further, the data from one state suggest that at least half of people with co-occurring disorders also report histories of trauma. (Jennings, 2004, p. 6)

Similar to our earlier discussion on implementing evidence based practices, a trauma-informed system creates a culture that enhances the development of policies and guidelines for organizations (e.g., state agencies) and for trauma-specific services. Trauma-informed services are those that “are not specifically designed to treat symptoms related to sexual or physical abuse or other trauma, but are informed about and sensitive to trauma-related issues present in survivors” (Jennings, p. 15). Trauma-specific services focus on the assisting individuals to address symptoms resulting from the abuse or trauma.

In addition to Jennings review of the literature, she studied over 50 trauma-informed organizational approaches and services being implemented and tested in various states (2004). These initiatives range in status from having some research-based evidence demonstrating successful outcomes to having no research. Most studies were quasi-experimental. Those with some research-based evidence (emerging or promising practices) or under study are listed below:

**Trauma-informed Service Systems/Organizational Approaches**

- National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and coercion Free Mental Health Settings – 17 module, 2-day training sponsored by the National Association of State Mental Health Directors and
designed for executive and middle management staff. The training includes development of an individual facility prevention plan to reduce seclusion and restraint. An evaluation study of the first eight states participating in the training demonstrated that the incidents of seclusion and restraint events decreased by as much as 68%.

- The Sanctuary Model® is a trauma-informed method for changing an organization’s culture to promote healing from psychological and social traumatic experience. Originally developed in an acute inpatient setting, it has been adapted for use in longer-term state hospitals and private psychiatric hospitals, as well as for children in residential settings. Other settings include domestic violence shelters, group homes, outpatient settings, substance abuse programs, and parenting support programs. Research includes two studies involving adults. One study found the Sanctuary Model® coupled with a therapeutic community approach at a 28-bed 6-week, inpatient treatment program reduced the symptoms of PSTD from admission to discharge. Another study in an adult inpatient program found that seclusion and restraint were significantly decreased. Mechanical restraint was virtually eliminated. Use of locked seclusion decreased from 50 annual episodes, to one episode in the last eleven months of the study.

Trauma-Specific Service Models

- Seeking Safety is an integrated treatment designed to address safety and recovery for individuals with PTSD or histories of trauma and substance abuse. Twenty-five topics are included in its design, focusing on cognitive, behavioral, interpersonal and case management domains. Designed for use in a variety of settings (substance abuse, mental health, correctional facilities), each of the twenty-five topics can be used flexibly, depending on the needs of participants, and in individual and group treatment. Jennings reports that this model is the most empirically studied treatment for trauma/PTSD and substance abuse. One of the 9-sites selected by SAMHSA’s Women, Violence and Co-occurring Disorders study, this model also shown positive results from seven outcome studies, including two with randomized trials. Additional national research is underway (2004, p. 30).

- TARGET is gender-specific individual or group treatment for 12-16 sessions that focus on teaching self-regulation skills. The model teaches skills for processing and managing the trauma-related components of current stressful experiences (e.g., PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, existential/spiritual alienation. Research Status: Three randomized studies are underway. Preliminary results suggest this model is effective. One randomized trial found that TARGET and trauma informed usual services were equivalent in achieving reductions in depression, anxiety, post-traumatic stress, post-traumatic cognitions, and substance use which were sustained at an assessment 12-months following entry to the study, and TARGET was superior to trauma informed usual care in sustaining participants’ self-efficacy related to addiction recovery.
Addiction and Trauma Recovery Integration Model (ATRIUM) is a peer or professional led 12-week group for adults who are survivors of sexual and physical abuse; those with substance abuse and other addictive behaviors; those who are actively engaged in harmful relationships, who self-injure, and have serious psychiatric diagnoses; and those who may be violent toward. The curriculum emphasizes cognitive-behavioral and relational treatment, also blending in psychoeducational process and expressive activities. Research Status: ATRIUM was one of 9-sites studied by the SAMHSA Women, Violence, and Co-Occurring Disorders Study and showed positive effects for trauma treatment and better treatment outcomes related to mental health and substance abuse.

Beyond Trauma: A Healing Journey for Women, developed by Stephanie S. Covington, is a group psychoeducational model for women’s treatment that is trauma specific and addresses the connection between trauma and substance abuse. The model teaches about trauma and its impact on the inner self (feelings, beliefs and values) as well as on the outer self (behavior and relationships, including parenting). The curriculum includes eleven sessions and uses a strengths-based approach and cognitive-behavioral techniques (CBT). Research Status: An evaluation and outcome study is underway funded by the California Endowment.

The Trauma and Recovery Group: Cognitive Behavioral Therapy Approach for PTSD in People with Serious Mental Illness was developed by Stanley Rosenberg and Kim Mueser at the Dartmouth Psychiatric Research Institute. The model uses a 16-session one-to-one psychoeducation intervention for women or men with severe mental illness and PTSD and is intended for use in outpatient or inpatient psychiatric services. It uses relaxation exercises and cognitive restructuring to help individuals understand trauma and its effects, focusing on here-and-now coping skills to manage intrusive memories. Research Status: This service has not been tested in a controlled trial, but data collected on 50 individuals in rural and urban community mental health settings suggest that participants show substantially greater improvement in PTSD and depression than people participating in fewer sessions or dropping out.

Triad Women’s Group Model, also a SAMHSA Women Co-Occurring Disorders and Violence Study site, is a 16-session cognitive behavioral group that focuses on specific goals and objectives related to reducing psychiatric and trauma-related symptoms associated with histories of violence/abuse and substance use. Research Status: Results of the SAMHSA study suggest this integrated treatment model achieves better outcomes than treatment as usual.

Next Steps for Implementation of Trauma-Informed and Trauma Specific Services
People with mental illness and co-occurring illness served by the public mental health systems have a high rate of trauma histories. The call to have trauma-informed systems of care and trauma-specific services is echoed in research, public policy directives, and in
the ongoing testing of emerging and evidence based practices. To further recovery of consumers and trauma survivors resulting from coercive measures (e.g., seclusion and restraint) or professional misunderstanding, the impact of trauma must be addressed. The following considerations are categorized by organizational level and service specific tasks.

**Organizational Level Tasks – Considerations for Next Steps:** The literature summarized in this section emphasizes the need for state mental health agencies and other organizations to operate trauma-informed systems. Strategies could include the following tasks:

- Collaborate with other public agencies (e.g., criminal justice, social service/child welfare, substance abuse, public health) to promote a culture that understands trauma, identifies and enhances trauma-informed approaches, develops policies, addresses workforce issues and training, and develops trauma-specific services.
- Include trauma-specific services as part of the service array.
- Develop strategies to conduct early screening of trauma in mental health systems and across other public service organizations.

**Trauma Specific Services: Considerations for Next Steps**

- Follow the research on the trauma-specific services to identify evidence-based and promising practices.
- Focus on providing components of trauma-specific services that have promising results or are evidence-based:
  - Early screening for trauma histories
  - Cognitive-behavioral approaches
  - Psychoeducation
  - Integrated treatment
- Implement an evaluation component to any new trauma-specific services to contribute to the evidence on their effectiveness.

**Pennsylvania’s Experience and Results from Interviews with Other States**

Mercer selected four states for interview: Arizona, Massachusetts, Michigan, and Ohio. The criteria for the selection of states was based on information from the literature, Mercer’s knowledge of the states, and 2004 CMHS Uniform Reporting System Output Tables on state hospital utilization. Arizona and Michigan reported lower state hospitalization utilization rates and lengths of stay than Pennsylvania in 2004. (Ohio did not report any data in the CMHS Table. However, the Ohio system is noted for its focus on community integration.) We also interviewed Massachusetts, a northeastern industrial state with a similar SH utilization statistics for comparison purposes.
Table 9 below summarizes the state hospital utilization data from these states:

### Table 9 – State Hospital Utilization

<table>
<thead>
<tr>
<th>State</th>
<th>SH Utilization Rate (a)</th>
<th>Average LOS, DC (b)</th>
<th>Average LOS by Resident (c)</th>
<th>Median LOS, DC (d)</th>
<th>Median LOS, Resident (e)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>.29</td>
<td>573</td>
<td>2386</td>
<td>134</td>
<td>936</td>
</tr>
<tr>
<td>AZ</td>
<td>.13</td>
<td>243</td>
<td>886</td>
<td>86</td>
<td>806</td>
</tr>
<tr>
<td>MA</td>
<td>.26</td>
<td>254</td>
<td>254</td>
<td>71</td>
<td>378</td>
</tr>
<tr>
<td>MI</td>
<td>.19</td>
<td>58</td>
<td>197</td>
<td>31</td>
<td>243</td>
</tr>
</tbody>
</table>

(a) State Hospital Utilization Rate per thousand; (b) Average Length of Stay for Discharged Patients; (c) Average Length of Stay for Resident Patients; (d) Median Length of Stay for Discharged Patients; (e) Median length of Stay for Resident Patients

In 2004, Pennsylvania served 168,523 individuals in its substance abuse and mental health community system; 3,608 of them in state hospitals for a hospital utilization rate of .29 per 1,000 population. (The national hospital utilization rate was .61 per 1000.) Pennsylvania’s state hospital admission rate (.45) and readmission rates (8 percent at 180 days) were lower than the national average (1.02 and 20.4 percent respectively), but the admission rate for adults to other inpatient facilities (1.54) was higher than the national average (.84). Further, the median and average lengths of stay (LOS) for discharged and resident state hospital clients were significantly higher than the national median and average LOS as illustrated in the table below.

### Table 10 – Pennsylvania's Median and Average Lengths of Stay Compared to the US

<table>
<thead>
<tr>
<th></th>
<th>Median LOS Discharged Clients</th>
<th>Median LOS Resident Clients</th>
<th>Average LOS Discharged Clients</th>
<th>Average LOS Resident Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>134</td>
<td>936</td>
<td>573</td>
<td>2386</td>
</tr>
<tr>
<td>US</td>
<td>54</td>
<td>266</td>
<td>153</td>
<td>815</td>
</tr>
</tbody>
</table>

Taken together, these data indicate that individuals in Pennsylvania state hospitals in 2004 were discharged at a slower rate than in other parts of the country and had longer lengths of stay. In addition, those with the longest lengths of stay were less likely to be discharged than those who have been hospitalized for shorter periods of time. There are waiting lists for some Pennsylvania State Hospital beds, likely contributing to artificially lower than average state hospital admission and readmission rates and higher than average admission rates at other inpatient facilities.

The experts in Ohio and Arizona stated that the most important factor in preventing readmission to state hospitals is whether the individual has meaningful activity that keeps him or her busy during the day. Work, training, school, peer support, clubhouses, community programming or leisure activities can provide this structure, but productivity is necessary to community integration.
Strategies Employed During the Closure of Pennsylvania State Hospitals

Since 1955, Pennsylvania has closed 12 state psychiatric hospitals. “Lessons learned” point to various strategies used by OMHSAS and the counties that were helpful to reducing reliance on state hospitals:

- Each individual residing in a state hospital was individually evaluated and community services were agreed to by the consumer, family and advocate.
- Annual funding was available to establish and continue community services through redirection of hospital funds, increases in federal financial participation (FFP) and state funds.
- Community treatment teams (CTT) were central to maintaining community placement. The CTTs, comprised of former state hospital employees (and salaried by the Commonwealth), provided intensive case management with a strong medical and psychiatric orientation, emphasis on 24-hour, community-based services and symptom reduction, followed by addressing social and environmental issues.\(^9\)
- Residential facilities consisted of supported apartments, group homes or scattered apartments and structured long-term residences. Some clients lived with family or independently with the CTT supports.
- A hospital diversion system including an emergency evaluation center (EEC) was developed to provide medical and psychiatric evaluation, short-term respite and stabilization services.
- Mobile emergency teams (MET) provided 24 hour crisis prevention and intervention services.
- Access to extended acute care beds was created in two general hospitals with an average length of stay of 98-106 days.
- Long term structured residential care facilities (LTSRs) were created, each with less than 16 beds that provided therapy and rehabilitation, rather than hospital or nursing care, in a secure setting.
- Intensive care residential facilities (ICRRs) were supervised group homes for 6-18 residents that focused on community-living skills development.
- Subsidized housing became available and was supplemented by community mental health services, social and vocational programs, and support services for families.
- A consumer satisfaction team was developed in one county to assess quality of services.
- Federal financial participation increased by 300 percent for services provided to former state hospital residents providing a funding base for ongoing services.
- A centralized database permitted enrollee tracking for follow-up

State hospital bed allocations are operational in some counties and rigorous utilization management occurs, including authorization of payments by the county administrators.

While some of the above strategies have changed over time, they include essential element for the future “right-sizing” of state psychiatric hospitals:

- individualized plans of care
- ongoing funding for community resources
- availability of CTT and intensive case management
- consumer involvement in quality management
- access to crisis management services
- residential supports

Merely making these services available is insufficient to impact hospitalization rates and increase community integration, however. If these evidenced-based practices are delivered in a fragmented manner, without fidelity to the model and appropriately aligned financial incentives, they will not be effective. Further, failure to take into account and address stigma and community resistance to deinstitutionalization will also decrease the changes of success. Examples of effective strategies are described below.

Educating the public on mental illness in communities where housing is located is insufficient to foster acceptance of people with serious mental illness. If housing is located near state hospitals, improving facility outcomes about issues such as escapes, of lack of housing support is likely to have a more positive impact on attitudes (Wolff and Stuber 2002). Engaging in public dialogue and being a “good neighbor” can enhance acceptance.

Finally, if individuals must be readmitted for inpatient services, readmission to the same facility has been shown to reduce the length of stay (Geller, Fisher, et al., 1998). In Michigan, mental health centers function as BH-MCOs. They make provider funding contingent upon fidelity to evidenced-based practice models. Further, providers who start up evidence-based services receive an upfront allocation of $70,000 to encourage development.

**Strategies that Avoid Unnecessary Hospitalization**

**The Importance of After Care.** Linking individuals with after care and assuring follow through reduces rates of re-hospitalization and decreases lengths of stay. The rate of readmission increases overtime for patients who do not keep outpatient appointments (Nelson and Maurish, et al., 2000). Persons who lack 24-hour follow-up services after discharge are more likely to be recidivists or lost to follow-up than others Yeaman and Gambach et al., 2003). One study found that if there was an outpatient contact in the sixty days following discharge, the readmission rate was only .3 percent. No outpatient contact was associated with an 18 percent readmission rate (Zahniser and McGuirk 1995).
Direct communication between inpatients and new outpatient service providers facilitates transition and increases the likelihood of attendance (Olfson and Mechanic 1998). Persons with psychotic symptoms, co-morbid substance abuse and personality disorders are less likely to follow through with aftercare and more likely to return to the hospital post-discharge. Targeting these individuals for pre-discharge contact with peer support specialists, case mangers, and outpatient providers may improve transitions. Tracking aftercare compliance may be equally important in reducing readmission rates. When Indiana closed Central State Hospital in 1994, researchers found that requiring providers to report monthly regarding each discharged client’s location, service contacts and clinical status and making funding contingent on timely reporting was associated with no one being lost to follow up (McGrew and Wright 1999). Increasing provider accountability for follow-up activities, with financial incentives to do so, may be an important strategy that increases community integration.

The Maricopa County BH-MCO has a tracking mechanism. A computer program identifies individuals with serious mentally illness who miss clinic appointments for outreach. Follow-up by telephone, in-person wellness checks and in-home visits by professionals who can provide medication may occur depending on the needs of the individual.

**Providing Access to Primary Health Care.** Experts also reported on the need for access to primary health care for people with serious mental illness that tend to have: Complex health needs.

- Higher mortality rates at earlier ages than the general population.
- Poor health status.
- Higher use of emergency room services and hospitalization due to the lack of physical health care when an illness or injury could be treated earlier.
- Lower utilization of routine health care.
- Limited follow-through on health plan enrollment, selection of a primary care physician (PCP), and scheduling physical health care appointments.

Models that emphasize integrated treatment approaches or assistance with linking individuals with primary care physicians were recommended. The Mental Health Community Reentry Program in Springfield, MA serves about 150 individuals with serious mental illness. Within the last few years, the agency became increasingly concerned about unmet physical health needs of their consumers. They designed an integration model that focused on co-location of a nurse practitioner at the mental health site.

- The Massachusetts Department of Mental Health (DMH) provided advance funding for a physical exam table, sink, and other basic requirements that resulted in setting up an exam room at the mental health agency’s main residential office.
Baystate Medical Center operates a number of neighborhood health clinics and a freed up a Nurse Practitioner to be on site at the Community Reentry Program one day a week for four hours: usually 9:00 AM to 1:00 PM.

Consumers recently discharged from psychiatric hospitals who prefer to enroll in a health plan or select a PCP may need assistance with enrollment and PCP selection.

**Admission Gate-keeping.** The experts interviewed agreed that one of the most effective strategies for reducing reliance on state hospitals and increasing community integration is the implementation of an effective gate-keeping function for state hospital admissions that is implemented by an entity at risk or otherwise financially responsible for services.

In Michigan, the community mental health agencies serve as the MC-BHO. They are at risk for and preauthorize all state hospital care. In Arizona, the BH-MCO is the gatekeeper. The BH-MCO is not at risk for state hospital services, but financial sanctions can be imposed if state hospital census is too high. Each year in Ohio, the county boards submit anticipated state hospital utilization, set a hospital rate and buy bed days. Funds are provided to the state hospital up front. The county boards are functionally at risk for state hospital services.

This gate-keeping function must be supplemented with a comprehensive crisis response system that operates around the clock. An array of housing options with varying degrees of supervision must also be available. Recommendations for local control were also consistently made.

**Strategies to Enhance “Discharge Readiness”**

The literature identified several strategies that can be implemented by a state hospital to reduce reliance on the hospital and increase community integration, especially for those long term residents suffering from institutionalization. One study found that implementation of a therapy group over a year and a half, utilizing a non-directional approach that was reality-based, focused on strengths, accepted participants’ fears, instilled hope, taught self-advocacy and was non-judgmental resulted in the successful discharge of five of seven members initially resistant to discharge and the group (Vijayalakshmy and Russell, 2006).

Hospital staff must have and communicate hope for discharge to be successful. Creating a climate where patients experience success and competent demonstration of life skills (e.g. practicing riding the bus) in the community was associated with effective community reintegration. Visiting a new residence before discharge reduces discharge anxiety. Encouragement of friendships with former patients and others promotes social familiarity. Relapse prevention training effectively reduces relapses and re-hospitalizations (LeClerec and Lesage et al., 2000).
Several authors found that hospital staff was also resistant to discharge (Berkman et al., 2006; Bellus et al., 2000; Deci et al., 1995). Deinstitutionalization had resulted in demoralized employees, overcrowding, inadequately funded services, lack of performance standards and unsustainable efforts at rehabilitation. Outside consultants provided training and education for staff regarding rehabilitation philosophy, group facilitation and communication skills, effective discharge planning, how to implement a community re-entry module and reduce symptom severity through cognitive behavioral programs. The process was long and had mixed results.

Early case management and discharge planning support community reintegration. In Ohio, the case manager receives an email before admission that an individual is being admitted. The individual’s existing housing is held and the case manager participates in discharge planning on the date of admission. In Arizona, the BH-MCO employs a full time discharge planner who works with the State Hospital. If necessary services are not available, the BH-MCO issues an RFP to local providers to solicit bids for the recommended aftercare services.

Lastly, the role of the state hospital must be clearly defined in the continuum of care and communicated widely (Hunter, 1999). It should NOT be a placement of last resort. In each of the states interviewed, state hospital services were clearly defined. Ohio’s state hospitals are used only for acute care and stabilization. Michigan’s hospitals provide long term treatment. The Arizona state hospital is only used for active treatment purposes that cannot be provided in another setting. Treatment goals, rather than placement issues, are a requirement for Arizona state hospital admission.

In Ohio and Michigan, state laws support the limited role of the state hospitals. In Ohio, individuals are “probated” to county boards rather than facilities for involuntary treatment. The county boards determine what services are needed. In Michigan, least restrictive environment laws move care into the community. In Arizona, a long standing court case and associated BH-MCO contractual requirements to reduce the number of state hospital patients encourage deinstitutionalization.
Strategies to Address the Needs of Older Adults

As discussed in early sections of this paper, there is more limited information on EBP toolkits for older adults with mental illness. Yet, the literature provides some useful guidance. Aupperle et al. (1998) discuss underutilization of mental health services by older adults who tend to present at their primary care settings or at the emergency room rather than at specialty mental health clinics. Practical and attitudinal barriers, such as lack of a social support networks and/or transportation, affordability, and stigma contribute to underutilization of services.

Kohn et al. evaluated the feasibility of using a multidisciplinary psychiatric mobile team for homebound elderly and found the team approach appeared to lessen psychiatric disability (2002). The mobile team included psychiatrists, nurses, social workers, and aides. The team addressed pharmacology, psychiatric treatment, and medical and social needs. Their rationale for mobile teams is based on the conclusions that “elderly patients are more reluctant to seek out psychiatric care” and “less likely to recognize the signs and symptoms of mental illness” (Kohn et al., 2002, p. 469). Professional attitudes toward aging and mental illness also may also be barriers toward provision of appropriate psychiatric care. Physical disabilities may also limit access to clinic based care. The need for mobile outreach and treatment programs for elders, especially homebound elders, is highlighted by the authors, particularly because homebound elders are at greater risk of mental illness. They suggest mobile treatment is appropriate for “those who are homebound for psychiatric reasons, medical reasons, physical disabilities, or those who are non-compliant in traditional psychiatric settings” (Kohn et al., 2002, p. 470). Their findings suggest that hospitalization and institutionalization can be prevented, similar to the outcomes of assertive outreach and treatment programs for the non-elderly population.

Another promising practice is the Gatekeeper program, a community-based system of proactive case-finding across professionals and other that frequently come into contact with older adults. The model provides early identification of persons at risk for substance abuse or mental health needs. The program has been documented to target clients that were “more frequently socially isolated, economically disadvantaged, more likely to live alone, less likely to have physical health problems, less likely to have a physician, and had greater service needs at the time of referral” (Bartels et al., 2005, p. 15). Outcomes after one year showed Gatekeeper-referred clients did not need or use more services than those referred by other sources, and evaluations report that the model is relatively inexpensive to implement and benefits communities through increased collaboration among service providers.

Bartels et al. (2002) report the prevalence of any mental disorder in older adults is at least one in five persons and project the number of people older than 65 with psychiatric disorders in the U.S. will more than double by 2030. Van Citters and Bartels, in a systematic review of randomized controlled trials, uncontrolled cohort studies and quasi-experimental outcome studies emphasize the importance of multidisciplinary psychogeriatric outreach and treatment services. They suggest “untreated mental illness has a significant impact on health, functioning, and health service use and costs” (Van
Citers and Bartels, 2004, p.1273). Key findings of their review of randomized controlled trials, uncontrolled cohort studies and quasi-experimental outcome studies emphasize the importance of multidisciplinary psychogeriatric outreach and treatment services (such as the Gatekeeper program). The also found that outreach (such as the Gatekeeper program) alone was not as effective as providing home-based mental health treatment by trained mental health clinicians (2004).

Gallo and Lebowitz discuss the importance of addressing late-life mental disorders that are common in the community to minimize the effects of mental conditions on disability, promote use of health care services, and improve the quality of life for older adults and their caregivers, particularly as the U.S. population ages. They suggest the need to assess cultural factors and risk for mental disorders in older adults, and emphasize three themes to help with treatment of late life disorders: 1) attention to the effect of disorders on functioning; 2) prevention of the consequences of mental disorders; and 3) integration of mental health care and primary health care services. They particularly emphasize the importance of cross collaboration among specialties with integration of mental health into a general medical framework for this population (1999).

The Institute of Medicine’s (IOM) report “Improving the Quality of Health Care for Mental and Substance-Use Conditions” notes that “co-location of multiple services (mental, substance and primary care services) is a frequently cited feature of many care collaboration programs” (IOM, 2005, p. 218). Further, the report suggests strategies such as co-location and improved integration of treatment are important due to the frequency of co-occurrence of chronic medical diseases such as diabetes, heart disease, neurologic illness, and cancers. The IOM referenced work on post-myocardial infarction depression by Bush et al., which found “a significantly increased risk of death” for persons with depression post heart-attack (1995). Outreach and mobile outpatient treatment are strategies to enhance cross collaboration and integrated treatment and reduce both psychiatric and medical disability.

Housing is also a gap for older adults who may lack the resources to live independently. Thus, collaboration with primary care and long-term care systems to provide options that support elders in their home as an alternative to institutional care are important.

Strategies to Prevent Criminalization of People with Mental Illness

The OMHSAS Forensic Work Group draft report (August 2006) outlines a set of goals, priorities, and strategies for improving the response to people with mental illnesses involved in the criminal justice system in Pennsylvania. The report emphasizes the need for collaboration among mental health organizations and the criminal justice system to increase:

- treatment options for individuals with mental illnesses involved in jail, prison, and community corrections
- opportunities for cross training;
- communication and data sharing between the mental health and criminal justice systems

The report also describes best practice models and services in Pennsylvania for people with mental illness involved in the criminal justice system, including those with formal evaluation components. Efforts to develop, evaluation and replicate best practices are underway. Thus, we will focus our discussion on the following areas:
- Sequential Intercept Model recommend by the Forensic Work Group to collaborate with the criminal justice system on treatment of people with mental illness.
- Barriers to implementing R/R in collaborative criminal justice and mental health initiatives.
- Strategies to promote R/R in collaborative efforts.

The Forensic Advisory Workgroup report emphasized the need for diversion programs, focusing on the Sequential Intercept Model (Munetz and Griffin, 2006), which highlights key intercept points related to criminal justice contact where diversion efforts can be targeted. These include:
- Law enforcement and emergency services
- Initial detention and initial hearings
- Jail, courts, forensic evaluations, and forensic commitments
- Re-entry from jails, state prisons, and forensic hospitalization
- Community corrections and community support services (Munetz and Griffin, 2006, p. 545).

**Sequential Intercept Model:** The sequential intercept model provides a useful framework for OMHSAS and counties seeking to collaborate with criminal justice and to systematically address both decriminalization of people with mental illness as well as prevent criminalization. Communities can choose to focus their collaboration at any one of the intercept points as a start to addressing a comprehensive approach. It also provides a frame work to consider recovery principles. Underlying this model is the concept that “best clinical practices” are the “ultimate intercept” to prevent criminalization of individuals with serious mental illness (Munetz and Griffin, p. 545). Thus emphasis on early intervention approaches such as collaboration with law enforcement on emergency services and crisis intervention is critical and can provide successful diversion. Yet, revolving door use of criminal justice system by people with mental illness suggests the need for a sequential intervention model where at any point along the criminal justice continuum, mental health treatment is available to both prevent recidivism and address mental health rehabilitation.

**Adoption of R/R Principles in Criminal Justice Systems:** The introduction of R/R concepts is difficult for mental health organizations. In criminal justice agencies, where there is an element of coercion resulting from the nature of criminal justice and infractions of the law, special effort to facilitate understanding of R/R is necessary. Further, the cultures of criminal justice and mental health systems are very different and require extensive collaboration to understand respective goals and operating standards, as
summarized well in the following quote from the literature: “Criminal justice systems favor the needs of society and the legal system that employs them while mental health professionals are trained to put the interests of their clients first…” (Ashford and Sales, et al., 2001, p. 31).

In the criminal justice system, the focus of aftercare (probation and parole) is control and surveillance, not rehabilitation (Ashford, et al., p. 375). Decisions about aftercare involve assessment of risk to community safety, and the criminogenic needs and responsivity of the individual. The mental health system focuses on treatment and rehabilitation to help individuals live in the most integrated community setting. Under an R/R model, coercion, (such as mandated treatment overseen by a court or probation/parole officer) is not the desired service option. EBPs that address this tension and promote recovery while operating in close collaboration with the legal system are yet to be developed.

Individuals with mental illness that have entered the criminal justice system have clear needs for rehabilitation, not only to address their mental illness but also their infractions of the law. If an individual becomes acculturated to a criminal lifestyle, treatment must also target criminogenic factors. Yet, when control and surveillance are integrated with treatment and there is more surveillance, there may be an increase in probation violations (Feder, 1991; Heilbrun and Griffin, 1993). This can result in a return to jail and further criminalizing the individual when the cause of the violation may have been an exacerbation of their illness and not criminal intent.

Thus, collaborative efforts between criminal justice agencies and mental health, such as mental health courts and forensic assertive treatment teams must broaden their responses to individuals with serious mental illness who do not comply with probation requirements as a result of their illness. In practical terms, this means having more treatment options available to address the underlying cause of the probation violation. For example, if an individual receives Assertive Community Treatment and intensive probation supervision, and violates probation (e.g., use of illegal substance), sanctions other than returning to jail must be available. The response to a violation could be developed in advance with the individual or as part of the probation/court process to help the person address either lifestyle factors or treatment gaps (e.g., medication, cognitive behavior therapy) that impede recovery.

In research on specialty courts, some participants view the judge as a “powerful advocate” and as someone truly invested in their achievements (Ashford, 2004). Thus, fostering attitudes of hope, choice and control, and emphasizing strengths in collaborative criminal justice and mental health programs is possible. A serious gap also exists in developing evidence based strategies to assist individuals achieve recovery and new roles, given the stigma associated with their dual status as mentally ill and offenders (Ashford, 2006).

As discussed earlier in this report, peer support can be very helpful, especially with navigating the challenges of stigma. Assigning peer specialists to diversion teams and
other collaborative services not only provides peer support, but offers successful role models for people with mental illness as well as for staff of the mental health and criminal justice organizations. However, it is important to orient all parties to the effectiveness of peer specialists and other peer-run programs, and to provide the peer specialists with enough support to face concerns about their participation.

In summary, while EBPs are emerging and demonstrate positive outcomes for offenders with mental illness, adopting R/R principles into these models is challenging, due in part to the coercive nature of legal oversight. Thus, it is imperative to intervene at multiple points along the criminal justice system to minimize criminalization of people with mental illness when service alternatives would facilitate recovery and limit infractions of the law.

Strategies to Increase Community Integration of Transition Age Youth and Adults with Autism Spectrum Disorders

The Pennsylvania Autism Task Force Report (2004) highlighted approaches to improve services for people with Autism Spectrum Disorder (ASD). We provide a brief summary in this report to highlight issues where there is debate about the role of mental health agencies in serving transition-age youth and adults with autism. Key findings of the Task Force Report emphasize that ASDs are “chronic, neurodevelopmental disorders that may improve with treatment, but will almost always require continuous services and ancillary supports throughout an individual’s lifetime” (Executive Summary, Autism Task Force, p. 2). Despite the need for continuous support, the Task Report emphasized that people with ASD can live satisfying lives as integrated members of the community.

About half of people with ASD also suffer from mental retardation and receive services from the mental retardation system of care. People with IQs above 70 receive services from the mental health system. While schools are the primary locus of services for children, the Task Force Report found, that as individuals age, especially when turning 21, there are few services and no entitlements to services, often resulting in institutionalization or heavily supported housing. Furthermore, the report cites no defined set of benefits/services for ASD. A broadened array of services and supports that address life and social skills, vocational skills and job coaching, and education would allow people to live independently as members of the community. The Task Force report identified the need for:

- Improving integration among different agencies to reduce fragmentation in the structure of the delivery system treating ASD;
- Increasing access to qualified, trained professional to work with people with ASD;
- Identifying and providing best practices, as well as a wider array of community services;
- Addressing individual differences among people with ASD;
- Establishing Regional Autism Centers to provide access to high quality assessment, treatment, services and supports; and,
- Establishing a consumer-led information and advocacy organization.
Further, for transition age youth, it is important to begin assessing post-secondary education and vocational options in mid-adolescence.

These findings echo many of the goals of R/R, as well as the challenges of implementing emerging or EBPs more broadly. A compounding factor related to implementing emerging practices for transitional age youth and adults having ASD is the debate in the field about the causes of ASD and the best treatments. Mercer’s interview with Vincent Strully, Founder and Executive Director of The New England Center for Children discussed the challenges related to the limited evidence available on best practices for adults. He noted that more research on the causes of ASD and best practices is essential, as is staying informed about the latest research and fostering implementation of emerging practices. Most of the research-based services focus on early intervention with children and school-based service models. Research on adults with autism and best practice models appear to be limited. As noted previously, services for adults with autism and mental retardation are typically addressed by a states developmental disabilities agency. For adults with IQs over 70, there is a gap in services and research on best practices.

If the Task Force’s recommendation to establish regional centers across Pennsylvania is implemented, these centers could have the task of disseminating information on emerging practices. Establishing a consumer-led information and advocacy organization could help people with ASD and their families to navigate systems and could also identify practices that work. Yet, it is clear (as discussed in the Task Force report) that integrated community housing options, post-secondary education, vocational training, and life and social skills training are important services for transition age youth and adults with ASD.

**Key Overall Strategies to Reduce Reliance on State Hospitals and Increase Community Integration**

The following strategies are based on findings from the literature reviews and our experts’ recommendations. We offer them for consideration by OMHSAS leadership, its advisory groups, and other stakeholders as they seek to promote transformation for adult services.

**Service Array**

Throughout Pennsylvania, OMHSAS should consider the following minimum community-based service array for BH-MCOs and their networks:

- ACT teams to assist people who frequently use high intensity services (e.g., inpatient, crisis), integrated with a continuum of less intensive levels of case management assistance for other individuals.
- A full continuum of crisis services, including pre-screening for hospital admission.
- Illness Management and Recovery.
- Standardized pharmacological treatment for adults and older adults.
Peer support and other peer-run services (described earlier in this report), including access to peer specialists while hospitalized and peer-run advocacy organizations for adults and older adults and their families.

- Case management.
- Supported housing.
- Psychosocial rehabilitation, including supported employment and vocational rehabilitation.
- Diversion interventions for people involved in the criminal justice system.
- Outreach and mobile outpatient treatment for older adults and cross collaboration with primary care and long-term.
- Suicide prevention resources at the community level, as well as more targeted interventions for older adults.
- Integrated Dual Disorder Treatment (IDDT) for persons with intensive and disabling co-occurring mental illness and substance use disorders, within an overall system that incorporates best practices more broadly (such as welcoming and integrated assessment).
- Life and social skills training, housing, educational and vocational supports/job coaching tailored to people with ASD.
- Family Psychoeducation for family members of adults with severe mental illness.
- Transportation supports, particularly for individuals with mobility needs and in rural areas.

**Key Clinical Support Tools**

**Best practice strategies include:**

- Service integration and agency collaboration could be facilitated by the BH-MCOs through care management.
- Case management, at the level of intensity needed and desired by the individual, should be available to support access to services and community integration.
- Individuals should have access to a “clinical services home,” to work with the individual so that the service plan is comprehensive and consistent with R/R principles, and also provide information about EBPs that may be helpful to meet the person’s needs.
- Should individuals require acute readmission, they should have access to the same hospital, unless the person requests another facility or requires specialized services that cannot be provided there.
- Relapse prevention plans, crisis plans and other interventions that prepare individuals for successful discharge should be initiated during hospitalization prior to discharge and well-documented by providers. The person’s “clinical home” upon discharge should incorporate these plans into the community treatment and recovery plan.
- Access to primary health care services is an important part of the recovery process, thus the case management function should emphasize linking individuals with mental illness to health plans and selection of primary care physicians. As an alternative, models of integrated service delivery are also emerging as a promising practice particularly for older adults.
The role of each state hospital in the continuum of care should be clearly defined and widely communicated. Additional staff training to hone necessary skills to fulfill the role should be considered.

Funding

Financing community integration requires targeted strategies:

- Providers should be financially rewarded for developing EBPs and maintaining fidelity with those models. The additional funding should be contingent on adequacy of follow-up tracking and timely reporting.
- For discharge of individuals with long-term stays at state hospitals, funding needs to be identified and assigned to support the discharge plan.
- Funding mechanisms to encourage outpatient contact prior to discharge should also be explored.

Attitudes/Messaging

OMHSAS leadership should consider the following strategies to help drive the message on reducing reliance on state hospitals and improving community integration:

- A gate-keeping function for state hospital admissions should be instituted. Counties could be placed at risk for state hospital utilization through the purchase of bed days as currently done in Ohio. In conjunction with this or alternatively, the BH-MCOs could be placed at risk for state hospital utilization and implement integrated pre-authorization processes.
- Establish performance requirements related to state hospital use and community integration for counties and BH-MCOs (see below for specific recommendations).
- Provide state hospital training on R/R and psychosocial rehabilitation services that can be implemented throughout the hospital stay including training on:
  - R/R principles offered by consumers (for staff and patients) who have successfully integrated into the community, to instill hope and provide role models
  - Motivational interviewing skills for staff; and
  - Developing treatment and recovery plans with consumers that focus on discharge.

Performance Measures

The following performance indicators should be considered for implementation:

- **Performance indicators for inpatient utilization.** BH-MCO performance guarantees could include the following indicators related to inpatient utilization rates for state hospitals and other inpatient facilities:
  - x days/1000
  - x admits/1000
  - x readmits/1000 30 days post-discharge
  - x readmits/1000 90 days post-discharge
- x discharges /1000
- follow-up within 7 days of discharge
- average length of stay for discharged
- average length of stay for residents
- percent of clients restrained or secluded
- number of adverse incidents
- average waiting time for admission
- percent occupancy
- denial rate

**Performance indicators for community-based services for individuals discharged from state hospitals.** Community-based services performance indicators could include:
- Percent receiving substance abuse treatment
- Percent receiving treatment through Co-occurring Disorder Competent facilities or programs
- Percent discharged consumers participating in community services
- Percent discharged consumers not participating in services located in last month
- Percent discharge consumers employed or in school OR average number of days without work or school
- Percent discharged arrested within a specified time period (e.g., 30 days, 1 year)
- Mortality rate of individuals discharged from inpatient within a specified time period (e.g., 30 days, 1 year)
- Percentage discharge with symptom reduction
- Percentage discharged who are homeless
- Percent discharged receiving EBP services upon discharge:
  - ACT
  - Case Management
  - Crisis stabilization
  - IDDT
  - Illness Management
  - Mobile outreach and treatment for older adults
  - Psychosocial rehabilitation
  - Peer support
  - Supported Housing

**Consumer/family satisfaction with:**
- Hope
- Quality of Life
- Treated with dignity
- Access
- Needs met
- Safety
- Crisis management
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Family-Based Services Findings

This section of the report focuses on evidence based strategies for Family Based Mental Health Services (FBMHS). For ease of presentation, first we briefly review several specific evidence based programs that have been widely adopted as family based approaches to deliver mental health services. We describe findings from the literature and expert interviews, highlighting strategies in use in other states. Finally, we provide suggestions for an optimal service array and implementation strategies.

Family Based Evidence Based Practice Models

The field of family based mental health services is characterized predominantly by relatively new treatment models. In keeping with this, the literature base for family-based EBPs is growing rapidly and changing quickly as the research base moves from being dominated by studies in controlled settings to evaluations of real-world applications in state and local systems of care. In order to tap the most current information, the literature search for this review emphasized non-traditional sources to augment the little that is available in refereed journals.

The recent research and trends analyzed for this report identified multiple challenges facing public mental health systems that lead to gaps between what we know works and what is practiced in the field:

- Children and families who need mental health services should receive appropriate care that meets their needs and is evidence-based,
- Strong research evidence exists for effective practices,
- Much (or most) treatment provided in public mental health systems is not evidence based and has no empirical basis to suggest it will be effective,
- Current providers and stakeholders are threatened by perceived competition between EBPs and existing service options,
- When EBPs are selected and implemented it is hard to realize improved outcomes or system change within the first one to two years of implementation,
- Transition costs are often high, and
- Perception of high cost and lack of confidence of long-term savings.

Multisystemic Therapy (MST)

MST is an intensive home based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with
low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory where behavior is multi-determined and best understood in the naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of youth anti-social behavior (Weiss et al., 2004).

At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth’s family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth’s interaction with “prosocial” peers and a reduction in association with “deviant” peers, primarily through parental mediation (Huey et al., 2004).

MST features well developed training and fidelity tracking protocols. Therapist adherence to these protocols has demonstrated a clear relationship to outcomes in which improved family functioning (specifically, increased parental monitoring, reduction of conflict, improved communications, and related factors) leads to decreased delinquent peer affiliation, causing a subsequent decrease in delinquent behavior. Findings revealed the successful implementation of MST leads to improved family functioning, and indirectly to a decrease in peer affiliation and youth delinquency. Studies have also found that therapists who are directive without first gaining the trust and support of family members may be less effective or even detrimental. This finding fits with increasing evidence that suggests that an initial focus on collaborative, relationship building elements is necessary before the more active components of MST can be effectively applied.

MST is widely implemented in many states, including Connecticut, Ohio, Colorado, Washington, Hawaii and Tennessee.

Schoenwald et al. (2004) in their research on MST outcomes report that several variables mediate outcomes and must be carefully attended to. These include:

- **Therapist Adherence** (also referred to as fidelity) – Higher adherence predicted post-treatment decreases in child behavior problems (relationship held through 6-12 month post-treatment follow-up) and positive discharge circumstances.

- **Organizational Structure** – In organizations with more hierarchical structures, discharge decisions were more often made by individuals outside the MST team. In organizations characterized by greater participation in decision making, discharge was more often based on treatment success.

- **Organizational Climate** – Opportunities for employee advancement and reward predicted less favorable discharge circumstances and increases in behavior problems when adherence was low. No affect noted when adherence was high.
Multisystemic Therapy is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency. In addition, the developers of MST are currently working closely with several states to develop specialized supplements to meet the needs of specific sub-groups of youth. At this time, MST should be included in the system of care as an intensive family based treatment for youth with relatively severe behavioral problems or willful misconduct.

**Functional Family Therapy (FFT)**

FFT was developed by Thomas Sexton (2004) and his colleagues. It is a research-based family program for at risk adolescents and their families targeting youth between the ages of 11-18 and has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (service delivery, supervision, and organizational support), and quality assurance and improvement.

FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on risk and protective factors. Intervention incorporates community resources for maintaining, generalizing and supporting family change (Rowland et al., 2001)

FFT has been widely implemented in over 130 sites (individual and statewide) in many states, including Washington, Idaho, Nevada, and Colorado. Evaluation in Washington has demonstrated reductions in recidivism and improvements in school functioning for juvenile justice involved youth\(^\text{10}\) (Barnoski 2003).

Functional Family Therapy is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity. FFT should be included in the system of care as a moderate-intensity family based treatment for youth with moderate to severe behavioral problems involving disruptive and oppositional behavior, as well as some with willful misconduct and lower level delinquency.

**Multidimensional Treatment Foster Care (MTFC)**

Unlike MST and FFT which are delivered in community settings to children and youth generally living with their families, MTFC is a type of therapeutic foster care provided to children living with foster parents or for families who require an intensive period of

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\(^\text{10}\) A Washington State Institute for Public Policy study demonstrated reductions in 18 month recidivism rates of over 15% for overall recidivism, 31.2% for felony recidivism, and 45.5% for violent recidivism. The study also demonstrated cost benefits of $16,250 per adolescent when comparing costs of providing FFT compared to the costs of traditional treatments, incarceration and victim costs for youth not receiving FFT.
treatment before reunification. This approach is well described in literature disseminated by the developers of MTFC (TFC Consultants, Inc., 2006), with a primary goal to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.

MTFC treatment goals are accomplished by providing close supervision; fair and consistent limits; predictable consequences for rule breaking; a supportive relationship with at least one mentoring adult; and reduced exposure to peers with similar problems. Intervention is multifaceted and occurs in multiple settings. Components include:

- Behavioral parent training and support for MTFC foster parents
- Family therapy for biological parents (or other aftercare resources);
- Skills training for youth;
- Supportive therapy for youth;
- School-based behavioral interventions and academic support; and
- Psychiatric consultation and medication management, when needed.

There are three versions of MTFC designed to be implemented with specific ages. Each version has been subjected to evaluation and found to be efficacious. The programs are:

- MTFC-P for preschool-aged children (3-5 years);
- MTFC-L for latency-aged children (6-11 years); and
- MTFC-A for adolescents (12-18 years).

MTFC is a well established EBP that has demonstrated outcomes and cost savings when implemented with fidelity. FFT should be included in the system of care as a service option for children and families for whom a temporary out-of-home placement is necessary or as a transition between more restrictive out-of-home settings and a return to the community.

Wraparound Planning

The Wraparound process for planning and coordinating care to children experiencing emotional and behavioral disorders has been cited widely as a promising service delivery option. However, to date the research base is only emerging and more extensive implementation and empirical research is needed (Burns, Hoagwood, & Maultsby, 1998; U.S. Public Health Service, 2001). Unlike interventions such as Multisystemic Therapy and Functional Family Therapy, there are no nationally recognized standards nor any definitive blueprint or “manual” to guide service delivery activities. As a result, many of Wraparound’s philosophical principles have not been consistently operationalized into specific provider behaviors. This situation has hindered service delivery and frustrated efforts to fully evaluate the impact of the intervention (Burchard, Bruns, & Burchard, 2002).
Walker (2004) describes Wraparound as an individualized service planning process undertaken by a team that includes the family, child, natural supports, agencies, and community services working together in partnership. The plan created by the team is to be culturally competent and strengths based, and should include a balance of formal services and informal, community, and natural supports.

Teams that engage in a greater number of creativity-enhancing practices tend to produce plans that are more highly individualized than teams that engage in fewer such practices. Research on team creativity and effectiveness in other settings has shown that teams are better able to come up with good solutions to complex problems when they employ two particular sorts of creativity-enhancing practices: practices for broadening perspectives, and practices for generating multiple options. Within Wraparound, team activities serve as means both to broaden perspectives (by providing new information or new vantage points) and to generate options (particularly when the team consciously constructs goals and strategies from information about strengths).

The National Wraparound Initiative (Bruns et al., 2004) has defined ten core Wraparound Principles that guide the implementation of this planning model. These principles include:

- **Family voice and choice** – Families must be full and active partners in every level of the wraparound process, exercising both voice and choice.
- **Team-based** – The wraparound approach must be a team-based process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
- **Natural supports** – Wraparound plans must include a balance of formal services and informal community and family resources.
- **Collaboration** – The plan should be developed and implemented based on an interagency, community-based collaborative process.
- **Community-based** – Wraparound must be based in the community.
- **Cultural competence** – The process must be culturally competent, building on the unique values, preferences, and strengths of children and families, and their communities.
- **Individualized** – Services and supports must be individualized and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community.
- **Strengths-based** – Services and supports must identify and build upon the strengths of the child and family.
- **Persistence** – An unconditional commitment to serve children and families is essential.
- **Outcome-based** – Outcomes must be determined and measured for the system, for the program, and for the individual child and family.

Researchers participating in the National Wraparound Initiative (for example, Bruns et al., 2004) note that studies have generally found disappointing outcomes for treatments
and EBPs delivered in real world or usual care settings. They suggest that Wraparound, with its emphasis on family engagement, might play a role in improving success of related EBPs. In light of emerging research evidence that has found less beneficial outcomes for treatments, including some EBPs, delivered in real world settings, as compared to the more controlled settings of efficacy studies (Bruns, 2004), Wraparound planning can have an impact in helping families to understand the fit and relevance of services and facilitate their engagement.

On the other hand, the same consortium (Bruns et al., 2004) notes that Wraparound itself is currently not implemented consistently or with fidelity. They recommend that sites considering implementing Wraparound meet basic standards at the organizational and systems levels that relate to the empirically-derived set of necessary conditions for Wraparound. Manuals for practice and supervision linked to implementation fidelity measures are being developed, as are guides for parents, youth, team members, and community members, and may be of use to support improved fidelity when available. Web-based supports based on existing fidelity monitoring protocols such as the Wraparound Fidelity Index have also been developed.

Wraparound planning is an emerging practice approach with emerging support. The current state of the research base is weakened by the lack of experimental or quasi-experimental studies that include fidelity measures, leading to a high level of uncertainty about the model used (Bruns, 2004). However, in light of compelling evidence regarding the important impact of youth and family engagement in the success of EBPs, as well as the potential for Wraparound planning to facilitate engagement and increased informal supports. Wraparound should be considered as a component of the system of care for youth and families with complex needs who are likely to receive services from multiple providers or systems. Given the model’s dependence on multi-agency resources, it should only be implemented in local systems that demonstrate readiness for effective multi-system coordination and buy-in into the Wraparound model.

Given that Wraparound planning is not as well established as the other FBMHS models reviewed for this paper, we have included in this section additional information regarding the cost-effectiveness of Wraparound within a system of care. The studies reviewed together document the demonstrated cost-effectiveness of Wraparound planning as a transformational activity for individual children and families, and by implication, systems as a whole.

Cost-Effectiveness of Wraparound Planning
While there remain only a few published studies of the cost-effectiveness of Wraparound, the emerging research base is promising – suggesting significant cost savings and reductions in restrictive out of home placements when Wraparound planning is implemented as an alternative to traditional service management approaches.

Wraparound Milwaukee. When issues of Wraparound cost-effectiveness are discussed, Wraparound Milwaukee is most often referred to as the exemplar. In 1994, Milwaukee
County was awarded a Comprehensive Community Mental Health Services for Children and Their Families Program grant. Through this grant, Wraparound Milwaukee was developed as a system of care for the county’s children with serious emotional disturbance and their families. The program’s goals include minimizing out-of-home placements, supporting families and building on their strengths, helping families to access an array of services, coordinating care, and delivering services in a cost-effective manner. The program is administered by the Milwaukee County Mental Health Department, part of Milwaukee County Human Services, which also includes Probation and Developmental Disabilities services, among others. The program is funded through a blending of child welfare and juvenile justice funds, along with a monthly capitation payment through Medicaid.

The President’s New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America – Final Report (July 2003, p. 35), states: “An exemplary program that expressly targets children with serious emotional disturbances and their families, Wraparound Milwaukee strives to integrate services and funding for the most seriously affected children and adolescents. Most program participants are racial or ethnic minority youth in the child welfare and juvenile justice systems. Wraparound Milwaukee demonstrates that the seemingly impossible can be made possible: children’s care can be seamlessly integrated. The services provided to children not only produce better clinical results, reduce delinquency, and result in fewer hospitalizations, but are cost-effective.”

In terms of funding, in 2004 of the total of $31.8 million in blended funding, Medicaid was the largest funding source for Wraparound Milwaukee. Wraparound Milwaukee received nearly $14 million in capitation payments and fee-for-service billing for crisis intervention services. Child Welfare (CHIPS) and Delinquency, and Court Services funding represent the balance of funding for the initiative.

Wraparound Milwaukee has consistently demonstrated significantly lower costs per youth/month when compared to residential care. The figure on the left illustrates those savings, with the yellow bars representing monthly Wraparound costs per youth for Wraparound and the blue bars representing residential treatment costs. While the two groups were not rigorously matched on all variables, they both represented a comparable target population and case mix.
The chart on the left illustrates reductions in expenditures for residential treatment in Milwaukee between 1994 and 2004. Wraparound Milwaukee assumed responsibility for the residential treatment population in July 1996. Since Wraparound Milwaukee assumed responsibility for all residential placements for Child Welfare and Juvenile Justice, expenditures for residential treatment were decreased by $12 million and redirected to serving more youths in community placements.

**Other Examples.** Potter and Mulkern (2004) note that while much of the literature indicates that Wraparound programs provide less costly community based services than those provided in residential treatment facilities, few rigorous cost-effective studies have been conducted. They point to a quasi-experimental study, which matched children receiving Wraparound with similar children in a comparison group receiving traditional services conducted by Brown and Loughlin (2004) in Ontario, Canada. Due to the complexity of calculating costs based on frequency of service, the cost analyses were limited solely to the most costly portion of treatment: out-of-home placement. Researchers found that average out-of-home costs for children receiving Wraparound were significantly less than those for children in the comparison group ($9,175.30 vs. $27,748). Although the amount of time each group spent in out-of-home care was approximately the same, the children receiving Wraparound were placed in less costly settings (either in treatment foster care or group homes) compared to the comparison group (residential treatment or juvenile detention facilities). Potter and Mulkern add that funds to support Wraparound vary across programs and depend on community assets, youth needs, and the population served.

A Washington State Institute for Public Policy (WSIPP) May 2001 report conducted a meta-analysis of the costs and benefits of juvenile criminal programs. This analysis included four published studies of unspecified Wraparound approaches being used in the context of services for juvenile offenders. WSIPP found approximately $3,131 in cost savings for each youth. Adding the benefits that accrue to crime victims increases the expected net present value to $14,831 per participant, which is equivalent to a benefit-to-cost ratio of $25.59 for every dollar spent.

Hewitt Clark and his associates (1995 and 1996) at the University of South Florida developed the Fostering Individualized Assistance Program (FIAP) to provide
individualized Wraparound supports and services to foster children with emotional/behavioral disturbance (EBD) and their families. The primary program goal was to improve permanency outcomes for foster children. The children served in the FIAP were the most challenging 10 percent of children within the foster care system and had been in out-of-home placement an average of 2.6 years and had an average of four placement changes prior to entering the FIAP study.

A random assignment study was designed to evaluate the effectiveness of the FIAP (Clark, Lee, Prange, and McDonald, 1996). The research design compared children receiving services, which were standard practice (SP) with those who received FIAP. The outcome variables evaluated in this study included placement settings and change rates, runaway status, and incarceration. In addition to lower costs, the study found that:

- Children in the FIAP group were significantly less likely to change placements than were those in the SP group during the intervention.
- Both groups showed significant improvement in their emotional and behavioral adjustment over time.
- FIAP boys had significantly lower rates of delinquency and fewer externalizing behaviors than their SP counterparts.
- Older FIAP youths were significantly more likely than their SP peers to live in permanency settings with their parents, relatives, adoptive parents, or living on their own.
- The subset of children in the FIAP group who had histories of incarceration and running away spent fewer days per year, on average, on runaway or incarceration status during the post intervention period than did the SP children.

In Vermont, Tighe and Brooks (as cited in Kendziora, et. al., 2001) compared 26 youth receiving Wraparound planning through Vermont’s Individualized Care Programs with 26 matched youth referred to out-of-state facilities and found that the average cost of out-of-state treatment facilities was $4,893 per month, while community treatment was 18 percent less with a savings of $857 a month ($10,284 per year).

Cost savings were also found in Kansas. A formal evaluation of Wraparound planning provided through the KanFocus project found Wraparound cost $13,587 per year compared to $26,236 for a matched sample in institutional care. In 1994 Kansas implemented Wraparound through two federally funded pilot projects in an urban (Wichita) and rural (13 Southeast Counties). Following the success of these programs, Kansas funded statewide implementation in a stepwise fashion beginning in FY 1998 with full implementation in FY 01. Through this
process, Kansas was able to reduce institutionalization costs by 67 percent or over $4.3 million. Furthermore, this savings was used to leverage over $10 million in new community-based services. The result was that many more children with SED were served and the rate of institutionalization and length of stays were significantly reduced, resulting in positive outcomes in behavior, mental health symptoms, and school performance.

In an informal study of youth in the child welfare system in Los Angeles County, significant cost savings were found when comparing services coordinated through Wraparound planning with high cost residential services (California’s Residential Care Levels 12–14). Residential treatment costs were estimated at $59,172 compared with $23,332 per youth for Wraparound. Moreover, 18 months after completion of services 50 percent of youth who received Wraparound were still at home versus 36 percent of youth who participated in residential care.\(^{11}\)

Because the studies reviewed in this section did not report in detail the variables on which study participants were matched, further studies are needed to assess the impact of severity of illness on cost-effectiveness. It is possible that cost-effectiveness is greatest with children in out-of-home placements, specifically residential treatment.

**Arizona’s Child and Family Teams.** In Arizona, Wraparound planning is available to all children with serious mental health needs who are Medicaid-eligible in the behavioral health system. Following a settlement in federal court (the J.K. Settlement, 2001), Arizona gave priority to developing Wraparound for children in the foster care and public mental health systems. At the core of the children’s mental health system are multidisciplinary Child and Family Teams using Wraparound to conduct a comprehensive assessment of each child and then develop a care plan oriented to improving the child’s functioning in school, their family, and their community. Over one third of all children served by Arizona’s public behavioral health system have functioning Child and Family Teams.

The Child and Family Team includes, at a minimum, the child, the child’s family, any foster parents, a behavioral health representative, and any individuals important in the child’s life who are identified and invited to participate by the child and family. Teams are typically convened by a facilitator, covered by Medicaid. For children with less intense needs, a clinician or, in some cases, a family member serves as the facilitator of team. Teams usually meet from once a week to once a month, depending on the intensity and urgency of the child’s needs. Children ages 12 and older participate in the teams.

Child and Family Team roles include:

- Engagement,
- Immediate Crisis Stabilization,

\(^{11}\) Interview with Eric Bruns in August 2006.
- Strengths, Needs and Cultural Discovery,
- Child and Family Team Formation,
- Child and Family Team Meeting Preparation,
- Child and Family Team Facilitation,
- “Wrap-Around Plan” Development,
- Crisis Planning,
- Tracking and Adapting, and
- Transition.

Every child and family is assigned a Clinical Liaison. The Liaison’s role includes clinical assessment and service formulation; consultation to the Child and Family Team; consultation to other service providers; and serving as a Child and Family Team member and/or Child and Family Team facilitator.

The professional members of the Wraparound teams include psychiatrists, psychologists, social workers, and direct service workers. The direct service workers work with children to teach them self-care skills, provide in home support and carry out the behavioral plan the team develops for the child and family.

Intervention plans include a wide range of natural and professional support services. Arizona’s Medicaid agency funds the work of the Child and Family Team and pays for most of the services the team identifies as necessary for the child, including (but not limited to) case management, direct services, behavioral aides, and therapy. Medicaid does not pay for school-related services (for example, reading tutors), which are funded by the school system or for “flex funds” to provide unconventional support such as material supports for the family.

**Parent and Family Involvement.** Family involvement is a core value of Wraparound planning and a key element of most system’s implementation. A recent study by Behar, Friedman, and Lynn (2005) looked at Wraparound implementation in several states, with a particular emphasis on family involvement. The two tables on the following pages are taken directly from that study and summarize family involvement across multiple Wraparound programs.
Table 11 - Key Variables (Including Family Involvement) Across Select Wraparound Projects

<table>
<thead>
<tr>
<th>Site/Project Name</th>
<th>Population Served/ Treatment Setting</th>
<th>Infrastructure/ Provider Network</th>
<th>Funding Structure</th>
<th>Use of Data</th>
<th>Family Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indiana: Dawn Project; Indianapolis</td>
<td>Services for youth with serious emotional disturbances and their families involved in either the juvenile justice system or the foster care system in Marion County</td>
<td>Non-profit organization leading collaborative effort among child welfare, special education, juvenile justice, and mental health leaders operating under the aegis of the court</td>
<td>Federal grant monies pooled with funds from other agencies and expended according to a case rate; Medicaid funds cover some services</td>
<td>Family plays a strong role in monitoring services; families interview providers, work with the case manager, and monitor progress of the child</td>
<td></td>
</tr>
<tr>
<td>2. Kentucky: Building Bridges of Support: One Community at a Time [Bridges Project]</td>
<td>Prevention and intervention strategies for youth with or at risk of developing serious emotional disturbances in rural school settings</td>
<td>Expanded, 3-tier, school-based intervention and prevention model, with universal, targeted, and intensive tiers. School staff, Bridges personnel and parent groups provide services; Bridges personnel have offices in the schools</td>
<td>Operated by the Kentucky Department of Mental Health</td>
<td>In the intensive tier, an interagency family team designs services for the child and family; family members are key participants on this team</td>
<td></td>
</tr>
<tr>
<td>3. Massachusetts: Arbour Health Systems Trauma Center, Community Services Program</td>
<td>Intervention in communities in Metro-Boston that have experienced psychological trauma</td>
<td>Community Services Program trains community providers to assist program staff. Trained provider network includes mental health professionals, school personnel and community workers (e.g., YMCA, Boys and Girl’s Club) probation officers, religious leaders</td>
<td>Funded by the Massachusetts Department of Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Michigan (2 sites): 1. Pathways in Marquette; 2. Community Mental Health Program of Clinton, Eaton and Ingham Counties</td>
<td>Coordinated services for children with severe emotional disturbances in a rural area (Pathways) and the area surrounding East Lansing (Community MH Program)</td>
<td>Part of Michigan’s public community mental health and development disabilities system.</td>
<td>Regional Medicaid behavioral health entities. Funding provided by Medicaid managed care program, other health insurance and state funds</td>
<td>CAFAS analysis allows each community mental health program to track its effectiveness and develop a database to strengthen services</td>
<td>The child and family help the care coordinator/ case manager develop individualized service plans</td>
</tr>
</tbody>
</table>

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12 Excerpted from Behar, Friedman, & Lynn (2005)
<table>
<thead>
<tr>
<th>Site/Project Name</th>
<th>Population Served/ Treatment Setting</th>
<th>Infrastructure/ Provider Network</th>
<th>Funding Structure</th>
<th>Use of Data</th>
<th>Family Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Nebraska: Nebraska Family Central, Region III Behavioral Health Services</td>
<td>Services for children with severe emotional disturbances in rural counties in central and south central Nebraska</td>
<td>Partnership of Region III Behavioral Health Services, Nebraska Department of Health and Human Services, and the Nebraska Department of Education. Integrated infrastructure across public agencies</td>
<td>Mental health, child welfare and education funds support services: Region III Behavioral Health Services manages the funds and provider network; Medicaid funds treatment services</td>
<td>The project utilizes MST, and progress and outcomes for children are tracked through the data system to provide feedback to parents, child, team, and providers</td>
<td>Parents have a central decision-making role in developing individualized service plans for the child</td>
</tr>
<tr>
<td>6. New Jersey: The Children's Initiative</td>
<td>Services for youth with serious emotional disturbances in the State of New Jersey</td>
<td>The State of New Jersey contracted with a private agency to serve as the Administrative Services Organization (ASO) to authorize children to receive services, oversee the appropriateness of the plan, and ensure that providers are available and responsive</td>
<td>Funding services include agencies within the Health and Human Services Department (but not Education) and Medicaid</td>
<td>The ASO tracks service utilization, needs and costs. Standardized assessment measures and protocols are also utilized.</td>
<td>Expected increase in family and child participation in decision-making</td>
</tr>
<tr>
<td>7. New York: Kids Oneida; Oneida County</td>
<td>Services for children with serious emotional disturbances in Oneida County who are at risk for out-of-home placement and/or to shorten the time in such placements</td>
<td>Jointly established by the New York State Office of Mental Health, the New York State Department of Health, and Oneida County; a not-for-profit care management entity operates the program; children are accepted into the program by the Oneida County Committee on Appropriate Placement or the Oneida County Department of Social Services Placement Committee</td>
<td>Funded through a blend of Medicaid, mental health and social services funds, including a bundled case payment fee from Medicaid and a case payment from Oneida County Department of Social Services. Flexible funds are also available for family strengths and needs.</td>
<td>Individualized plans of care are developed in partnership with the child and parent(s), other relevant agencies or providers, and the Kids Oneida individual service coordinator</td>
<td></td>
</tr>
<tr>
<td>8. Wisconsin: Wraparound Milwaukee</td>
<td>Services for children with serious emotional disturbances and their families in Milwaukee County who are at risk of entering residential care or psychiatric hospitalization</td>
<td>Part of the Milwaukee Community Mental Health Center. Collaboration among child welfare, juvenile justice, mental health and education</td>
<td>Funds are pooled from child welfare and juvenile justice, along with a capitation payment from Medicaid</td>
<td>A data system is used to manage services and funding, with output on quality assurance/ quality improvement and client outcomes</td>
<td>The child and family team designs the service plan, and a strong parent organization oversees service delivery and program management</td>
</tr>
</tbody>
</table>
Table 12 - Detail on Family Roles\textsuperscript{13}

<table>
<thead>
<tr>
<th>Site</th>
<th>Family Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Equal member of service planning team</td>
</tr>
<tr>
<td>Michigan: Pathways in Marquette</td>
<td>X</td>
</tr>
<tr>
<td>New Jersey’s State Department of Human Services</td>
<td>X</td>
</tr>
<tr>
<td>New York: Kids Oneida</td>
<td>X</td>
</tr>
<tr>
<td>Nebraska Family Central</td>
<td>X</td>
</tr>
<tr>
<td>Dawn Project in Indianapolis</td>
<td>X</td>
</tr>
<tr>
<td>Wraparound Milwaukee</td>
<td>X</td>
</tr>
<tr>
<td>Kentucky: Building Bridges</td>
<td>X</td>
</tr>
<tr>
<td>Michigan: Community Mental Health Center</td>
<td>X</td>
</tr>
<tr>
<td>Massachusetts Community Services Program</td>
<td>X</td>
</tr>
</tbody>
</table>

The Importance of Wraparound Fidelity. Work by Walker and colleagues (2003) using observations and interviews of multiple stakeholders has revealed a wide range of approaches and quality levels of different “wraparound” programs across the country. At the same time, Bruns and colleagues in a series of studies have found that programs nationally that claim to use the Wraparound process demonstrate a wide range of service quality, with programs unable to consistently provide services with adherence to the recognized Wraparound principles. These studies have found (1) that administrative and system characteristics of programs can explain much of the variation in sites’ adherence to Wraparound’s philosophical principles (Bruns, Burchard, Suter, & Leverentz-Brady, 2003) and (2) that, in turn, adherence to these principles predict future child and family service and functioning outcomes (Bruns, Suter, Force, Burchard, & Dakan, 2003). They interpret these findings to suggest that programs and sites employing the Wraparound process will be more likely to achieve desired child and family outcomes if they maintain fidelity to Wraparound’s philosophical principles in the course of service delivery.

The tracking of fidelity represents a critical component of a comprehensive implementation and quality assurance plan. If only outcomes are tracked and reported, it is not possible without fidelity data to use the information to improve service delivery. Any positive or negative result would have little meaning if those attempting to use the information to make decisions do not know what happened or how closely the services that were actually delivered resembled the program model. Having information about adherence to key activities and principles allows for interpretation of the results in a manner consistent with good evaluation and management practice.

\textsuperscript{13} Excerpted from Behar, Friedman, & Lynn (2005)
While research has shown that fidelity monitoring in itself is not sufficient to ensure positive outcomes, it is nonetheless necessary. The National Wraparound Initiative has recently established principles and performance standards. Ongoing fidelity monitoring protocols should be required, tracked, and monitored at both the local and state level. There are several approaches to fidelity monitoring; the best appear to share common elements of an easy user interface (web enabled) and input from professional, parents and youth. In addition, tracking fidelity is not enough; outcomes must also be tracked to ensure that individual, family, and system goals are achieved.

Fidelity scales tend to be face-valid (i.e., they are straightforward and make sense to an informed reader) and reflect the principles of the model being implemented. There are four basic elements of a good scale:

1. Scales and items should refer to specific aspects of program structure and staff behavior.
2. Scales and items should refer to things that are under the control of program staff and subject to change based on staff or administrator behavior.
3. Scales and items should fit the culture and context of the setting being evaluated.
4. All items should be clear and understandable to informed respondents.

The most widely used scale for assessing Wraparound fidelity is the Wraparound Fidelity Index-3.0 (WFI-3). The WFI-3 is composed of three respondent forms: the caregiver form, the youth form, and the resource facilitator form. A demographic form is also part of the WFI-3 battery. The WFI-3 was designed to assess adherence to 11 essential principals of Wraparound. Information obtained from the WFI-3 has been used for both program improvement and research. Fidelity profiles across elements and items can illuminate areas of relative strength and weakness that can guide program planning and training.

In order to address limitations in the WFI-3, primarily that it only assesses adherence to principles, not fidelity to a model or set of specific activities, a revised version of the tool has been developed. This version, the WFI-4, reflects recent development of a model that includes a description of specific phases and activities of the Wraparound process (Bruns, Walker et al., 2004). The WFI-4 assesses both adherences to principles as well as fidelity to these activities.

The WFI-4, at this time, exists only as a pilot form for caregivers. The Wraparound Evaluation and Research Team, based at the University of Washington and headed by Eric Bruns, PhD, has made the form available for sites that wish to participate in the pilot.

In addition to the WFI, user-friendly web-based applications can be customized and implemented in a tailored fashion to support local or statewide implementation of Wraparound. This web-based approach could represent a practical supplement to the WFI. For example, a web-based system referred to as 1-2-3 Fidelity! includes three
scales, implemented at one, two, and three month intervals. Fidelity is tracked by both Wraparound facilitators and the team supervisor as follows:

1. Every month, the Wraparound facilitator submits a monthly tracking form to report on the Wraparound meetings and process.
2. Every other month, the Wraparound supervisor conducts an interview with the youth’s caregiver to get their feedback on the Wraparound planning process (a youth interview can also be added, if desired).
3. Every three months, the Wraparound facilitator submits a plan tracking form to report on how well the Wraparound plan supports youth and family goals.

**Bottom Line on Wraparound.** Based on our in-depth review of its cost-effectiveness and potential for system transformation within a Child and Family Team context, Wraparound planning can be a critical support for youth in families with complex needs who are likely to need significant support for family engagement and coordination for services received from multiple providers or youth-serving systems. Despite limited controlled studies on the cost impact of Wraparound planning, there is emerging evidence that the process enhances the cost-effectiveness of other evidenced based treatment approaches and reduces reliance on more costly institutional care when targeted toward children and youth currently in or at-risk of expensive out-of-home placements such as residential treatment. To realize cost savings, however, careful targeting to high-need populations, fidelity to Wraparound principles, and outcomes need to be monitored. In addition, consideration needs to be given to system design features, such as aligning funding to support Wraparound planning and related services at a level that is equitable in terms of profitability in comparison to other more traditional treatment options. Given its dependence on multi-agency cooperation, Wraparound Planning should only be used in local systems that demonstrate readiness for effective multi-system coordination and a commitment to high quality implementation and ongoing fidelity and outcome tracking.

**Optimal Family Based Service Array**

An optimal family-based service array will include the specified EBPs discussed above for youth and families at highest risk due to behavior or complex multi-system involvement. In addition to these rigorously evaluated EBPs, a fully functioning continuum of services will also include innovative and “home grown” service approaches. If these approaches are defined and based on the key elements that underlay the success of proven EBPs, there is much reason to expect that they also will bring about successful outcomes. The distinction we suggest here is between evidence-based programs (those discussed above such as MST, FFT, and MTFC with a strong research base) and evidence-based practices. The latter are innovative approaches that are based on the researched elements of success for other more established EBPs (Hawkins & Catalano, 1992). These elements include:

- Concentrating on changing behavior and improving prosocial skills;
- Focusing on problem solving with both youth and their families;
- Employing multiple modes of intervention;
- Goal-oriented treatment;
- Promoting healthy bonds with prosocial members within the child or youth’s family, peer, school, and community network;
- Attention to transitions and links to community; and
- Training and quality assurance to support quality clinical work.

If these elements are present, it should be possible for local systems to define their local programs sufficiently to design fidelity tracking protocols and measure their outcomes. Thus, the more traditional or existing practices that have been developed in provider communities may join the evidence-based culture if a true culture of evidence-based care is developed around them. Such an approach to a mixed service array, in addition to encouraging choice for consumers, may also help facilitate the buy-in of the provider community and help bring about better overall outcomes than an approach where a small set of EBPs are exclusively mandated.

**Improving Quality and Cost-Effectiveness of Care Strategies.** Robert Friedman (Friedman et al., 2004), co-author of the CASSP and Director of the Research and Training Center for Children’s Mental Health, offers the following list of issues to be considered in improving the quality and cost-effectiveness of public child and family mental health systems:

- The capability of professionals must be increased through training, coaching, and supervision.
- The range of services offered must be expanded.
- Integration between systems and agencies at the service and/or system level must be strengthened.
- More individualized care must be offered.
- Provide truly informed choice of services and providers to families.
- Implement continuous quality improvement procedures for all services (not just for EBPs with existing manuals and protocols).
- Apply treatment guidelines/standards consistently.
- Provide more flexible funding and funding mechanisms to support individualized and comprehensive service plans.
- Expand use of natural supports.
- Apply Evidence Based Programs.
- Identify active agents of change in effective interventions and provide training/coaching in them.
- Apply system of care values/principles such as partnerships with families, focus on strengths, and cultural competencies.
- Identify practices that are ineffective and stop doing them.

**Summary of Interviews**

Interviews were conducted with nine informants: six experts (researchers and representatives of EBP organizations) and representatives from three state systems (Connecticut, Hawaii and New Mexico). Interviews were conducted using a two step
process. First, national experts in the research and implementation of evidence based strategies for child and family based mental health were interviewed. These interviews covered recommendations regarding FBMHS and identified appropriate comparison states. National experts included Keller Strother and Molly Brunk from MST (Multisystemic Therapy) Services; Tom Sexton from Functional Family Therapy, Inc.; Eric Bruns from the University of Washington and the National Wraparound Initiative; Jim Rast, a leading researcher in Wraparound planning; and Jeanne Rivard from the National EBP Consortium at the National Association of State Mental Health Program Directors (NASMHPD) Research Division.

Based on interviews with these national experts, additional interviews were conducted with representatives from Connecticut, Hawaii and New Mexico. Interview questions were developed through a collaborative process with Mercer staff and consultants and national experts. Interviews were conducted by telephone – typically in one to two half hour to one hour sessions. Responses were summarized by content area and are presented following an overview of information from the literature review.

This section summarizes the results of these interviews. The section is organized by state, with overarching issues discussed as part of the Conclusions section immediately following the Summary of Interviews. Due to the breadth of experience of some of the experts interviewed, information is included from states for which we did not include a designated interviewee (specifically California and New York).

As a key leader in one of the state’s interviewed for this document stated, “We know more about what ‘works’ than we are actually doing.” Key informants that were interviewed for this review were consistent in their caution that selecting and implementing evidence-based practices is not as simple as selecting from a menu of EBPs and utilizing information to guide decisions regarding implementation. Administrators designing child and family service systems must respond to multiple obstacles. Funding sources do not always support new, innovative or nontraditional services. Politics and policy exert influence that can work against practices that have scientific support. Human resource shortages, and the need to retrain an existing work force, hamper implementation, and the overall process that effectively moves a practice from a research environment to communities is complicated.

**New York**

The New York State Office of Mental Health (OMH) has undertaken several major initiatives since 2002, to identify, implement and disseminate EBPs in both the state outpatient and inpatient mental health systems, as well as school districts statewide. In the New York EBP initiative, four levels of change have been identified as instrumental for improving implementation efficiency and effectiveness. These are:

1. System and Policy Level – These include financing policies and governance structures, policy leadership, fiscal reimbursement, and rate enhancement as levers;
2. Organizational Level – Factors center on characteristics of the work environment, including culture, climate, and structure;

3. Clinical Care Level – These include attitudes, beliefs, and expectancies among clinicians and supervisors regarding training, support, characteristics of EBPs, flexibility/adaptability of model, and related factors; and

4. Family and Youth Engagement and Empowerment – The attitudes, beliefs, and expectancies among caregivers and youth about services, as well as their potential to become active partners and agents of change.

In addition to the four levels of change, New York has also developed three distinct emphases for training and knowledge dissemination. The three emphases of these initiatives have been:

1. Re-training and supporting frontline clinicians to deliver empirically-grounded clinical services within routine care settings;

2. Training clinicians in engagement strategies to improve their outreach and collaboration with families; and

3. Training families in empowerment strategies to improve families’ self-efficacy in seeking services.

In close collaboration with academic partners at Columbia University and Mount Sinai School of Medicine, OMH has deployed a mix of family-based (Functional Family Therapy) and individual and school-based interventions (CBT for trauma in the Child and Adolescent Trauma Treatments and Services Consortium – CATS); Treatment Recommendations for the use of Antipsychotics for Aggressive Youth (TRAAY); Coping Cats in a School MH Support Program (SSP); and Interpersonal Therapy for Adolescents) into the state system. These initiatives have typically involved 2-3 days of training of master’s level social workers, followed by 12-month intensive consultation and support, either in-person or by phone, with attention to adherence and fidelity.

**California**

In California, the selection, dissemination and implementation of EBPs is facilitated by the California Institute for Mental Health (CIMH). CIMH is a private non-profit organization providing training, technical assistance, and program evaluation to publicly funded children’s service organizations in California. The Institute uses a model referred to as Community Development Teams (CDT) to help organizations adopt and successfully implement evidence based practices. The CDT model is driven by four basic goals: (1) to improve outcomes for California children and families participating in public services systems; (2) to promote the delivery of evidence-based services in California
Commonwealth of Pennsylvania  
Office of Mental Health and Substance Abuse Services

Implementation of Recovery/Resilience and EBPs

Communities; (3) to continually evaluate the effectiveness of methods and services to improve subsequent efforts; and (4) to build on and build up positive relationships, collaborations and partnerships among consumers, system and political leaders, agencies and practitioners. Current evidence-based implementations includes two family-based EBPs (Multidimensional Treatment Foster Care and Functional Family Therapy), as well as two individual-focused EBPs (Aggression Replacement Therapy and Depression Treatment Quality Improvement).

CIMH works closely with the State Department of Mental Health and County Mental Health Directors Association, and is very responsive to the needs of county mental health agencies. However, CIMH has no direct authority concerning state or county decisions.

CIMH offers training and technical assistance activities. Participation by counties in these activities is generally voluntary (there are occasional exceptions when the state requires counties be trained in a particular content area and CIMH is the designated trainer). The agency often offers these activities at very low or no cost to counties (typically funded by a private or government grant).

CIMH has over several years taken a leadership role in relation to the promotion of evidence-based practices, and has taken concrete steps to:

- Explore evidence-based practices;
- Explore dissemination and implementation models and challenges;
- Select specific practices (based on their relevance to the state’s public mental health consumers, level of demonstrated effectiveness, and readiness to be disseminated) to be promoted; and
- Conduct training activities to increase interest among counties and agencies to implement evidence-based practices in general, and selected practices specifically.

CIMH activities are designed to promote excellence in the state’s public mental health system. The agency’s primary partners include the State Department of Mental Health, county mental health agencies, consumers and family members, private mental health providers, and other public agencies that work in partnership with county mental health agencies (probation, child welfare, CalWORKs – TANF, schools, public health). CIMH has diverse funding including contracts with the State Department of Mental Health and individual county mental health agencies, and grants from private foundations and government agencies.

CIMH partners with purveyors of each EBP to support sustainable, model-adherent implementation of specific practices by county mental health agencies (including private providers and other public agencies). In general, CIMH functions as a planning, convening and funding intermediary, as follows:

- CIMH promotes implementation of the practices by counties and works with counties to organize practice-specific training and supervision.
The EBP purveyors provide the practice-specific training and supervision.

CIMH works with the purveyors to adapt their dissemination strategies to better meet the needs of California counties.

CIMH provides support and direct assistance to counties around critical operational structures needed for sustainable model-adherent implementation.

Most of this work is conducted through the Community Development Team model in which a cohort of counties or agencies implements a specific practice together. This approach benefits from peer-to-peer support and assistance. The model begins with education about the selected practice and solicitation of participating counties/agencies to join the implementation effort through a Community Development Team. The approach involves assessing and supporting readiness factors, subsidizing clinical training and supervision costs, and providing concrete support to help counties/agencies develop operational structures needed to support the practice.

In terms of access and breadth of EBP implementation California has no exclusion criteria in working with sites. However, there are several separate steps in the process designed to allow sites to make fully informed decisions about either proceeding with the implementation or selecting out of the project, before committing. If there is strong commitment by the county/agency based on a full understanding of the practice requirements, CIMH would be inclined to include the site. Support and assistance around operational issues is customized to the needs of each county/agency and provided in the context of the Community Development Team learning environment.

The CIMH selects practices for implementation that address high need areas. In these initiatives CIMH selects the practice and actively solicits participation from counties/agencies. Selection criteria have included:

- Appropriateness for addressing the needs of public mental health consumers (fit with county mental health programs);
- Evidence of effectiveness (e.g. random clinical trials, real world settings, replications);
- Degree to which the purveyor has a successful dissemination model;
- Costs; and
- Strategy for achieving sustainability (autonomous, model-adherent sites).

CIMH is supported with private and government grants, but generally does not write grants for individual counties or other agencies.

**Connecticut**

"In five years, the State went from 0 to 25 MST teams and state agencies went from over 25 providers for juvenile justice youth to just 5." Peter Panzarella, Director of Substance Abuse Services, Department of Children and Families.
EBPs in Connecticut are implemented through the Department of Children and Families (DCF). Connecticut’s implementation of EBPs began with Multisystemic Therapy. MST was championed by the two State agencies most involved with juvenile justice population (DCF and the Court Support Services Division (CSSD). While MST implementation and quality assurance was originally carried out under contract with MST Services, the dissemination affiliate of the developer, leaders within the State soon realized that they could achieved increased cost savings and ownership of data through moving to local control. A local managed care entity, Advanced Behavioral Health (ABH) was selected through RFP to conduct training and quality assurance, as well as maintain fidelity tracking protocols. In addition, ABH conducts state-specific tasks such as targeted surveys of parents and youth.

As EBPs are selected and implemented, Connecticut begins with the developing or disseminating organization and then, once the EBP is ready to go to scale across the state, responsibility for training, data tracking and quality assurance is shifted to an in-state intermediary provider organization. At this point, ABH is the only entity providing these services. Other EBPs being disseminated currently include Multidimensional Family Therapy (MDFT), Functional Family Therapy (FFT), Brief Strategic Family Therapy (BSFT), and treatment foster care. In coordination with the intermediary ABH, both the Department of Children and Families and the juvenile justice system have created data bases for client tracking including outcomes.

To date, funding for family based EBPs within the mental health system has relied almost exclusively on state funds and specific grant funding. DCF is now working to develop a fee for service model under Medicaid, with supplemental state funds for special populations not Medicaid-eligible. One of the biggest challenges noted by informants was that of ensuring that the revenue stream is structured so as to support fidelity to the model.

Connecticut is also looking at incentive strategies wherein providers receive additional payments if youth served remain out of the juvenile justice system or high-cost child welfare placements.

In terms of access to EBPs, portals for entry into MST have mostly been a function of the system in which the youth finds him or herself. With a move to Medicaid funding, Connecticut plans to define clinical criteria as opposed to what is typical in other states (that a youth has to get arrested to receive the “best services”). As part of this shift, Connecticut is piloting the GAIN diagnostic tool using seed funding and technical assistance from the federal Center for Substance Abuse Prevention (CSAP).

Each youth has a state Care Coordinator who facilitates a “community collaborative meeting” featuring some of the elements of Wraparound. When MST is identified as appropriate, the Care Coordinator temporarily hands off responsibility for the care plan to
MST. Typically care coordination lasts for about one year whereas MST lengths of treatment average 3-4 months.

Connecticut’s approach to MST is also shifting to a greater emphasis on specialty programs such as MST for problem sexual behavior or child welfare specific services.

Another EBT that has gained significant popularity, especially with the provider community, is Multidimensional Family Therapy (MDFT). MDFT is disseminated out of the University of Miami and differs significantly from MST because it is newer and less specified. Because it is, in many ways, more like traditional family “therapy” many providers are immediately comfortable with it and see it as less of a threat than newer, more strictly behavioral interventions such as MST. MDFT is an emerging model with a growing evidence base. It has shown particular promise in family-based treatment where youth substance abuse is focus of concern. As the research base grows, MDFT should be considered as a potential element of the system of care.

In addition, Connecticut is also beginning to implement FFT as well as the less specified Intensive Community child and Adolescent Psychiatric Services (ICAPS). ICAPS has been developed at Yale and is being examined as a step-down from psychiatric hospitalization.

As each of these models becomes more established in the state, responsibility of training and quality assurance will gradually shift to in-state IPOs like Advanced Behavioral Health.

**Implementation Challenges.** As suggested by the quote at the opening of this section, Connecticut has experienced extremely rapid growth in implementation of MST. This growth pattern resulted in an insufficient workforce, high turnover, and “push back” from the larger provider system as provider infrastructure struggled to keep pace.

Another challenge noted related to evaluation and tracking. As Connecticut lacked a database or outcome measures for models other than MST, MST was evaluated in a vacuum without meaningful comparisons. In a sense, non-EBPs do not have built in data tracking protocols and remain “black boxes” in terms of understanding intermediate variables. The nature of the relationship between mental health, housed within the DCF and juvenile justice also poses challenge as the juvenile justice system carries responsibility for front end admission decisions and treatment while DCF carries responsibility for back end discharge planning.

Finally, as voiced consistently by interviewees, stakeholders can be fickle in their support of EBPs if results are not evident and they were not involved in initial section process. Thus attention to Communities of Practice and Evidence Based Culture once again are seen as important to long term success of EBPs.
Hawaii

Hawaii has implemented diverse and far-reaching EBP initiatives that incorporate a wide variety of quality improvement activities (Daleiden & Chorpita, 2005). The initiatives may be characterized generally as adopting a two-pronged strategy of (1) building specific empirically supported programs and (2) pursuing incremental improvements in actual care toward evidence-based ideals. The former strategy involves identifying, selecting, and implementing specific evidence-based programs, such as Multisystemic Therapy (MST; Henggeler et al., 1998) and Multidimensional Treatment Foster Care (Chamberlain & Reid, 1991). The latter approach involves defining evidence-based practices more generically in terms of their common components, and increasing the prevalence of those components in routine care (Chorpita, Daleiden, & Weisz, 2005).

Both components of the evidence-based services initiative were supported by the following steps:

- Program planning and treatment selection,
- Initial implementation of specific evidence-based programs,
- Efforts to increase awareness and enthusiasm for evidence-based services,
- A program of large-scale training using a variety of models,
- Contractual integration through published performance standards and practice guidelines,
- Delineation of an integrative evidence-based decision-making framework, and
- The integration of information systems, performance measures, and feedback tools for administrative management and clinical supervision.

In Hawaii, the public mental health authority is organizationally situated in the Department of Health’s Behavioral Health Service Administration (BHSA). The BHSA consists of the Child and Adolescent Mental Health Division (CAMHD), Adult Mental Health Division (AMHD), and Alcohol and Drug Abuse Division (ADAD). In addition, mental health services are available through the Department of Education’s Comprehensive Student Support System School-Based Behavioral Health program and through the provider networks associated with the state Medicaid authority, the Department of Human Services (Med-QUEST Division). Funding to CAMHD comes from state general funds, the Med-QUEST health plan, the Federal Mental Health Block Grant, Title IV E reimbursement funds, and other government grants (for example, SAMHSA).

Service authorization takes place through child and family service teams that develop coordinated service plans for each youth. Youth are eligible for CAMHD’s mental health services through three primary channels. Youth in need of mental health services to benefit from their public education are determined eligible through the Department of Education’s special education processes and linked to CAMHD through weekly peer review meetings at each school. Youth age 3 through 20 with Medicaid insurance (Med-QUEST or Fee-for-Service) are also eligible if they have significant functional impairment (e.g., a Child and Adolescent Functional Assessment Scale [CAFAS] score of
80 or above) and an eligible DSM-IV Axis I diagnosis. Finally, youth are eligible through
the juvenile justice system to receive risk assessment and mental health services during a
period of detention or incarceration and through court ordered mental health services.
Outside of its primary service array, CAMHD also funds other prevention and
intervention services through special purpose programs (such as youth outreach, early
intervention, and preschool programs).

CAMHD maintains an active internal Compliance Program and a Performance
Management Office that provides monitoring and quality assurances for contracted
providers and for regional Family Guidance Centers (FGCs) compliance with state and
federal (Medicaid) requirements. In addition, the Department of Health and Education
have developed local Interagency Performance Standards and Practice Guidelines that
provides the cornerstone for integrated accountability through outcome and performance
standard monitoring. A variety of performance measurements and methods are used to
assess adherence and outcomes including case based reviews, standardized instruments
(including the CAFAS and CBCL), law violation, days served in home, family
satisfaction surveys, complaints, sentinel events, and personnel turnover, among others.
CAMHD monitors provider functioning through contract monitoring including case based
review and child status outcomes.

For implementation of EBPs, CAMHD acts as the Intermediary Provider/Purveyor
Organization or IPO for both the public and private branches of the service system.
CAMHD maintains a Practice Development section within its Clinical Services Office
(CSO) that is tasked with promoting improvements in clinical practice, including EBP
promotion. Thus, CAMHD strives to build infrastructure to support development of
practices throughout the state. The Practice Development section employs program staff
to work as supervisors for EBPs who fulfill the role of an external IPO (for example,
Statewide System Supervisor for the MST Program). During initial roll out of a new EBP,
CAMHD typically contracts with an external IPO (such as MST Services, Inc., Oregon
Social Learning Center, University of Hawaii) to help establish the program and build the
skills of the local practice development specialists. Thus, the system is generally designed
to sustain itself internally without extensive continual external IPO input. This design is
in part a function of CAMHD’s commitment to promote a self-sustaining EBP-based
system-of-care. It should be noted, however, that CAMHD continues dialogue and formal
contracting when necessary with the original IPO to ensure fidelity to the original model
(such as MST, MTFC, FFT). The Practice Development section also maintains a
comprehensive plan for implementation of EBPs in the context of broader practice
improvement efforts. CAMHD maintains several quality review committees that provide
oversight to the practice development initiatives (for example a Training Committee,
Evidence-based Services Committee).

A primary goal of the Clinical Services Office (CSO) is to disseminate EBPs in all
communities. One method of accomplishing this goal is through regular updating of the
CAMHD website. The website contains numerous EBP-related documents that range
from descriptions of services offered to the “Evidence Based Services Committee Tip of
the Week.” The CSO is also creating EBP fact sheets for providers and families. Additionally the CSO is responsible for the Interagency Performance Standards and Practice Guidelines (IPSPG), a guiding document for contracted mental health providers providing EBPs. The IPSPG is a manual with a heavy emphasis on EBPs.

In keeping with the concept of evidence base culture, CAMHD also holds Community Stakeholder Meetings for the Performance Standards and Practice Guidelines, in large part to increase awareness of EBPs. The Evidence Based Services Committee is another way in which EBPs are disseminated in Hawaii. The committee is open to any interested party and consists of approximately 40 members representing various stakeholders and providers in the system, including parents, psychology, psychiatry, social work, psychiatric nursing, Family Guidance Branch Chiefs, contracted providers, and university faculty. Members of the committee promote EBPs through their own work and settings.

Hawaii stakeholders report a strong belief that selection of EBPs needs to include attention to community fit. That is, it is not just which EBP might seem appropriate on paper but which EBP is determined by the community as right for the community through a community based (or regional) processes for selection. When considering a new EBP, CAMHD will typically hold best practice conferences and invite speakers from candidate EBP approaches to present their programs and outcomes. Audience response to these presenters is evaluated and provides an indication of provider interest and demand. Preferred services will then move forward to Request for Information (RFI) meetings which present service proposals that describe program structure, potential funding, performance standards, and contract monitoring procedures for which to obtain formal public comment. Following, RFI meetings, a Request for Proposals (RFP) is issued and interested providers submit their plans for meeting services. Thus, much of the implementation site readiness is addressed through self-selection during the procurement process. Each RFP specifies the criteria by which the proposals will be evaluated, and these criteria serve as another readiness-like screen. RFPs have a selection effect which also helps with provider readiness in that providers applying for funding to provide EBPs must complete a thorough self-assessment of readiness in order to respond.

Proposal evaluation is generally performed at a regional level to promote integration of local knowledge into the selection process. A state-employed practice development specialist generally serves as a system-wide supervisor for implementation of the EBP for the selected sites. Recently, CAMHD has also worked to establish “best practice networks” within specific service domains that are provider peer networks facilitated by the CAMHD practice development specialists to promote further diffusion of best practices across similar provider agencies.

During implementation, CAMHD (acting as the IPO) actively works with service providers and specific EBP purveyors. As noted in the IPO facilitation discussion above, CAMHD generally plays the role of working with EBP purveyors, assembling an audience of potential implementation sites, assessing interest in specific EBPs, defining program standards, arranging funding, and establishing contracts with implementation
sites. CAMHD generally enters into a contract with the EBP purveyor to provide technical assistance and to establish local capacity to act as a purveyor organization. CAMHD is not involved in staff selection, but is actively involved in staff training, credentialing, and program monitoring. Sometimes, CAMHD will require that providers enter into a direct contract with the EBP purveyor (for example, MST Services), but this is not always the case. CAMHD’s long-term goal is to develop enough local capacity to sustain implementation sites and expand it to new sites as needed.

For long-term fidelity promotion, CAMHD employs several strategies targeting different aspects of the issue. When EBPs have standard adherence forms (such as the SAMS and TAMS used by MST), completion of these forms is generally contractually required and monitoring performed by the CAMHD practice development specialist responsible for that service. More broadly, adherence is monitored through the CAMHD Performance Management Office that coordinates reporting of performance measures and conducts annual case-based provider reviews. Additionally, CAMHD monitors service utilization against specific program standards (for example, length of service for MST less than 6 months, caseload size within established limits).

CAMHD also locally developed a generic practice monitoring system called the Monthly Treatment and Progress Summary (MTPS). This document is designed to track intervention techniques and treatment targets employed by providers for individual consumers. Information from this monthly form informs CAMHD about the match between treatment targets and evidence-based approaches to treating those targets. CAMHD may also conduct special studies of specific topics or programs that will include a focus on adherence to specific interventions. Finally, CAMHD has a strong commitment to workforce development. It is hoped that training future providers in EBPs will increase overall adherence to the practices as a young and informed workforce transitions into CAMHD.

Table 13 on the following page provides an overview developed by CAMHD of its performance standards and guidelines for EBPs it has implemented. Note that the table includes both family-based and individual EBPs.
# Interagency Performance Standards and Practice Guidelines

## Evidence-Based Child and Adolescent Psychosocial Interventions

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in developing appropriate plans using psychosocial interventions. Teams should use this information to prioritize promising options. For specific details about these interventions and their applications (e.g., age setting, gender) see the most recent Evidence Based Services Committee Biennial Report (http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html).

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Level 1 – Best Support</th>
<th>Level 2 – Good Support</th>
<th>Level 3 – Moderate Support</th>
<th>Level 4 – Minimal Support</th>
<th>Level 5 – Known Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious or Avoidant Behaviors</td>
<td>Cognitive Behavior Therapy (CBT); Exposure; Modeling</td>
<td>CBT with Parents; Group Cognitive Behavior Therapy; CBT for Child and Parent; Educational Support</td>
<td>None</td>
<td>Eye Movement Desensitization and Reprocessing (EMDR), Play Therapy, Individual (Supportive) Therapy; Group (Supportive) Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Attention and Hyperactivity Behaviors</td>
<td>Behavior Therapy*</td>
<td>None</td>
<td>None</td>
<td>Biofeedback; Play Therapy, Individual or Group (Supportive) Therapy, Social Skills Training; “Parents are Teacher,” Parent Effectiveness Training, Self-Control Training</td>
<td>None</td>
</tr>
<tr>
<td>Autistic Spectrum Disorders</td>
<td>None</td>
<td>None</td>
<td>Applied Behavior Analysis; Functional Communication Training; Caregiver Psychoeducational Program</td>
<td>Auditory Integration Training; Play Therapy, Individual or Group (Supportive) Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>None</td>
<td>Interpersonal and social rhythm therapy*</td>
<td>Family psychoeducational interventions*</td>
<td>All other psychosocial therapies</td>
<td>None</td>
</tr>
<tr>
<td>Depressive or Withdrawn Behaviors</td>
<td>CBT</td>
<td>CBT with Parents; Interpersonal Therapy (Manualized IPT-A); Relaxation</td>
<td>None</td>
<td>Behavioral Problem Solving, Family Therapy, Self-Control Training, Self-Modeling, and Individual (Supportive) Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Disruptive and Oppositional Behaviors</td>
<td>Parent and Teacher Training; Parent Child Interaction Therapy</td>
<td>Anger Coping Therapy; Assertiveness Training; Problem Solving Skills Training; Rational Emotive Therapy, AC-SIT, PATHS and FAST Track Programs</td>
<td>Social Relations Training; Project Achieve</td>
<td>Client-Centered Therapy, Communication Skills, Goal Setting, Human Relations Therapy, Relationship Therapy, Relaxation, Stress Inoculation, Supportive Attention</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>CBT* (bulimia only)</td>
<td>Family Therapy (anorexia only)</td>
<td>None</td>
<td>Individual (Supportive) Therapy</td>
<td>Some Group Therapy</td>
</tr>
<tr>
<td>Juvenile Sex Offenders</td>
<td>None</td>
<td>None</td>
<td>Multisystemic Therapy***</td>
<td>Individual or Group (Supportive) Therapy</td>
<td>Group Therapy***</td>
</tr>
<tr>
<td>Delinquency and Willful Misconduct Behavior</td>
<td>None</td>
<td>Multisystemic Therapy: Functional Family Therapy</td>
<td>Multidimensional Treatment Foster Care, Wrap-Around Foster Care</td>
<td>Individual Therapy, Juvenile Justice System</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>None</td>
<td>None</td>
<td>Behavioral Family Management*; Family-Based Intervention*; Personal Therapy*; Social Interventions*</td>
<td>Supportive Family Management*; Applied Family Management*</td>
<td>None</td>
</tr>
<tr>
<td>Substance Use</td>
<td>CBT**</td>
<td>Behavior Therapy; Purdue Brief Family Therapy</td>
<td>None</td>
<td>Individual or Group (Supportive) Therapy, Interactional Therapy, Family Drug Education, Conjoint Family Therapy, Strategic Structural Systems Engagement</td>
<td>Group Therapy</td>
</tr>
</tbody>
</table>

* Based on findings with adults only; ** Appropriate if youth is in out of home setting, otherwise consider level 2; *** If delinquency and willful misconduct are present. 5 Consider medication or combined treatment as strongest options for hyperactivity only, or combined treatment as strongest for hyperactivity, academics (reading), and family interaction.
Strategies
In spite of the breadth of literature available regarding EBPs for family based mental health services, the evidence base remains limited with regard to specific populations, specific settings and specific outcomes. Experts interviewed for this review were in agreement that the generation of scientific knowledge is not keeping pace with the need for information driven by EBPs and their implementation. Furthermore, EBP implementation is generally at the point of promotion, consensus-building, and development, and has not yet been systematically incorporated within Medicaid managed care plans.

For this reason, a system, whether a State or more local jurisdiction, must attend to many elements beyond the scientific evidence base. As stated by a national expert interviewed for this paper: “... you’re always innovating here – these EBPs don’t necessarily line up with your system – so it’s absolutely imperative to look at all the details regarding the fit and readiness of your system. If you don’t do this problems will include under utilization, poor fidelity and worse outcomes.”

Similarly, interviewees posed the question “whose evidence?” when discussing the state of the research base. That is, when examining empirically-supported practices identified through various sources, state and local decision makers must still ask themselves if these results are applicable to their local situation? A common theme throughout the interviews was that the usability of a program has little to do with the weight of the evidence regarding that program, but rather it’s fit with the needs and strengths of a given system of care.

With these caveats in mind, we nevertheless offer the following strategies as the Commonwealth of Pennsylvania moves forward to implement family-based mental health services that are increasingly standardized and evidence-based.

Dissemination and Training Supports – The most important findings, based on our review of the literature and key informant input involve the development and promotion of evidence-based cultures among child and family service providers and agencies. Emerging research seems clear that the likelihood of achieving desired outcomes from family-based EBPs is maximized (and may in fact only be possible) if they are implemented in the context of a comprehensive effort to develop a culture that values and acts in light of evidence-based findings. We offer the following strategies in support of this.

Commitment to an evidence-based culture – A common theme in the literature on successful implementation and our interviews was a need for some variant of the evidence based culture described by Dixon (2003) featuring supportive state, local and agency infrastructures that have the policy, procedural, and funding mechanisms to sustain EBPs. This combination of infrastructure supports and favorable culture/climate form the foundation for successful implementation of EBPs (Rivard, et al., 2006).
Broadly, key components of successful preparation for program implementation include many factors. Among these are:

- Clear goals,
- Data collection with frequent and consistent feedback loops within and across levels of implementation: clinical practice, program management, and system performance; and
- Focus on innovation and consistent attention to creating change to improve outcomes, with a rigorous insistence on quality given that innovation can sometimes be used as an excuse for not working through the challenges of high fidelity implementation or as a cover for program drift without attention to outcomes.

In addition to promoting quality interventions, an evidence-based culture must be mindful that one of the biggest challenges facing a system seeking to improve the quality of services is the identification and elimination harmful and ineffective practices, in addition to doing more of what works and improving access to evidence based practices and programs (Blasé & Dean, 2005).

Once an intervention program has been selected, the chances of successful implementation can be increased by:

- Ensuring that sites and therapists/communities are well informed and prepared,
- Building “alliances” between purveyors of the EBP and sites implementing the EBP,
- Building a strong data set for decisions,
- Accommodating local “differences” without changing the integrity of program, and
- Paying constant attention to community awareness, understanding and support (Sexton, 2004).

A common theme throughout the literature and interviews conducted for this paper was the tendency of systems to underestimate what it will take (at all levels) to move a state of local system to a more evidence based platform.

**State-Level Resource Development Agency** – Connecticut and California both emphasized the importance of local in-state program development resources and these resources seemed critical to their success to date. Such a state-level capacity to promote and develop EBPs was seen as essential to supporting local administrative efforts and providing a quality assurance mechanism to utilize local data for program support. Such a capacity can also help in preparing the field with education, information, and discussion opportunities.

The establishment of a state-level intermediate purveyor organization may also be beneficial. These systems, like those in Connecticut and California allow efficiency, cost savings, and local ownership of training, dissemination, and data. By developing such local capacity either through an RFP-based procurement process (such as in Connecticut) or development of a quasi-governmental entity (such as in California), a state is able to
develop its own capacity to implement and expand evidence-based programming, while reducing reliance on the established purveyors of a given EBP, whether university-based or private.

**Recommended Family-based EBP Service Array**

The following considerations regarding a minimum family-based EBP service array are made in the context that a state would simultaneously take steps to develop and promote an evidence-based culture among providers. We do not recommend that EBPs be mandated without such a supportive framework, given the reasons discussed above.

Based on our review of the literature and key informant interviews, it appears that four family-based services currently have sufficient empirical support to be identified as a minimum service set:

- **FFT** – This is recommended as an intensive family therapy for youth living at home with moderate to severe behavioral problems involving disruptive and oppositional behavior, as well as some with willful misconduct and lower level delinquency.
- **MST** – This is recommended as an intensive family therapy that includes assertive outreach for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.
- **MTFC** – This is recommended as an intensive family therapy option for children and families when a temporary out-of-home placement is necessary or as a transition between a more restrictive out-of-home placement and return to the community or to preparation for reunification.
- **Wraparound Planning** – This is recommended as an adjunctive support for youth in families with complex needs who are likely to need significant support for family engagement and coordination for services received from multiple providers or youth-serving systems. Given its expense, it should be targeted to children and youth currently in or at-risk of expensive out-of-home placements such as residential treatment. The potential of targeting its use as an alternative to high use of other services (for example, Therapeutic Support Services under Behavioral Health Rehabilitative Services) could also be explored. Given its dependence on multi-agency cooperation, Wraparound Planning should only be used in local systems that demonstrate readiness for effective multi-system coordination and buy-in into the Wraparound model.

In addition to these four service types that currently have sufficient evidence to merit their inclusion as a minimum service set of family-based EBPs, Multidimensional Family Therapy (MDFT) should also be actively considered for inclusion on a more limited basis. Despite its more limited evidence base, it has shown promise in family-based treatment where youth substance use is focus of concern. Systems interested in implementing a less intensive, more traditional family therapy may have interest in MDFT, and the state as a whole should continue to monitor its development for future consideration to add it as a required service element.
It is also important to recognize that there are other important practices that should not necessarily be limited by the research base on the four recommended EBPs. Other effective practices reflect clinical values, priorities, and common sense and will be implemented prior to availability of supportive research. To differentiate and support the effective components of current local practices, local service systems should actively monitor and seek to identify the effective components of their current service delivery systems, including their family-based mental health services. As an evidence-based culture takes hold, the evidence base of current practices should also be identified over time.

The importance of local data collection and analysis cannot be overstated. One of the common advantages cited for EBPs include the rich data collection and reports which are typically not present in traditional services that lack fidelity and quality assurance protocols. In the absence of these data, interventions remain a black box. However, data practices can be developed and applied to a wide range of innovative practices and it is not always the best answer to abandon current practice and move to a well-established EBP.

**Funding Options**

After launching an EBP implementation initiative and determining the fit of which EBP best meets local needs and builds on local resources, another major challenge that must be addressed is the creation of funding structures that provide incentives for high quality implementation and do not work against maintaining fidelity. Two possible strategies are offered based on our review.

**Pay for Training and Transition Costs Through an Intermediary Organization** – There are significant costs to move a system to an evidence-based culture and promote the adoption of specific EBPs. However, simply allocating additional funds to local systems in the hope that they will be able to develop such culture and practices has not been shown to work. The experience of states such as Connecticut, California, and others has shown that an intermediary organization such as those discussed above can serve as a medium for providing both the resources and guidance needed to support local EBP implementation. The funding and supporting of local program evaluations to provide evidence of effectiveness is also an important component of changing the culture of treatment to outcome based.

**Financial Incentives to Implement EBPs.** In addition to support for transition costs, the use of financial incentives for EBPs is growing in popularity. Systems like that of New York and Michigan provide higher rates if providers conform to EBP standards and additional benefits if high cost and restrictive outcomes are avoided.
Quality Management

Develop Local and Statewide Data Monitoring Capacity – As emphasized previously, the establishment of data-driven quality management processes is essential to both development of an evidence-based culture and the successful implementation of specific EBPs. Strong data systems that allow the monitoring of both outcomes, utilization, and the quality of care can facilitate both the quality of EBP implementation and control of system development, as demonstrated in states such as Michigan and Hawaii. Because information on the generalizability of many evidence-based treatments is limited, it is particularly important to monitor outcomes of these treatments when they are implemented in routine clinical practice. Furthermore, although monitoring fidelity is critical in ensuring that treatments are faithfully implemented, it is not a substitute for outcome monitoring. A treatment that shows excellent efficacy for one population may not yield a good outcome when applied to a different population or in a different context.

In addition to the need to support a broad data-driven quality management capacity to promote local evidence-based cultures, the following two more specific options are also offered:

- **Require fidelity monitoring** – While research has shown that fidelity monitoring in itself is not sufficient to ensure positive outcomes, it is nonetheless necessary. Simply put, a system cannot know if it is implementing an EBP is fidelity is not monitored. Each of the four EBPs recommended as the minimum service set (FFT, MST, MTFC, and Wraparound) have established fidelity monitoring protocols available that should be required, tracked, and monitored at both the local and state level. Establishing this data tracking and analysis capacity within a state-level entity (rather than relying on the purveyors of the separate EBPs) is preferred. For Wraparound Planning, there is not the same level of consensus regarding standardized outcome monitoring, but emerging frameworks through the National Wraparound Initiative and other sources are available. The lack of consensus requires more local infrastructure development and consensus building for implementation of fidelity monitoring for Wraparound Planning.

- **Require outcome evaluation** – As noted above, establishing fidelity is not enough; the desired outcomes for each EBP must also be tracked to ensure that system goals are achieved. Recent research in real world settings has clearly shown that simply implementing a given EBP is not enough. Local evaluation is needed to ensure that the EBP is successfully incorporated into the local system of care in a manner that yields desired outcomes.

Administrative Requirements

**Base Eligibility on Behavioral Needs, Not System Involvement.** Too often currently the primary eligibility factor determining access to EBPs is system involvement (usually in the juvenile justice system). Youth cannot get access to the most appropriate service until they have come to the attention of that system. Increasingly states such as
Connecticut are moving to base eligibility for MST, FFT and other EBPs on behavioral needs rather than system involvement.

Toward that end, we recommend that eligibility for each EBP be based on demonstration of behavioral needs in the target areas established for each EBP (discussed previously for each EBP). In addition, there is emerging evidence that these EBPs may be used effectively serve other populations (such as the use of MST to treat youth in need of treatment for sexual offenses). We recommend that these EBPs only be extended to other populations if there is systematic validation within a local system of their effectiveness and that such validation be confirmed by the state-level independent entity charged with developing EBPs.

**Implement a Standardized Screening Protocol.** Most of the states successfully implementing EBPs have also implemented standardized screening methods to guide eligibility decisions and track outcomes over time. Most of the states discussed in this paper have used the CAFAS, given that it was the preeminent screening method available three to five years ago when many EBP efforts were just getting underway.

While the CAFAS is a sound and established tool, there is emerging consensus among child-serving agencies (child welfare, juvenile justice, and mental health) that the Child and Adolescent Strengths and Needs (CANS) offers a superior choice. The CANS was designed to serve as a communication and decision-making tool for psychiatric services. It has demonstrated utility in improving decision making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1998). The strength of the measurement approach has been that it is face valid and easy-to-use, yet provides comprehensive information regarding the clinical status of the child or youth.

The CANS-MH has been described in April 2005 issue of the Journal of the American Academy of Child and Adolescent Psychiatry as a “layperson or clinician administered interview intended to measure the functional impairments and strengths of youths with emotional and behavioral disorders and to use these results to develop treatment algorithms that guide service delivery. For the individual youth and family, the CANS-MH uses a structured assessment of youths along a set of dimensions relevant to decision making that aids in developing an individual plan of care. For the system of care, the CANS-MH provides information regarding the youth and family’s service needs for use during system planning and/or quality assurance monitoring.”

The CANS is ideally suited for use in multi-agency service settings to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality in of life. The CANS is designed to be used either as a prospective assessment tool for decision support during the process of planning services or as a retrospective assessment tool based on the review of existing information for use in the design of high quality systems of services. This
flexibility allows for a variety of innovative applications. The CANS can be used for retrospective file reviews for planning purposes. Retrospective review of prospectively completed CANS allows for a form of measurement audit to facilitate the reliability and accuracy of information (Lyons, Yeh, Leon, Uziel-Miller & Tracy, 1999).

The CANS is designed for use at two levels-for the individual child and family and for the system of care. The CANS provides a structured assessment of children along a set of dimensions relevant to service planning and decision making. Also, the CANS provides information regarding the child and family’s service needs for use during system planning and/or quality assurance monitoring. Due to its modular design the tool can be adapted for local applications without jeopardizing its psychometric properties.

Bringing It All Together
Across the findings offered above, one final consideration should be kept in mind: that the success of any single strategy depends on the implementation of multiple other strategies. Changing complex youth and family service systems is difficult. The research reviewed in this report clearly demonstrates that the best route to success is a comprehensive approach that blends EBP implementation, training and dissemination strategies, financing methods, administrative supports, and quality management within an overall effort to develop evidence-based cultures. As such, we end by recommending that no single option identified in this report be undertaken without careful consideration of the other options and development of a comprehensive strategy with families and youth to ensure that EBPs realize their significant and costly promise.

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Early Childhood Mental Health Consultation

This section of the report focuses on the emerging practice of early childhood mental health (MH) consultation. This emerging practice is relatively new, with the best documented models (in Connecticut and Vermont) being developed on a permanent state-wide basis only in the last several years. As such, this service type does not yet have a well-established research base establishing its cost-effectiveness, so we focused on a review of the available outcome literature and detailed interviews with key informants in five states that are currently implementing the service: Colorado, Connecticut, Florida, North Carolina, and Vermont.

For ease of presentation, first we briefly review key concepts in the field of early childhood mental health services. We then summarize research findings, focusing on outcomes of mental health consultation, consultant skills, screening approaches, practice principles, and funding strategies. We then summarize the approaches to early childhood MH consultation in the five targeted states, as well as other state examples found through the literature review. Finally, we provide strategies for the development of early childhood MH consultation services in child care settings.

Interviews were conducted with eight informants knowledgeable about the development and funding of mental health consultation services in five states that have been at the forefront of early child mental health service development nationwide:

- **Colorado** – We interviewed Sarah Hoover, who serves as Project Director of Colorado’s SAMHSA-funded system of care initiative Project BLOOM for Early Childhood Mental Health, and Claudia Zundel, who is the lead for Project BLOOM at the Colorado Division of Mental Health.

- **Connecticut** – We interviewed three people involved in this state’s national model Early Childhood Consultation Partnership (ECCP): Judith Meyers, PhD, President and CEO of the Children’s Fund of Connecticut and the Child Health and Development Institute of Connecticut, Inc.; Bert Plant, Director of Community
Services, Connecticut Department of Children and Families; and Mark Schaeffer, PhD, Director of Medical Policy, Connecticut Department of Social Services.

- **Florida** – We interviewed Celeste Putnam, MS, an independent consultant who is very involved in Florida’s child mental health and child welfare services development over the past decade.
- **North Carolina** – We interviewed Tara Larson, Assistant Director, Clinical Policy and Programs, North Carolina Division of Medical Assistance.
- **Vermont** – We interviewed Brenda Bean, who was centrally involved in development of that state’s nationally renowned Children’s Upstream Services (CUPS) program.

### Key Early Childhood Mental Health Concepts

#### Defining Mental Health in Very Young Children

The Zero to Three Infant Mental Health Task Force defines infant mental health as the ability of zero to three year olds to experience, regulate and express their emotions; form close and secure relationships and learn by exploring their environment (Zero to Three, 2002). These activities occur in the context of family and community. Simply put, infant mental health can be viewed as appropriate social and emotional development. Some states and programs include children ages zero to five in this definition and expand the definition to include the prevention and treatment of mental health problems in this population. Research demonstrates that high-quality early care and education produces children who are emotionally secure and self-confident, proficient in language use, able to regulate impulsive and aggressive inclinations, and with age appropriate cognitive development.

Terms such as “early childhood mental health” and “early intervention” are often used interchangeably with “infant mental health” but Simpson, et al. (2001) caution that the terms may not mean the same thing especially when used in different service sectors. Johnson and Knitzer (2005) indicate that regardless of the term used, early childhood mental health efforts emphasize the goal of promoting “healthy relationships among and age-appropriate social and emotional behaviors in all young children, even those whose early experiences place them at the greatest risk”. We use the term “early childhood mental health” in this paper.

There is considerable consensus that early relationships and experiences form the foundation for social and emotional development. Caregivers and parents may benefit from guidance and support to promote children’s social and emotional development by creating safe and nurturing environments (Collins, et al., 2003). Simpson, et al. (2001), cite 1991 data from the Children’s Defense fund which indicates that 64% of mothers who have children under the age of six are in the work force and 41% percent of children under five spend 35 or more hours per week in child care. This presents an opportunity to serve children where they spend the majority of their time and to ensure that those they spend that time with have the skills to support their development.
Alkon, Ramler, and MacLennan (cited in Florida State University, Center for Prevention and Early Intervention Policy, 2006) reported that behavioral or emotional problems can be found in one out of five pre-school age children; a diagnosable psychiatric disorder is present in eight out of every 100 children; preschool children with persistent behavior disorders continue to have problems later in childhood; and the prevalence of behavioral problems later in childhood and adolescence can be altered through interventions at the pre-school age.

**Early Childhood Mental Health Perspective**

Cohen and Kaufmann (2000) introduce the concept of an early childhood mental health perspective. This term refers to an approach that programs and systems should:

- promote the wellness of all children in child care,
- prevent the development of new problems, and when indicated
- intervene with children having difficulties.

This perspective stresses that children must be understood in the context of age appropriate development, the relationships between them and their caregivers within their environment, and factors in the overall environment that impact those relationships. This perspective underlies emerging practices through which mental health professionals have increasing opportunities to support prevention efforts early childhood settings such as child care centers.

According to Johnson and Knitzer (2005), in order to promote social/emotional development and school readiness, policy makers should target the following types of interventions: 1) Promotion and prevention strategies (such as screening, and training and support to caregivers) targeted to all children, 2) Early intervention strategies (such as training and mental health consultation for caregivers) for young at-risk children (those with special needs, in foster care or whose parents have mental health or substance abuse issues) and 3) intensive child and family-focused, relationship-based strategies for children with serious social, emotional, and behavioral problems (such as addressing parent needs, providing behavioral supports for the child, and providing wraparound planning for the family). They indicate that funding barriers include funding restrictions, eligibility criteria, limited funds for parent-child interventions, systems not adequately tracking at-risk children, and limited funding for training. They describe the three categories of major federal funding streams (health and mental health programs such as Medicaid, early care and learning programs, and programs serving children and families at higher risk) that can be used for these children and guidelines for how these funding streams may be used or combined with other funding streams to support the social and emotional development of children.

Simpson et al. (2001) point out that “a coordinated or systematic early childhood mental health response does not exist across the country,” resulting in fragmented services. They add that although efforts in the early intervention field are guided by the consensus that early childhood presents an opportunity to enhance child development and support families, further research is needed in several areas. Among their recommendations is that
further knowledge of brain development and factors that promote healthy development is needed. They recommend further research on early intervention programs, practices and outcomes, along with the development of diagnostic, assessment, and evaluation measures. They add that effective family-centered services may be guided by further research in the areas of resilience and protective factors. A final but important area that the authors recommend be researched is the relationship between funding, public policy and early childhood mental health programs and how local, state, and national policies affect funding and outcomes.

**Mental Health Consultation**

Cohen and Kaufmann (2005) offer the following definition of early childhood mental health consultation:

> “Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families.” (p. 4)

The authors add that the goal of early childhood mental health consultation is to help staff incorporate the mental health perspective into how they work with children and their families. Consultation assists child care staff in promoting learning and enhancing the social and emotional development of each child and in building relationships with parents; it builds on the skills and knowledge that caregivers already have but does not attempt to turn them into mental health professionals.

Two types of early childhood mental health consultation are generally discussed, program level and child/family-centered. The goals of program level mental health consultation are seek to improve a program’s overall quality and/or address a problem that affects more than one child, family, or staff member. Consultants may assist the setting in creating an overall approach to enhance the social and emotional development of all children.

Child/family-centered consultation seeks to address a specific child or family’s difficulties in the setting. The consultant provides assistance to the staff in developing a plan to address the child’s needs, may participate in observation, may meet with the parents of the children and in some cases refer the child and/or family for mental health services.
Research Findings

Outcomes of Mental Health Consultation

Johnson and Knitzer (2005) stress that social and emotional skills form the foundation for school success and that relationship-focused mental health interventions can help promote these skills in children, thereby promoting school readiness. They add that mental health consultation provided to child-care staff is an effective intervention that can address how caretakers respond to children. Children with social and emotional developmental challenges may exhibit behaviors which interfere with learning, such as not listening to the teacher, disruption of the classroom, or not engaging with the teacher and peers.

In a report for two Maryland Early Childhood Mental Health consultation pilot sites (Baltimore City: Early Intervention Project and Eastern Shore: Project Right Steps), Perry (2005) indicates that mental health consultation has been found to reduce expulsion rates for young children with behavioral problems by providing caretakers with the skills to implement behavior and classroom management and more developmentally appropriate strategies. Consultation also resulted in children being screened and identified for treatment earlier. In these pilot sites almost 90% of the children at-risk for expulsion were maintained in their setting and about 75% displayed improvements in social skills.

According to Gilliam (2005), expelled pre-kindergarteners are less likely to be prepared for kindergarten and elementary school and at risk for school failure. As part of the National Pre-kindergarten Study, the first study on prekindergarten expulsion rates due to behavioral concerns (Gilliam, 2005) found that students in prekindergarten are expelled at a rate more than three times that of students in K-12th grade. The study found that expulsion rates varied by settings, with the lowest rates reported in school and Head Start settings and the highest rates (about twice as high) reported in for-profit child care and faith-affiliated centers. Boys were found to be over four times more likely to be expelled than girls.

The study found that the likelihood of expulsion was lower when teachers had access to a mental health consultant who could provide classroom-based strategies for dealing with challenging behaviors. While teachers with ongoing and regular access to consultants who are based in the same building or regularly visit the classroom (at least monthly), reported the lowest rates of expulsion, teacher requested access to a mental health consultant was better than no access to a consultant at all. In a policy brief summarizing this study, Gilliam (2005) reports that classroom-based behavioral consultation appears promising for decreasing pre-kindergarten expulsion rates.

A Center for the Study of Social Policy (CSSP) Strengthening Families through Early Care and Education report (2004) cites that early childcare and education programs can help build protective factors that reduce child abuse and neglect. The protective factors include: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. Mental health consultation was identified as a specific program element that
helps build protective factors. Mental health consultation was described as supporting children with challenging behaviors by providing their parents and caretakers the skills to manage those behaviors, which may result in children maintaining their current placement thereby reducing parent stress. Parents may learn improved skills by seeing staff be nurturing and loving towards children. Consultation also helps build relationships, enhances communication between staff and parents, and helps families access mental health services. The CSSP makes resources available to support early childhood programs in implementing aspects of the Strengthening Families Approach, which focuses on building the protective factors that reduce child abuse and neglect. In partnership with CSSP, seven states are part of the Strengthening Families Pilot project, in which they implement the Strengthening Families Approach through collaborations with early childhood, child abuse prevention, and child protective services sectors in each state and look at how state policy changes, new linkages, and training opportunities can result in more programs implementing the Strengthening Families Approach.

Benefits are also reported for programmatic mental health consultation at the staff and center level. A formal evaluation of the Early Childhood Mental Health Project in San Francisco found that teachers and directors report that mental health consultation is supportive, effective, and improves the effectiveness of teachers along with the likelihood that services offered by a center will be developmentally appropriate (as cited in Florida State University, Center for Prevention and Early Intervention Policy, 2006).

Brennan et al. (2006) conducted an extensive literature review for a 2005 national conference “Establishing the Evidence Base for Early Childhood Mental Health Consultation.” They looked at the evidence for the effectiveness of mental health consultation on staff and program outcomes and found that mental health consultation was associated with staff’s improved ability and confidence to address children’s social and emotional needs; staff’s increased sensitivity to children’s needs; reductions in staff’s job stress and levels of burnout; and staff’s improved ability to engage parents. Program level outcomes included reduced staff turnover; more positive effects when consultants were seen as part of the team; staff adoption of a consistent mental health philosophy through the help of the consultant; and improved family access to mental health services.

Consultant Skills

A 1998 Roundtable discussion on mental health consultation approaches recommended that mental health consultants be state licensed and possess the following skills (Cohen and Kaufmann 2005):

- Understanding of child development;
- Understanding of socio-emotional development and underlying concepts;
- Ability to integrate mental health philosophies into group settings;
- Observation, listening, interviewing, and assessment skills;
- Knowledge of adult learning principles and ability to work with adults;
- Community sensitivity;
- Cultural competence;
- Knowledge of treatment alternatives, including behavioral interventions;
Ability to differentiate between resistance and culturally appropriate behavior;
Knowledge of family systems;
Ability to recognize diverse perspectives of staff and to facilitate communication of these perspectives; and
Understanding of early childhood serving systems.

The Roundtable also noted that consultants should have culturally specific knowledge about topics affecting the population he or she will be working with. While it may be difficult for local programs to identify mental health professionals with early childhood consultation experience or training, programs such as Day Care Consultants (San Francisco) and the Institute for Clinical Studies of Infants, Toddlers and Parents (New York City) provide specialized training. Hepburn and Kaufmann (2005) have created a training manual to introduce early childhood mental health consultation to program administrators and other early childhood staff.

Early Childhood Mental Health Screening Approaches
A crucial step in addressing social and emotional difficulties and preventing further problems is early identification through screening. As cited in a Colorado work group report on social and emotional screening for infants, toddlers, and preschoolers (Stainback-Tracy, 2004), the screening process is a tool for identifying children who may benefit from early intervention treatment programs; is useful for determining when a child may require further assessment; includes input from those close to the child (parent, caretakers, teachers); includes referrals for further evaluation or treatment when indicated; and is available in settings such as a primary care or early care and education settings. Given different settings’ needs and processes for screening children, the group convened for this report made recommendations for the use of screening tools in early care, education, and primary care settings.

The group recommended that screening tools used in early care and education settings, which include center and home-based child care settings and pre-school programs (including Head Start and Early Head Start), should include classroom strategies to assist teachers in addressing the social and emotional needs of children. The group also recommended that ongoing support from a mental health professional or early childhood educator with a background in social, emotional, and behavioral development would not only help teachers address children’s needs but also help them interpret screening results and determine when a need for further evaluation is present.

For children younger than two, they suggested the Ages and Stages Questionnaire – Social-Emotional (ASQ-SE), which can be used with children 6 to 60 months old. The ASQ-SE is a 30-item parent completed questionnaire which focuses on self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people.

The Deveraux Early Childhood Assessment (DECA) for ages 2-5 was also suggested as a tool for use in early care and education settings by the group because of its development.
for and testing with early childhood teachers along with program inclusion of strategies
for promoting positive behaviors in children. Attachment, self-control, initiative, and
behavioral concerns are measured in the DECA’s four subscales.

Child care centers which receive early childhood mental health consultation services from
Community Outreach Services in Sarasota, Florida, use the Ages and Stages
Questionnaire (ASQ) to screen all children in the setting. When further screening is
indicated, consultants use the ASQ-SE as one of the instruments to screen for behavioral
and emotional needs. The Child Care Intervention Team in Colorado uses the ASQ and
ASQ-SE as screening tools and the DECA as part of a more comprehensive assessment
process. Early care and education programs receiving intensive classroom consultation
services from Child FIRST Community Consultation in Greater Bridgeport screen all
children in the classroom using the DECA. Based on those results, consultants then
develop a classroom profile and identify areas of need along with strategies to address
them. Children’s individual problems are also identified through this screening, allowing
the consultant to work with the teacher to develop strategies to address those individual
needs as well.

The Colorado group (Stainback-Tracy, 2004) recommended that Child Find teams (who
complete the screening, evaluation and assessment services required by the Individuals
with Disabilities Education Act or IDEA), use tools that allow them to gather information
through parent report (focusing on typical behaviors) and/or a one-time observation. The
Temperament and Atypical Behavior Rating Scale (TABS) Screener, Brief Infant Toddler
Social-emotional Assessment (BITSEA), and the ASQ-SE were suggested by the group
as parent report tools for use by Child Find teams.

The work group recommended that the use of screening tools in primary care settings
should be promoted since research they cited indicated that primary care providers may
fail to identify children with diagnosable problems when they rely on clinical judgment
alone. The group recommended that tools used in primary care settings would be more
feasible to implement if they could be completed by parents in the waiting room, were
easy to administer and interpret and provided guidance for whether further screening or
evaluations were needed. They suggested the Parents’ Evaluation of Developmental
Status (PEDS), ASQ, ASQ-SE and the Family Psychosocial Screener for use in primary
care settings.

Environment Rating Scales offer another set of screening resources to assess the process
quality of early childhood and child care programs, including the interactions among
children; among staff and children, parents and other staff; the interactions children have
with the environment; and the space and materials that support these interactions (Frank
Porter Graham Child Development Institute, 2000-2005). The key aspects of quality child
care programs measured by these scales include their capacity to protect the health and
safety of children; to build positive relationships; and to provide opportunities for
learning and stimulation through experience and are included in the scales. Each of the
scales evaluates: physical environment; basic care; curriculum; interaction; schedule and
program structure; and parent and staff education. Scales are available to assess different settings available for different age groups:

- The Infant/Toddler Environment Rating Scale, Revised Edition (ITERS-R) is a 39-item scale for use in center-based programs caring for infants and toddlers through the age of 30 months. The scale assesses stimulation through language and activities and supportive interactions, important to working with young children.

- The Early Childhood Environment Rating Scale, Revised Edition (ECERS-R) is a 43-item scale that assesses center-based programs that care for young children ages 2 ½ to 5. The revised scale includes new items which assess staff-child interactions, child-child interactions and discipline.

- The Family Day Care Rating Scale (FDCRS) is designed to assess home-based child care programs. The 40-item scale includes supplementary items for programs that enroll children with disabilities. Many programs throughout the country use the scales to prepare for accreditation and as they engage in quality improvement efforts.

### Promising Practices Principles

Simpson and colleagues (2001) developed a set of principles to examine promising practices at five early childhood mental health sites they visited. Those principles, which provide a framework for considering effective interventions, are that early childhood mental health practices should be:

- Family-centered – Services and supports are designed with the family’s needs and preferences in mind.

- Individualized – Interventions are designed to meet the unique needs and strengths of the family, while being respectful to their racial, ethnic, cultural, and socioeconomic background.

- Comprehensive – Supports take into account developmental, health, and mental health needs of the family and may incorporate both preventive and therapeutic interventions.

- Community-based – Interventions are provided in the child/family’s natural environment and incorporate their natural supports.

- Coordinated/transdisciplinary – Transdisciplinary collaboration and coordinated services since no one agency can meet every need a family may have.

- Fully inclusive of families in decision making – Family members are equal partners and decision-makers at all levels.

- Focused on developmental needs – Supports should address children’s developmental needs in all areas of functioning.

- Built on strengths and resilience – Interventions designed to promote resiliency in children and build on family strengths by enhancing self-esteem, coping strategies, and increasing positive social support.

As part of their analysis of Florida’s Medicaid-funded services for children under 5, Berson and colleagues (2002) had stakeholders identify sites throughout the country that demonstrated “best practices” based on the promising practices principles identified by Simpson et al. (2001) and Knitzer (2000). The programs identified included IDEA Part C
initiatives, Early Childhood Developmental Specialists in Primary Healthcare Practice Initiatives, Starting Early Starting Smart, the Children’s Upstream Services (CUPS) Program in Vermont, and other local projects, many of which are described later in this report. Among their recommendations, the authors suggest that evidence-based prevention and intervention strategies be researched and outcomes be tracked so that research informs practice.

Funding Strategies

Despite the growing acceptance of the need for early intervention and prevention, funding to promote a comprehensive approach to early childhood mental health treatment is has been cited frequently as a challenge. Wishman and colleagues (2001) note that there is no public policy regarding financing of children’s mental health services, and because different agencies fund different services, collaboration between those agencies and a blending of funds is essential. Because early childhood mental health addresses children’s relationships with their caretakers, adult funding streams must also often be accessed.

Cohen and Kaufmann (2005) note that Medicaid is used as a funding source for many programs receiving child-focused early childhood mental health consultation, in part because eligibility is broadest for the under six population and because the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program pays for health and mental health services needed by each enrollee. Among programs discussed in more detail below, Vermont and North Carolina both fund child-specific services through Medicaid, and Connecticut is developing such funding.

While Medicaid can fund needed screening, diagnosis, and intervention services for eligible children and families, it has been criticized as being based on a diagnosis-driven medical model which does not easily accommodate relationship-focused interventions (Berson et al., 2003). Informants interviewed for this report noted efforts in Vermont and North Carolina to include DSM-IV V Codes as covered diagnoses, as well as expanding use of the Diagnostic Classification System for Children 0 – 3 Years – Revised (DC 0:3 R), crosswalking the DC 0:3 R diagnosis for early childhood mental health services with more traditional diagnostic schemes (DSM-IV, ICD-9) in states such as Arizona, Florida, and Maine.

The Individuals with Disabilities Education Act (IDEA) Part C program also provides early intervention services to children 0-36 months identified as at risk for developing a developmental delay or who have a developmental delay. Services are family-focused, multi-disciplinary, and provided to all children regardless of family income, but children must not be eligible for special education services in order to qualify.

However, funding program-level consultation is more challenging with Head Start being one of the few programs which funds this type of service. Some programs fund mental health consultation through private foundation grants or publicly funded programs such as the Child Care Development Fund (CCDF), Temporary Aid to Needy Families (TANF) and Social Services Block Grants (SSBG) (Johnson and Knitzer, 2005). In Vermont,
Commonwealth of Pennsylvania  
Office of Mental Health and Substance Abuse Services  

Implementation of Recovery/Resilience and EBPs

providers have explored supporting consultation through Medicaid administrative funds and training through Title IV-E of the Social Security Act, though recent policy developments related to the Deficit Reduction Act of 2005 have raised significant concerns about the use of Medicaid administrative in service settings and initiatives which blend Medicaid and Title IV-E funds.

Berson and colleagues (2003) conducted a study to look at the policy and funding issues impacting behavioral health services for children under three in Florida. As part of this study they conducted stakeholder interviews with Medicaid, IDEA Part C, and behavioral health providers and coordinators to look at funding stream interactions, access barriers by funding sources, and identify gaps and overlaps in services. Stakeholders mentioned that referrals are often determined by which funding stream will cover a service. The funding stream may reimburse for a certain specialty or provider, but that provider may not have experience in working with young children. While stakeholders pointed to promising initiatives (such as the DC: 0-3 crosswalk noted above), the authors note that “inadequacies of funding for early intervention therapies remain a concern since financial incentives appear to be in conflict with emerging standards of quality care.” In the Florida Infant and Young Child Mental Health Pilot Project, direct treatment is covered by Medicaid, but “engagement” efforts similar to case management are not. A recommendation by Adams and colleagues (2003) was for the state to look into matching Alcohol, Drug Abuse and Mental Health (ADM) under “outreach” and look at the use of EPSDT funds to cover case management.

Vermont amended its Medicaid plan to include reimbursement for targeted-case management for developmental therapy for 0-3 year olds by parent-child center staff that are certified as Early Interventionists. Medicaid can also be billed by Community Mental Health Center staff for eligible children with a mental health diagnosis. For children with serious emotional disturbances, targeted case management, which allows collateral contact with families, can be billed to Medicaid. Simpson and colleagues (2001) point out that “Vermont’s early intervention and support services can be provided for the very young children of transition-aged youth with serious emotional disorders. This allows case managers to target and serve a group of high-risk young children without placing a diagnostic label on them.” North Carolina directly funds mental health consultation services for children through Medicaid, and Connecticut is developing regulations to guide future Medicaid funding of such services based on its successful Early Childhood Consultation Partnership (ECCP) detailed below.

The Ohio Department of Mental Health developed a $2.6 million state grant program (Early Childhood Mental Health Initiative) for local agencies to promote the social/emotional development of young children through mental health consultation and training to early childhood programs, mental health/early childhood cross training, development of family support groups, and public awareness activities. Despite this, use of Medicaid funds for prevention and early intervention remains challenging due to the interpretation of medical necessity and treatment plan requirements for young children.
Colorado launched a similar state-funded initiative in the last year through its community mental health centers and is exploring Medicaid funding in the future.

San Francisco has identified the need for early childhood mental health consultation to center and home-based care centers. Through memoranda of understanding, it uses pooled funds from sources such as general revenue, Medicaid, city funds, and Temporary Assistance to Needy Families (TANF) funds transferred to child care in order to enhance funding for mental health consultation. Consultation services are also reimbursed through the Children, Youth and Family Section of the Department of Public Health, Community Mental Health Services.

California passed its Children and Families First Act (Proposition 10) in 1998, which imposed an excise tax on cigarette sales to improve early childhood development through comprehensive and integrated services (Simpson et al., 2001). This, along with the Children’s Health Act make it possible to address early childhood mental health concerns and health concerns for a more comprehensive approach.

State Examples of Mental Health Consultation

**Colorado**

Project Bloom in Colorado is a partnership of the Colorado Department of Human Services and JFK Partners at the University of Colorado Health Sciences Center. The Project is funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) federal grant. The project serves children 0-5 with serious emotional disturbances (SED) in pilot sites across the state. The project seeks to provide training, integrated service support and delivery, statewide workgroups focusing on system improvements, and ultimately, sustainable statewide resources for addressing children’s mental health. One of the goals of the project is to provide training and mental health consultation to early childhood staff so that they can address mental and behavioral needs.

Colorado is in the process of developing sustainable funding strategies and competencies for mental health consultation. Project BLOOM just completed a survey of early childhood mental health services across Colorado and found that a variety of funding sources are used, including Medicaid, TANF child care funds, and Head Start / Early Head Start. To help support parents and other seeking these services, the project has drafted “fact sheets” which provide guidelines for mental health consultation funding sources. The fact sheets include state and local level recommendations that providers (primary care, schools, community mental health centers) may adopt in order to increase their provision of and reimbursement for consultation.

Informants also noted Colorado has been able to bill early childhood consultation related services to Medicaid, using the following approaches:
Targeted Case Management and Rehabilitation Case Management, both of which require active MH treatment and a formal treatment plan (which are barriers to consultation in many emerging circumstances);
- Consultation as a stand-alone service under Colorado’s 1915(b)(3) waiver;
- A variety of traditional treatment modalities when the child or family is present, including individual psychotherapy and family therapy, supported by a DC:0-3R cross-walk to covered ICD-9 codes; and
- Limited use of EPSDT funds.

Efforts are being made in Colorado to broaden access to early childhood MH resources. An initiative using state funds in the past year is funding an early childhood MH specialist in each of 17 community mental health centers (CMHC) across the state. A key underlying principle in developing this CMHC-based infrastructure was the need to develop longer-term relationships with child care agencies, rather than have to establish such relationships only when specific children were identified as needing enhanced supports.

The Colorado Division of Mental Health has developed standard requirements for early childhood MH specialists. One observation made by informants in Colorado was that consultation skills differed from clinical practice skills and that the better early childhood MH specialists were more often not MH clinicians by training. As a result, the standard requirements allow a range of degrees and backgrounds. Requirements focus on a master’s level clinical background with early childhood mental health specialization as determined by education, training and experience, training in the use of the DC:0-3R, and use of “appropriate evidence based treatment,” keeping “current on innovations in the early childhood mental health field.”

Connecticut

Connecticut has undertaken comprehensive efforts to improve the quality of early care and education, including pilot project to inform the development of a statewide system (Child Health and Development Institute of Connecticut – CHDIC, 2005). This statewide multi-disciplinary consultation system builds on other state and national initiatives and policy efforts. Connecticut’s State Early Childhood Comprehensive Systems (SECCS) Initiative funded by the Maternal and Child Health Bureau seeks to develop a comprehensive early childhood system for 0-5 year olds across the state. The initiative, called Early Childhood Partners seeks to provide access to a comprehensive health services and medical homes, social-emotional development, and mental health services for children, early care and education, and parent education and support.

Healthy Child Care Connecticut (HCCC) is funded through the Maternal and Child Health Bureau and has worked to address the goals of Healthy Child Care America (HCCA) since 1997. HCCC has provided trainings to build the capacity of child care health consultants and also provided education and mental health information.
Consultation efforts in Connecticut include three major programs: Multi-Disciplinary Team (ACES/New Haven), Child FIRST Community Consultation (Greater Bridgeport), and Early Childhood Consultation Partnership (Connecticut).

**Multi-Disciplinary Team (ACES/New Haven)** – The regional education service center (ACES) has provided multi-disciplinary consultation services to child care centers who serve preschool age children since 1998. The team includes specialists in early childhood, mental health, health, speech and language, occupational and physical therapy, behavioral health, social work, and a family advocate. The team may provide consultation to an individual or group of teachers, the entire center or a parent group. Consultation is funded through state, federal and private grants, such as Quality Enhancement funds associated with the state-funded School Readiness program.

**Child FIRST** – This early childhood system of care in Greater Bridgeport has provided intensive classroom consultation, targeted classroom consultation, and child-specific consultation to early care and education programs since 2000. Consultation is funded by a combination of federal, local and private funds and is provided by a social worker with knowledge in mental health and early childhood education.

**Early Childhood Consultation Partnership (Statewide)** – The Early Childhood Consultation Partnership (ECCP) is the largest and most widely known program in the state, and has provided mental health consultation to center based providers in efforts to promote the social/emotional development of children 0-5 since 2002. Eleven (11) Master’s level consultants are available to provide brief phone consultation, child-specific, core classroom, and intensive center-based services statewide. With an initial annual budget of $1 million, ECCP was initially funded by the Department of Children and Families, the State Department of Education, the Community Mental Health Strategic Investment Board, the Children’s Fund of Connecticut, and the Connecticut Health Foundation. Since then, the State Department of Education and the Department of Children and Families have taken over primary funding for the program. A non-profit managed behavioral health organization, Advanced Behavioral Health manages the ECCP.

The ECCP consultation model has three levels: 1) child-centered consultation (up to 8 hours); 2) classroom-centered consultation; and 3) program-level consultation that focuses on the overall child care agency across multiple classrooms (two assessments and 8 weeks of consultation at four hours per week with up to four classrooms). Parent engagement is a key to the program, as is the use of standardized assessment. The state Department of Public Health is currently developing regulations to define a MH consultant, and the current consultants are all master’s level, but vary in their backgrounds. The regulations under development are competency-based, in order to allow specialists with a variety of training backgrounds.

According to key informants we talked with, by the end of December 2005, the program has served over 4400 children (553 receiving child-centered consultation), reporting that
98% of those at-risk of suspension or expulsion remained in their classroom. Of those, 553 children received child-centered consultation; that number had grown to 678 by the end of August 2006. Just over 20% of the eligible child care centers had accessed services for their children over the first three years. Most children served have been Medicaid eligible. Just over a third of children served (34.8%) were referred for more extensive mental health services, generally at the mental health centers where the MH consultants worked. Most of those (30.7% of all children served) received additional child mental health services, with 2.7% receiving adult mental health services for the parent, 2.9% receiving early intervention program services, and 0.7% receiving emergency mobile psychiatric services (percentages sum to more than 34.8% because some children received multiple referrals).

According to Elizabeth Bicio, ECCP Program Manager, several “lessons learned” emerge from the early years of ECCP implementation (CHDIC, 2005, p. 14):

- It is important to have a consistent framework for a statewide program so that similar services and expectations exist across the state.
- The relationship between consultant and child care center staff is key to the model’s success.
- A shorter period of time for the consultation work may actually lead to greater improvements in quality than when services are stretched out over a longer period of time. The ECCP project found that classrooms in which services were provided over a two-month period demonstrated greater quality improvements than the classrooms in which consultants provided services over a six-month period. Program staff surmised that the consultant’s impact might diminish as he or she becomes more integrated into the center culture. In addition, with a longer timeframe, programs tend to take longer to implement the quality improvement action plan and the pace of progress is somewhat slower.
- The child-specific services are in her opinion generally not as effective as the core classroom services, when assessed in terms of the ratio of intensity of resources required and degree of impact upon other children within the classroom. The core classroom services tend to be more preventive in nature, while the child-specific services are reactive and tend to occur when issues have already reached a crisis point.

**Florida**

Florida experimented with expanding early childhood services through a three-year pilot that began in 2000. The Florida State Legislature funded the Infant and Young Children’s Mental Health Statewide Pilot Project in Miami, Sarasota, and Pensacola counties in 2000, and it ended in June 2003. The goals of the pilot included: 1) to improve parent/caregiver interaction and relationships, reduce abuse/neglect and improve the child’s developmental functioning; 2) to document the components of infant mental health interventions for effectiveness, sustainability and cost for possible statewide replication; 3) to identify barriers and solutions for system changes such as appropriateness of diagnostic classifications and assessment tools, Medicaid and third
party billing possibilities and ancillary services needs; 4) to develop model infant mental health treatment programs for statewide replication; and 5) to build capacity in the infant mental health field (Adams et al., 2003). The pilots focused on providing services to families of children under three who were either at-risk of removal from their homes because of abuse or neglect or were in foster placements.

The programs implemented a series of assessment tools and a range of techniques meant to enhance the mother’s awareness and responsiveness to her child’s needs, including modeling of appropriate parenting skills and looking at factors in the mother’s history that might impact how she interacts with her child. Referrals to other needed services were provided and therapists communicated with the child’s Department of Children and Families (DCF) caseworker. The programs also used extensive engagement efforts to involve families in treatment.

Forty-three (43) out of 84 infant/caregiver dyads who completed the pre-treatment assessment completed treatment. Outcome data based on the 43 dyads who completed treatment demonstrated the following: 1) a decrease in abuse and neglect reports from 97% prior to treatment to no reports during treatment; 2) timelier reunification based on increased compliance with DCF plans; 3) 58% of children improved in their developmental functioning (based on parent response to a screening instrument); 4) improved parent/child relationship; 5) the percentage of depressed caregivers decreased from 51% pre-treatment to 29% post-treatment; and 6) other positive impacts in participants’ lives such as re-entering the workforce, entering school and being advocates for their children (Adams, et al., 2003).

The program used the Florida DC: 0-3 to ICD-9-CM crosswalk to support Medicaid billing, which has been approved more broadly by the Florida Agency for Health Care Administration (AHCA) as a guideline identifying covered diagnoses for billing purposes. However, only direct treatment is covered by Medicaid, while “engagement” efforts similar to case management are not covered (unless the child is otherwise eligible for Targeted Case Management, which most of these children are not).

Since then, early intervention in Florida is coordinated through regional Early Childhood Coalitions, which may or may not offer mental health consultation in child care settings. Our review identified two programs, one in Miami through which a network of private providers are coordinated for access by child care centers and one in Sarasota operated by a community mental health center. In Sarasota, Community Outreach Services of the Florida Center for Children and Family Development runs an early childhood mental health consultation program, funded by the Sarasota County Early Learning Coalition (Florida State University, 2006). The program focuses on child care settings with a high percentage of subsidized care. Rather than wait for referrals from those centers, the program requested that the centers screen all children using the ASQ-SE. Further screening is completed by the program’s Inclusion Specialist when indicated and agreed to by the parent. The program screens and assesses children for special needs and makes referrals when appropriate and also provides targeted interventions in the child care...
programs. The specialists work with center staff to help them manage the situation and improve the relationship with the child. Some of the interventions provided include classroom interventions to manage behaviors. Children with more intensive needs are referred to mental health centers or a limited array of specialized community resources. As with the previous pilots, Medicaid funding is limited to direct services.

Florida is also home to the Florida State University (FSU) Center for Prevention and Early Intervention Policy, an in-state training and research institute to support capacity for early childhood MH services. The Center was funded by the Florida Developmental Disabilities Council, along with the Ounce of Prevention Fund of Florida and the Florida Department of Children and Families, in order to bring together key stakeholders from a wide variety of disciplines to address the lack of services, funding, and policies for enhancing the healthy social and emotional development of children ages 0 to 5. The group developed a strategic plan for building a system of mental health services for young children and their families through public awareness, increasing provider skills, using evidence-based interventions, obtaining funding and advocating for infant mental health policies (Florida State University, 2001). The three levels of services identified included: 1) strengthening all children’s social and emotional development; 2) relationship-based early intervention for children with developmental delays, disabilities or risk factors including abuse and neglect; and 3) treatment for children with emotional or mental health problems.

Massachusetts

Three initiatives were identified in Massachusetts offering some level of early childhood MH consultation:

- The Massachusetts Early Childhood Linkages Initiative (MECLI) is a collaboration between IDEA Part C early intervention services and child welfare to ensure that children in substantiated abuse and neglect cases receive developmental assessments and needed treatment. MECLI was implemented in three pilot sites. Every child under three years of age in new abuse and neglect cases was referred for early intervention services in those pilot sites and 74% were found eligible for services. Funding for the project came from federal and state dollars, private insurance and parent sliding-fee scales. The pilot project was implemented between November 2001 and December 2005 with statewide implementation planned for the upcoming year.

- The Massachusetts Early Childhood Comprehensive Systems Project (MECCS) coordinates services for children 0-5 with a focus on access to health insurance and medical homes, social-emotional development and mental health, early care and education, parenting education and family support.

- In partnership with Massachusetts’ Early Intervention programs, regional consultation programs to support child care workers who work with infants and toddlers with disabilities are available throughout Massachusetts. A number of Early Intervention-Income Eligible Vouchers are earmarked for infants and toddlers with disabilities who need individualized support in the child care setting.
North Carolina

Under its recent mental health system transformation activities, North Carolina has expanded access to Medicaid-funded consultation in child-care settings. The primary service type under Medicaid used to pay for consultation is “Child Service Coordination” (North Carolina Division of Medical Assistance, July 1, 2006). The service is child and family driven and includes outreach, identification and referral, enrollment, assessment of family strengths/concerns, assessment of the child’s development, assessment of parent/child interaction, development of a care coordination plan, follow-up, and evaluation. The service is available to children ages 0 to 3 who are at-risk of a developmental delay, disability, chronic illness, or social/emotional disorder, as well as children ages 0 to 5 who are diagnosed with any of the conditions just listed.

Staff providing the service must be employed by a qualified agency able to bill Medicaid. They must have a master’s degree in a human service area or a bachelor’s degree and two years of experience working with children and their families. They must also participate in an orientation and ongoing training through the Child Service Coordination program. Up to one and a half hours of service may be billed each month, in 15 minute increments. V Codes may be used as eligible diagnoses to support medical necessity, and a case management procedure code is used (HCPCS Code T1016).

The advantage of this service type is that it is comprehensive and readily accessible to children covered by Medicaid. But these are also limitations, in that many families that may be willing to benefit from less intensive consultation in child care settings may not be willing to participate in such a comprehensive program.

North Carolina has a special category of Medicaid funding called High Risk funding that makes children under 3 eligible for a range of mental health services if they are found to have a risk factor for mental illness. Session Law 2005-276 moved coverage of children 0-5 from North Carolina Health Choice to Medicaid and mandated Medicaid coverage for that age group to include families with incomes equal to or less than 200 percent of the federal poverty level beginning January 1, 2006. Children who meet the legislative definition for special needs services will no longer be required to be identified by a physician in order to receive services beyond the Medicaid core package. Early Intervention services, through the Children’s Development Service Agencies, are provided to children under three who are eligible for Infant-Toddler Program services. Three and four year olds transitioning to preschool services are eligible for evaluation and community-based rehabilitative services when the local education agency requests these services.

North Carolina also has individual programs that offer broad-based MH consultation. KidSCope serves children 0-5 with or at-risk for emotional, social, behavioral, or developmental difficulties in Orange and Chatham counties. Services (which include screening, evaluation, counseling, caregiver training and case management) are individualized and community-based. The Child Care Consultation Program was created in fiscal year 1998-1999 and includes program and child/family level consultation. Public
and private foundation grants, local, state, and Medicaid funds are used to cover the cost of consultation. The project has a Family Transitional Learning Classroom program which provides an alternative therapeutic classroom setting for children with a history of emotional and behavioral challenges. North Carolina also has a Smart Start initiative that assists child care and Head Start staff in serving children in need of specialized interventions.

In North Carolina, staff serving infants and toddlers in the Infant-Toddler Program (established through IDEA Part C) must meets standards of competence for early intervention practice. Children’s Developmental Services Agency (CDSA) staff, along with public and private providers of special instruction services and early intervention service coordination to Infant-Toddler Program recipients, must be certified regardless of education, license or certification. Competencies must be demonstrated in the areas of: child development, family development, screening and assessment, interdisciplinary family service planning, intervention strategies, interagency and community process, and professionalism and ethics.

Vermont

The Children’s Upstream Services program (CUPS) in Vermont was started in 1997 and funded through a five-year, $5.7 million Children’s Mental Health Services (CMHS) grant. Using a statewide planning process, the project has focused on strengthening local interagency coordination in order to expand or improve statewide and local services that enhance social and emotional development in young children. CUPS supports mental health training and consultation to agencies that serve young children, home visits, therapy, case management, playgroups, parent peer support and consultation to childcare centers and homes in the different regions it serves. The program is widely viewed as a national model guiding other state’s efforts in this area. While its federal grant funding period has ended and the program is now sustained with state and Medicaid funds.

Twelve regional interagency teams are responsible for CUPS project planning and services. CUPS project services are delivered through regional CMHCs, and are community-based, coordinated, and transdisciplinary in that the project has built relationships with agencies serving young children and collaborated with them to improve services. The project provides mental health training and consultation to those agencies, though the training is not required for participation or certification of MH specialists. However, detailed competency requirements have been developed for providers seeking to specialize in Competencies in Early Childhood and Family Mental Health.

Throughout the state, CUPS has expanded the number of early childhood mental health workers, who in turn work with other agencies to support and develop specific early childhood services, resulting in the provision of individualized and comprehensive services. CUPS supports services such as home visits, therapy, case management, playgroups and consultation to childcare centers and homes in the different regions it serves. Three family advocacy organizations are also involved with the project.
Vermont’s amended Medicaid plan allows reimbursement for targeted-case management for 0-3 year olds by certified Early Interventionist (parent-child staff) and community mental health center staff (for children with a mental health diagnosis). Collateral contact with families is covered for children with serious emotional disturbances (SED) so early intervention and support services can therefore be provided to the young children of transition-aged youth with SED without diagnosing the young child. Young children themselves are also eligible based on their own needs without having to assign an Axis I diagnosis, by using the V Code of parent-child relationship difficulties, a diagnostic code which has been approved for Medicaid reimbursement.

CMHCs providing the services are based in districts and work with the child care centers and day care homes in their districts, which supports the development of relationships with the child care agencies over time. Overall, only about 20% of the centers have received consultation through CUPS, but these tend to be the larger centers. Typical consultation lasts an hour to an hour and a half and extends across one to three sessions. At the three session point, if ongoing services are needed, there is generally a referral from the CUPS program to ongoing MH treatment.

In order to sustain program-level consultation, administrators explored the use of Medicaid administrative funds under 42 CFR §433.15, as well as training through Title IV-E of the Social Security Act. These funds are used to support consultation and education grants through the Agency of Human Services (the State Medicaid Agency) to mental health experts to provide consultation and education to parents, early care, education and community providers about available Vermont services for children 0-6 with mental health problems. One of the goals of this strategy is to enhance children’s access to Medicaid mental health services (early identification, intervention, screening and referral) and addressing factors which impede access. While the Vermont program described a careful process whereby they worked to comply with the Medicaid administrative billing requirements under 42 CFR §433.15, as well as Title IV-E training requirements, other experts we talked with expressed concern that provisions of the Deficit Reduction Act of 2005 raised significant questions about such a funding strategy. Furthermore, the provisions for administrative funding under 42 CFR §433.15 are quite restrictive, for example, only funding state personnel.

**Conclusions and Considerations**

Although the models and approaches reviewed in this report vary in terms of strategies, settings and age groups served, length of program services, and funding streams, several common themes emerged. The Child Health and Development Institute’s 2005 report entitled *Creating a Statewide System of Multi-Disciplinary Consultation for Early Care and Education in Connecticut* offered the following guidance, which summarizes the findings related to clinical programming in the current report well:

- The authors noted that consultants must appreciate and understand early childhood development and early care and education settings. Having knowledge in a specific...
discipline such as health or mental health is not sufficient to be an effective consultant. Cross-discipline knowledge is essential: consultants must understand early child development. In addition, consultants need to understand the particular challenges endemic to child care (e.g., low staff wages and education levels, high turnover) and know how to work in an early care and education setting.

- Relationships are important. A consistent lesson from most of the consultation models reviewed here is the importance of relationship-building between the child care staff and consultants. Given that the effectiveness of the consultation services appears to rest, in large part, on the quality of the relationship between the consultant and child care staff, it is important to understand what personal qualities are necessary for an individual to be an effective consultant. The literature indicates that these necessary personal attributes include: the ability to communicate warmth, acceptance, and concern; the ability to engage in self-examination and reflection; the ability to share control with others; a high threshold for frustration; a passion for problem-solving; an orientation to life-long learning; and self-direction, flexibility, and vision.

- Consultation should not be designed as a “one shot” intervention, but as an ongoing support to enhance and sustain program quality. Additionally, characteristics of early care programs, families, and children change over time, requiring consultation to change as needs evolve over time.

In addition to these observations, the CHDI (2005) report offered recommendations in three broad categories that, as modified below, summarize the clinical program findings of this report well:

1. Program design should:
   - Include a full range of disciplines in the consultation system, with a focus on health, mental health, and education;
   - Provide both program-level and child-specific consultation;
   - Offer consultation supports to the full spectrum of early care and education settings; and
   - Make consultation available to all programs, regardless of the population they serve.

2. Quality assurance mechanisms should:
   - Establish consistent qualifications for consultants;
   - Clarify consultants’ roles and responsibilities;
   - Provide training, resources, and networking opportunities for consultants;
   - Promote training and information to help child care agencies make best use of consultation; and
   - Incorporate a strong evaluation component, including screening measures such as the ASQ-SE and outcome measures such as the Child and Adolescent Needs and Strengths 0-4 Version.

3. Delivery structure/process should:
   - Develop a structure for statewide oversight and development;
- Create a regional service delivery system with clear relationships between early childhood MH providers and child care agencies;
- Support long-term relationships between early childhood MH providers and child care agencies within a multi-disciplinary framework for each region;
- Deliver child-specific consultation based on each child and family’s individual strengths and needs;
- Deliver program-level consultation based on each child care program’s individual strengths and needs; and
- Coordinate public and entrepreneurial funding mechanisms to expand and sustain the system.

In addition to these clinical strategies, should the Commonwealth develop early childhood MH consultation services in child care settings, the following administrative and funding options are offered for consideration:
- Pilot the service – The conceptual foundation for early childhood MH consultation is sound and evidence is emerging regarding its effectiveness, but it is not yet firmly established. Given this, it is recommended that any development efforts in the state begin with a regional pilot to assess the impact of the model.
- Explore Medicaid funding for child-specific direct services – Several states implementing this model (CO, FL, NC, VT) have been successful funding child-specific direct consultation services involving the child, family, and ancillary supports such as child care workers through their State Medicaid Plans, to the extent that rehabilitation-oriented behavioral management and system-level interventions such as case management are covered benefits. Pennsylvania’s State Medicaid Plan covers such services and the service description developed for early childhood MH consultation services should be developed in line with these covered services.
- Support program-level consultation with state funds – While Vermont has supported its program-level consultation with Medicaid administrative funding, we do not recommend this strategy given the current more restrictive climate related to the 2005 Deficit Reduction Act. Furthermore, administrative funding is limited to state personnel. While this can work in a state-administered community mental health system, Pennsylvania’s private provider-based system would not accommodate such a strategy. The experience of Connecticut to fund early childhood MH consultation with a mix of funds from the state agencies most involved in development of the program seems to offer the best guide.
- Consider the implications of case-finding when costing out development – There is evidence from Connecticut that approximately one-third of children and families served had needs identified which resulted in referrals for additional mental health services. Given national evidence that infants and young children are an underserved group, it is likely that outreach to child care agencies will result in the identification of needs that are currently unmet through Pennsylvania’s Medicaid system. While there is good reason to believe that investing additional service resources in the well-being of younger children and their families will result in future savings in avoided mental health, special education, child welfare, and other child and family-serving human services, cost increases in the near term seem likely.
References: Early Childhood Mental Health Consultation


North Carolina Division of Medical Assistance. (July 1, 2006). Clinical Coverage Policy No. 1M-1, Child Service Coordination.


Workgroups. Denver, CO: Project Bloom, Colorado Department of Human Services, Division of Mental Health.


## Summary of Considerations

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<th>Considerations</th>
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| **Implementation of Resilience/Recovery through BH-MCOs** | - Wellness Recovery Action Planning  
- Double Trouble in Recovery Groups  
- Other condition-specific recovery groups  
- Consumer-run Recovery Learning Centers to provide technical assistance and education on R/R, modeled similarly to the program in Massachusetts  
- Peer Support/Peer Specialists (at peer operated and traditional provider organizations) to provide:  
  - outreach and education of consumers to engage them in their recovery  
  - outreach and education to consumers in the hospital, as part of discharge planning  
  - education and support for use of self-management services/toolkits, e.g., depression management, and money management  
- Consumer-run Drop-in Programs including those that focus on employment supports  
- Consumer Quality Management/Satisfaction Teams |
| Institutionalize self-direction and choice in the assessment and treatment plan/process through intake, assessment, and treatment/recovery plans | - Redesign clinical format, medical records and treatment and recovery plans to assess relevancy to R/R.  
- Identify key data elements that each BH-MCO must include in their protocols/medical records.  
- Involve consumer experts and family members in the review and redesign of records and protocols.  
- Consider selecting standardized assessment tools and |
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<th>Considerations</th>
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<td>treatment/R/R plans that are age appropriate (children, transitional age youth, adults, and older adults).</td>
<td>▪ Assess the feasibility of implementing web-based tools for standardized assessments that incorporate R/R philosophy to facilitate assessing the individual’s treatment needs and developing recovery goals within a strengths-based framework that emphasizes self-determination.</td>
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<td>▪ Systematically introduce access to Wellness Recovery Action Planning (WRAP) and other self-management toolboxes for consumers that would like to use them and provide access to self-managed toolkits for consumers and staff to learn about specific recovery initiatives.</td>
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<td>▪ As part of the treatment planning process, provide the opportunity for individuals to develop crisis plans.</td>
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<td>▪ As part of the treatment plan reviews, assess whether the consumer has access to self-management tools such as WRAP. Review the treatment plans to verify consistency with the consumer’s WRAP or other self-management plans.</td>
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<td>▪ Provide access (as part of the assessment and treatment planning process) to self-managed tools, including online tools, for such topics as meal planning, money management, housing, smoking cessation, and other health and wellness strategies.</td>
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<td>▪ Train access line/member services staff, care managers, and utilization management staff on R/R philosophy and self-help principles and provide them with specific electronic tools that visibly address recovery principles and goals, (e.g., use of self-management techniques and consumer-run services).</td>
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<td>Institutionalize self-direction and choice in the BH-MCO care management and utilization management process through care management/utilization review</td>
<td>▪ Review and revise UM guidelines to assess R/R philosophy and use of consumer-run, peer support services and other community supports. Include consumer experts and consumers who are also professionals in the review process.</td>
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<td>▪ Assess the degree of individualization and recovery orientation in treatment and recovery plans through utilization review. Develop automated tools/on-line tools that include R/R principles to assist with UM and QM. (For example, one option is to use a checklist that helps the reviewer determine if key R/R principles are incorporated into the treatment plans and if there is a recovery plan and how these match to the level of care.</td>
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<td>and types of services and supports the person receives.</td>
<td>Because implementation of R/R is an iterative process, such tools can assist the BH-MCO to keep R/R principles visible.</td>
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<td>▪ Use utilization management to help network providers manage staff resources by providing the right level of care at the right time, and emphasize use of consumer-run services, peer support and community resources, (for example, identify strategies that match consumers to resources that correspond with their recovery stage, e.g., pre-contemplation, contemplation, etc.)</td>
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<td>Identify standards for BH-MCO networks to facilitate development of consumer operated/delivered services and an R/R philosophy</td>
<td>▪ Train Network Management staff at the BH-MCOs on R/R principles, as well as consumer-run and delivered services.</td>
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<td>▪ Establish criteria for network contracts with consumer-run programs and for peer support services.</td>
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<td>▪ Require the BH-MCOs to develop an annual network plan, in conjunction with consumers, family members, and providers that addresses the following areas:</td>
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<td>▪ Description of the planning process, implementation goals, and time frames for inclusion/development of consumer-run and delivered services.</td>
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<td>▪ Identification of peer services that address the phases of change in recovery, e.g., from pre-contemplative to recovery.</td>
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<td>▪ Development of and access to consumer self-management programs such as WRAP and Double Trouble in Recovery groups.</td>
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<td>▪ Education for consumers, families, and providers about R/R through EBPs.</td>
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<td>▪ Plans for financing consumer-run and delivered services and EBPs, including identification of existing resources, reinvestment strategies, and funding constraints that need to be addressed on a statewide and/or federal level.</td>
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<td>▪ Strategies to include consumers from diverse cultures in planning efforts for R/R, including identification of ethnicities, languages, and race of the member populations.</td>
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<td>▪ Inventory existing consumer-run services, analyzing geo-access to these services.</td>
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<td>▪ Requirements for training network providers on R/R through consumer-sponsored educational approaches as well as offering toolkits for providers to use in self-</td>
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<td>monitoring their R/R philosophy.</td>
<td>- Certification requirements for consumer-run programs and peer specialists</td>
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<td>- Organizational support that will be provided to support development of</td>
<td>- Pay-for-Performance (P4P) strategies that the BH-MCO can use to contract with providers to facilitate development of R/R philosophy and consumer-run services.</td>
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<td>consumer-run services, such as administrative and technology support and</td>
<td>- Training for providers on motivational interviewing and readiness to change.</td>
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<td>assistance until the services become self-sufficient.</td>
<td>- Consumer-delivered training and technical assistance for providers implementing peer specialists to facilitate the acceptance of peer staff by provider organization and the effectiveness of their incorporation of peers into the service delivery process.</td>
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<td>- Demonstration projects for use of peer supports and consumer-run programs</td>
<td>- Set performance goals and time frames for achieving changes in intake, assessment and treatment planning, in addition to the utilization management initiatives identified above, including maintaining cost effectiveness.</td>
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<td>that publicize successes and failures, improved outcomes – lesson learned.</td>
<td>- Set performance goals for achieving network requirements described above, specifically increasing access to consumer run services and adopting R/R principles.</td>
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<td>Establish system-wide performance indicators related to implementation of R/R</td>
<td>- Establish consensus on selected performance indicators.</td>
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<td>principles through an OMHSAS-sponsored initiative for consumers/families,</td>
<td>- Incorporate NOM service outcomes as guidelines for uniform performance indicators for statewide implementation:</td>
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<td>BHMCOs, providers, and professional organizations</td>
<td>- Abstaining from drug use and alcohol abuse, decreasing symptoms of mental illness and improving functioning</td>
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<td>- Getting/keeping a job, staying in school</td>
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<td>- Decreasing criminal justice involvement</td>
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<td>- Finding safe and stable living conditions</td>
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<td>- Improving social connectedness to others in the community</td>
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<td>- Increasing access to services</td>
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<td>- Reduced use of psychiatric inpatient beds</td>
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<td>- Improving client perception of care</td>
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<td>▪ Explore feasibility of using the Massachusetts and Ohio performance measurement protocols described in the previous section.</td>
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<td>▪ Modify current QM tools, including on-line tools (e.g., Chart Abstraction Tool in use for annual reviews to monitor treatment planning and utilization management practices that support R/R). Involve consumer experts and consumer clinicians in this activity.</td>
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<td>▪ Expand use of consumer satisfaction teams/quality management teams throughout the counties/BH-MCOs.</td>
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<td>▪ Develop, with input from consumers/families, a statewide consumer satisfaction questionnaire that addresses R/R principles.</td>
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<td>▪ Participate in research and evaluation initiatives to further evidence for use of consumer run services and involve consumers in the research on EBPs to incorporate the principles of R/R.</td>
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<td>▪ Conduct focused studies to identify, for example, if treatment plans and medical records are inclusive of consumer self-management tools (such as WRAP), or if there are referrals to consumer-run programs, and when not, if there is rationale noted (e.g., the individual does not want to use the tools).</td>
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<td>Establish funding for consumer-run programs and initiatives that support R/R</td>
<td>▪ OMHSAS, the counties, and the BH-MCOs should determine the percent of the BH-MCOs administrative fees for R/R development and the percent of funding for the BH-MCOs to include consumer-run services.</td>
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<td>▪ OMHSAS and the DPW should continue to explore ways to maximize FFP for service components of EBPs and R/R services that are eligible for Medicaid funding (e.g., peer support and reserve state general funds for R/R initiatives).</td>
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<td>▪ At the same time, Medicaid administrative dollars can address R/R quality management initiatives.</td>
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<td>▪ OMHSAS, the counties, and the BH-MCOs should develop arrangements to provide financial incentives that support the start up costs of consumer-run programs and provide administrative support to these organizations as they develop, including strategies to designate consumer-run programs as small disadvantaged businesses.</td>
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### Considerations

**Strategies to operationalize an R/R philosophy** must be a priority of the leadership of the Commonwealth, counties, consumers, BH-MCOs, and providers for people who are Medicaid eligible and those that receive care through state general funds, other federal, county, or local funds.

**Description**

- The Commonwealth with input from Counties, BH-MCOs, and consumers should review the various R/R metrics and the feasibility of data collection and establish priorities for statewide implementation of key metrics that demonstrate adherence to the principles and philosophy of R/R. These metrics should be reviewed annually and widely publicized.
- Establish Departments of Recovery and Resilience within the BH-MCOs. These departments should have leadership with status equal to other senior managers and enough staff to impact the culture and operations of the organization. When consumers are present and have voice, this can change the dynamics of an organization positively.
- Establish a partnership among the Commonwealth, consumers/advocates, counties, and providers the power of their voice at Federal levels to move forward legislation that supports R/R initiatives.
- Refer to New York State’s Office of Mental Health as a resource for its framework, messaging tone, expectations, and monitoring of R/R principles and EBPs.

### Implementation Strategies for Evidence-Based Practices

**Establish tools/strategies for implementing and monitoring best practices**

**Description**

- Establish a website/clearinghouse at the State level on state and national best practices, promising practices and innovations, and fidelity instruments.
- Analyze claims and encounter data from BH-MCOs to identify overall and provider-specific trends, establish benchmarks, and target areas for focused studies. For example, identifying individuals who have multiple hospitalizations within a 3-month period and providing outreach through ACT.
- Through use of electronic tools, review prescription patterns and formularies to identify opportunities to introduce EBPs. (Several states and MBHOs routinely accept Rx data for their membership and apply clinical algorithms to identify pre-scriber outliers or problem cases. The clinical algorithms target deviations from practice guidelines on a number of dimensions including medication adherence, inappropriate dosing, duplicate therapy within and across drug classes and/or due to multiple prescribers, inappropriate Rx for pediatric or geriatric populations, multiple doses per day, non-adherence to safety guidelines, Rx switching,
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<td>contraindications, multiple prescribers, one time fills, drug-disease interaction, etc.)</td>
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| Strategies to enhance funding of EBPs and address funding barriers | - Target reinvestment dollars to EBPs.  
- Develop financing transition plans to support parallel services while EBPs are being implemented, e.g., transition of consumers from Day Treatment to Supported Employment. This is similar to payment strategies developed by the Commonwealth for reallocation of state hospital funds to community services.  
- Assess benefit designs and reimbursement methods for EBPs currently in use in the Commonwealth to identify barriers to the use of EBPs, as well as strategies to address them, e.g., if providers were to institute a depression screening guideline, would this be reimbursable under Medicaid or through state funds?  
- Pay for service components of EBPs eligible for Medicaid reimbursement and reserve state and local funds for non-Medicaid reimbursable services, e.g., housing subsidies for supported housing. |
| Messaging strategies for OMHSAS to implement EBPs | - Establish Communities of Practice (COP) to facilitate readiness to change and create EBP climate.  
- Collaborate with universities within the Commonwealth and elsewhere to establish special initiatives on implementing and monitoring fidelity to EBPs. Include consumers and families in the collaboration to assist researchers with incorporating R/R principles.  
- Creating awareness of the importance of EBPs and R/R through ongoing “state of the union” messages that deal with the iterative process of moving the system forward on R/R and EBPs. |
| Service Array to Reduce Reliance on State Hospitals and Increase Community Integration | - ACT teams to assist people who frequently use high intensity services (e.g., inpatient, crisis), integrated with a continuum of less intensive levels of case management assistance for more moderate users  
- A full continuum of crisis services, including pre-screening for hospital admission  
- Illness Management and Recovery  
- Standardized pharmacological treatment for adults and older adults  
- Peer support and other peer-run services (described earlier in this report), including access to peer specialists |
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<td>while hospitalized and peer-run advocacy organizations for adults, older adults and their families.</td>
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<td>▪ Transportation supports, particularly for clients with mobility needs and in rural areas</td>
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<tr>
<td>Implement best practice strategies</td>
<td>▪ Service integration and agency collaboration could be facilitated by the BH-MCOs through care management.</td>
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<td>▪ Case management, at the level of intensity desired by the individual, should be available to support access to services and community integration.</td>
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<td>▪ Individuals should have access to a “clinical services home,” for example a providers that offers clinical services such as outpatient therapy, medication management and relapse prevention. A professional at this “home” should be responsible, in conjunction with the person, for determining that the service plan is comprehensive and consistent with R/R principles, and also provide information about EBPs that may be helpful to meet the person’s needs.</td>
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<td>▪ Should individuals require acute rehospitalization, they should have access to the same hospital, unless the person requests another facility or requires specialized services that cannot be provided.</td>
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|               | ▪ Relapse prevention plans, crisis plans and other interventions that prepare individuals for successful
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<td>discharge should be initiated during hospitalization prior to discharge and well-documented by providers. The person’s “clinical home” upon discharge should incorporate these plans into the community treatment and recovery plan.</td>
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<tr>
<td>• Access to primary health care services is important part of the recovery process, thus the case management function should emphasize linking individuals with mental illness to health plans and selection of primary care physicians. As an alternative, models of integrated service delivery are also emerging as a promising practice.</td>
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<td>• The role of each state hospital in the continuum of care should be clearly defined and widely communicated. Additional staff training to hone necessary skills to fulfill the role should be considered.</td>
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<td>Targeted strategies to finance community integration</td>
<td>• Providers should be financially rewarded for developing EBPs and maintaining fidelity with those models. The additional funding should be contingent on adequacy of follow-up tracking and timely reporting.</td>
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<td>• For discharge of individuals with long-term stays at state hospitals, funding needs to be identified and assigned to support the discharge plan.</td>
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<td>• Funding mechanisms to encourage outpatient contact prior to discharge should also be explored.</td>
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<td>OMHSAS leadership should drive the message on reducing reliance on state hospitals and improving community integration</td>
<td>• A gate-keeping function for state hospital admissions should be instituted. Counties could be placed at risk for state hospital utilization through the purchase of bed days. In conjunction with this, or alternatively, the BH-MCOs could be placed at risk for state hospital utilization and implement integrated preauthorization processes.</td>
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<td>• Establish performance requirements for counties and BH-MCOs (see below for specific recommendations).</td>
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<td>• Provide state hospital training on R/R and psychosocial rehabilitation services that can be implemented throughout the hospital stay including training on:</td>
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<td>– R/R principles offered by consumers (for staff and consumers) who have successfully integrated into the community, to instill hope and provide role models</td>
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<td>– Motivational interviewing skills for staff; and</td>
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<td>– Developing treatment and recovery plans with consumers that focus on discharge.</td>
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| Establish performance indicators for inpatient utilization                   | ▪ BH-MCO performance guarantees may include the following indicators related to inpatient utilization rates for state hospitals and other inpatient facilities:  
  – x days/1000  
  – x admits/1000  
  – x readmits/1000 30 days post-discharge  
  – x readmits/1000 90 days post-discharge  
  – x discharges /1000  
  – follow-up within 7 days of discharge  
  – average length of stay for discharged  
  – average length of stay for residents  
  – percent of clients restrained or secluded  
  – number of adverse incidents  
  – average waiting time for admission  
  – percent occupancy  
  – denial rate  
| Establish performance indicators for Community-based services for individuals discharged from state hospitals | ▪ Community-based services performance indicators:  
  – Percent receiving substance abuse treatment  
  – Percent receiving treatment through Co-occurring Disorder Competent facilities or programs  
  – Percent discharged consumers participating in community services  
  – Percent discharged consumers not participating in services located in last month  
  – Percent discharge consumers employed or in school OR average number of days without work or school  
  – Percent discharged arrested within a specified time period (e.g., 30 days, 1 year).  
  – Mortality rate of individuals discharged from inpatient within a specified time period (e.g., 30 days, 1 year).  
  – Percentage discharge with symptom reduction  
  – Percentage discharged who are homeless  
  – Percent discharged receiving EBP services  
    ▪ ACT teams to assist people who frequently use high intensity services (e.g., inpatient, crisis), integrated with a continuum of less intensive levels of case management assistance for more moderate users  
    ▪ A full continuum of crisis services, including pre-screening for hospital admission  
    ▪ Illness Management and Recovery  
    ▪ Standardized pharmacological treatment for adults and older adults |
### Considerations

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- Consumer/family satisfaction with:
  - Hope
  - Quality of Life
  - Treated with dignity
  - Access
  - Needs met
  - Safety
  - Crisis management

### Recommended Family-Based Mental Health EBP Service Array

Simultaneously take steps to develop and promote an evidence-based culture among providers.

We do not recommend that EBPs be mandated without a supportive framework.
### Considerations

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<td>Four recommended family-based services are FFT, MST, MTFC, and Wraparound.</td>
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<td>- FFT – Recommended as an intensive family therapy for youth living at home with moderate to severe behavioral problems involving disruptive and oppositional behavior, as well as some with willful misconduct and lower level delinquency.</td>
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<td>- MST – Recommended as an intensive family therapy for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.</td>
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<td>- MTFC – Recommended as an intensive family therapy option for children and families when a temporary out-of-home placement is necessary or as a transition between a more restrictive out-of-home placement and return to the community or to preparation for reunification.</td>
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<tr>
<td>- Wraparound Planning – Recommended as an adjunctive support for youth in families with complex needs who are likely to need significant support for family engagement and coordination for services received from multiple providers or youth-serving systems. Given its dependence on multi-agency cooperation, Wraparound Planning should only be used in local systems that demonstrate readiness for effective multi-system coordination and buy-in into the Wraparound model.</td>
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<td>Multidimensional Family Therapy (MDFT) also recommended on a more limited basis.</td>
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<td>Despite its more limited evidence base, it has shown promise in family-based treatment where youth substance use is focus of concern. Systems interested in implementing a less intensive, more traditional family therapy may have interest in MDFT, and the state as a whole should continue to monitor its development for future consideration to add it as a required service element.</td>
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<tr>
<td>The importance of local data collection and analysis cannot be overstated.</td>
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<tr>
<td>One of the common advantages cited for EBPs include the rich data collection and reports which are typically not present in traditional services that lack fidelity and quality assurance protocols. In the absence of these data, interventions remain a black box.</td>
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<td>Pay for training and transition costs through an intermediary organization.</td>
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<td>An intermediary organization can serve as a medium for providing both the resources and guidance needed to support local EBP implementation.</td>
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<td>Use financial incentives to implement EBPs.</td>
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<td>Use of financial incentives for EBPs is growing in popularity. Systems like that of New York and Michigan provide higher rates if providers conform to EBP standards and additional benefits if high cost and restrictive outcomes are avoided.</td>
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<tr>
<td>Develop local and statewide data monitoring capacity</td>
<td>Strong data systems that allow the monitoring of both outcomes, utilization, and the quality of care can facilitate both the quality of EBP implementation and control of system development, as demonstrated in states such as Michigan and Hawaii. Because information on the generalizability of many evidence-based treatments is limited, it is particularly important to monitor outcomes of these treatments when they are implemented in routine clinical practice. Furthermore, although monitoring fidelity is critical in ensuring that treatments are faithfully implemented, it is not a substitute for outcome monitoring. A treatment that shows excellent efficacy for one population may not yield a good outcome when applied to a different population or in a different context.</td>
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<tr>
<td>Require fidelity monitoring</td>
<td>Each of the four EBPs recommended as the minimum service set (FFT, MST, MTFC, and Wraparound) have established fidelity monitoring protocols available that should be required, tracked, and monitored at both the local and state level. Establishing this data tracking and analysis capacity within a state-level entity (rather than relying on the purveyors of the separate EBPs) is preferred. For Wraparound Planning, there is not the same level of consensus regarding standardized outcome monitoring, but emerging frameworks through the National Wraparound Initiative and other sources are available. The lack of consensus requires more local infrastructure development and consensus building for implementation of fidelity monitoring for Wraparound Planning.</td>
</tr>
<tr>
<td>Require outcome evaluation</td>
<td>Local evaluation is needed to ensure that the EBP is successfully incorporated into the local system of care in a manner that yields desired outcomes.</td>
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| Base eligibility on behavioral needs, not system involvement | • Eligibility for each EBP should be based on demonstration of behavioral needs in the target areas established for each EBP, not system involvement (such as the juvenile justice system)  
• There is emerging evidence that these EBPs may be used effectively serve other populations (such as the use of MST to treat youth in need of treatment for sexual offenses).  
• Only extend use of these EBPs to other populations if there is systematic validation within a local system of their effectiveness and that validation is confirmed by the state-level independent entity charged with developing EBPs. |
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| Implement a standardized screening protocol                                   | - Most of the states successfully implementing EBPs have also implemented standardized screening methods to guide eligibility decisions and track outcomes over time, the most common of which is the CAFAS.  
- While the CAFAS is a sound and established tool, there is emerging consensus among child-serving agencies (child welfare, juvenile justice, and mental health) that the Child and Adolescent Strengths and Needs (CANS) offers a superior choice. |
| The success of any single strategy depends on the implementation of multiple other strategies. | Changing complex youth and family changing service systems is difficult. The best route to success is a comprehensive approach that blends EBP implementation, training and dissemination strategies, financing methods, administrative supports, and quality management within an overall effort to develop evidence-based cultures. |
Experts Interviewed by Mercer

1. **Neal Adams, MD, MPH** is Director of Special Projects at the California Institute of Mental Health in Sacramento and the former Medical Director for the California Department of Mental Health. Previously, Dr. Adams was the Medical Director for Santa Cruz County which operates a managed care program that includes county operated and provider network services. He has expertise in designing knowledge transfer related to clinical programs and recovery.

2. **Aidan Altenor, Ph.D.** is the Director of the Bureau of Hospital Services for The Department of Public Welfare, Office of mental Health and Substance Abuse Services.

3. **Ken Anderson**, Vice President of Public Sector, United Behavioral Healthcare (UBH). Mr. Anderson is responsible for marketing and development of public sector programs for UBH and has worked with public sector programs in Washington and California. He is working with UBH’s research team to incorporate recovery and resilience initiatives throughout his organization.

4. **Lori Ashcraft, PhD, CPRP** is the Director of META’s Recovery Education Center in Arizona that promotes recovery principles and practices through training both staff and consumers. Dr. Ashcraft is a consumer and has administered mental health services as the Program Chief for Sacramento County Mental Health and for Napa State Hospital where she implemented day treatment that had a strong bio-psycho-social focus. She recently worked for the University of Arizona teaching psychosocial rehabilitation and managing one of eight SAMHSA funded employment demonstration program. As a national expert, Dr. Ashcraft lectures throughout the country on recovery.

5. **José B. Ashford, PhD, MSW** is the Assistant Director of the Department of Social Work and Professor of Social Work and Social Science and Law at Arizona State
University. He is widely published on topics related to specialty treatment courts and the treatment of adult and juvenile offenders with special needs.

6. **Brenda Bean**, who was centrally involved in that state’s nationally renowned Children’s Upstream Services (CUPS) program. She is Early Childhood Mental Health Programs Director for the Child Development Division, Vermont Department for Children and Families.

7. **Molly Brunk**, Ph.D. is a Manager of Network Partnerships with MST Services, Inc. and Director of Quality Improvement with the MST Institute. She is also a Clinical Associate Professor in the Department of Psychiatry at Virginia Commonwealth University.

8. **Eric J. Bruns**, PhD is an Assistant Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington, School of Medicine. He is a member of the National EBP Consortium and National Wraparound Initiative. He was also co-developer of the Wraparound Fidelity Index and is one of the leading researchers in children’s mental health systems of care.

9. **Bernie Centeio**, LSW, QCSW is the State of Hawaii MST System Supervisor within the Child and Adolescent Mental Health Division (CAMHD).

10. **Christie Cline**, MD, MBA, PC, President Zialogic Consulting and previous New Mexico State Behavioral Health Medical Director.

11. **Jonathan Delman, JD** is the executive director of Consumer Quality Initiatives, Inc., a Massachusetts-based consumer directed research and evaluation organization. Through the 1990’s, he and other members of M-POWER, a Massachusetts mental health consumer advocacy group, fought to create meaningful opportunities for consumers to influence managed behavioral health care policies.

12. **Ann Detrick, PhD**, Deputy Commissioner, Massachusetts Department of Mental Health. Ann oversees the operations of all mental health services provided through DMH in 6 regions of the state. She is a driving force behind DMH’s efforts to foster resilience and recovery throughout DMH and the State’s behavioral health carve out program. Ann also oversees the operations of state hospitals.

13. **Deborah Fickling**, Assistant BH Manager/BH Ombudsperson, New Mexico Human Services Department, Medical Assistance Division, is a consumer advocate with extensive experience designing recovery oriented approaches. Currently, on staff at the New Mexico Human Services Department, Ms. Fickling has the responsibility for working on recovery efforts for adults. She works with many entities in that State, including the ValueOptions’ managed behavioral health care program. Ms. Fickling is also a member of the Board of Directors of the American College of Mental Health
Administration (ACMHA) and chair of the membership committee of that organization.

14. Carol J. Fitzpatrick, Ph.D., is the Executive Director of Su Vida Behavioral Health Services for Children & Families in New Mexico. She has been a leader in New Mexico’s statewide efforts to integrate EBPs into the system of care.

15. Sarah Hoover, M.Ed., of the University of Colorado at Denver Health Sciences Center, who serves as Project Director of Colorado’s SAMHSA-funded system of care initiative Project BLOOM for Early Childhood Mental Health and Principal Investigator for the Mental Health Consultation in Child Care Project.

16. Jim Ignelzi, MSW is the CEO of Twin Valley Behavioral Healthcare, a public psychiatric hospital that serves adults in twelve counties in central Ohio and is operated by the Ohio Department of Mental Health.

17. Cynthia Kelly is the Director of Hospital Center Operations, for the Michigan Department of Community Health.

18. Ruth Kenzelmann, PhD is the recently appointed director of United Behavioral Health’s Public Sector program in San Diego. The program is the Administrative Services Organization (ASO), under contract with the County of San Diego Health and Human Services Agency, to support both Adult/Older Adult Mental Health and Children’s Mental Health Services. UBH provides administrative services for more than 600,000 Medi-Cal eligible children, adults and older adults. Dr. Kenzelmann assumed this position after directing services at a large provider agency in San Diego County.

19. Mark Kielhorn is the Director of Program Development, Consultation and Contracts, Michigan Department of Community Health, Mental Health and Substance Abuse Services.

20. Tara Larson, Assistant Director, Clinical Policy and Programs, North Carolina Division of Medical Assistance. Ms. Larson has been a leader in that state’s expansion of Medicaid services to include broader childhood mental health consultation services.

21. Clarissa Marques, PhD is a managed care industry expert and consultant to organizations implementing changes in behavioral health care systems. Dr. Marques was Executive Vice President and Chief Administrative Officer for Magellan Behavioral Health, a large managed behavioral health organization providing services to employers and state governments. Her experience includes clinical, medical, quality management services, network development, customer service, claims management and information technology. She has served on the Review Oversight Committee for the National Committee on Quality Assurance (NCQA) overseeing the
quality of accredited healthcare organizations and as Chairperson of the Committee
on Quality Improvement/Clinical Services, American Managed Behavioral Healthcare
Association.

22. **Danna Mauch, PhD** is a behavioral health industry expert, consultant and former
CEO of Magellan’s Public Solutions Group where she oversaw specialty managed
care programs and children’s services initiatives. She also held positions as Director
of Mental Health for the State of Rhode Island, Assistant Commissioner of Mental
Health for the Commonwealth of Massachusetts and was the Executive Director of an
ambulatory and long-term care provider. Presently, she is a senior researcher at Abt
Associates, the subcontractor for SAMHSA’s toolkits on Evidence Based Practices
(EBPs).

23. **Judith Meyers**, Ph.D., President and CEO of the Children’s Fund of Connecticut and
the Child Health and Development Institute of Connecticut, Inc., who has been very
involved in development of early childhood MH services in that state and also serves
on Connecticut’s transformation committee for child and family services.

24. **Candy Nardini**, Vice President for Public Sector at ValueOptions works with states
to implement managed behavioral healthcare solutions. She has extensive expertise
with managed care design and operations for public sector initiatives. Ms. Nardini
was a leader of Iowa’s medical assistance initiative that oversaw the implementation
of managed behavioral health care in that state.

25. **Kenneth Minkoff**, M.D, Dr. Minkoff is a board-certified psychiatrist with a
certificate of additional qualifications in addiction psychiatry clinical assistant
professor of psychiatry at Harvard Medical School. Dr. Minkoff was panel chair for
the CMHS Managed Care Initiative report entitled: Co-occurring Psychiatric and
Substance Disorders in Managed Care Systems: Standards of Care, Practice

26. **Richard Orndoff, MA** is a consultant and the former CEO of Magellan Behavioral
Health’s Public Solutions Division. He also ran and participated in the evolution of
the TennCare program and oversaw Magellan’s public sector initiatives in several
states. Previously, he was a Regional Administrator for the NY Department of Mental
Health and Hygiene.

27. **Peter Panzarella**, M.A., M.S., L.A.D.C., L.P. C., C.A.D.C. is the Director of
Substance Abuse Services for the Connecticut Department of Children and Families.
He coordinates Connecticut’s implementation of family based EBPs including MST
and Multi-Dimensional Family Therapy.

28. **Bert Plant**, Director of Community Services, Connecticut Department of Children
and Families.
29. **Celeste Putnam**, M.S., an independent consultant who has been very involved in Florida's child mental health and child welfare services development over the past decade, including development of early childhood mental health services. She is former Deputy Secretary for Substance Abuse and Mental Health at the Florida Department of Children and Families and former Health Care Administrator for the Florida Agency for Health Care Administration.

30. **Jim Rast**, Ph.D. is a leading researcher in Wraparound planning and provides consultation, training, and evaluation services related to Wraparound planning nationally.

31. **Estelle B. Richman** is the Secretary, Department of Public Welfare. Her career spans more than 30 years of public service, including her most recent position as Managing Director for the City of Philadelphia.

32. **Jeanne C. Rivard**, Ph.D. is a Senior Research Analyst at the NASMHPD Research Institute. She is also a founding member of the National EBP Consortium. The mission of the Consortium is to promote implementation of evidence-based and promising practices within state systems of care.

33. **Thomas L. Sexton**, PhD. is Director of the Center for Adolescent and Family Studies at Indiana University and training coordinator for Functional Family Therapy (FFT), Inc. He has developed training materials and outcome and adherence tracking systems that are an integral part of FFT and presented workshops, classes and presentations on FFT, both nationally and internationally.

34. **Mark Schaeffer**, PhD, Director of Medical Policy, Connecticut Department of Social Services, is centrally involved in that state’s development efforts for Medicaid-funded child and family services, including early childhood MH consultation.

35. **Keller Strother**, MS, MBA, is the President and a co-founder of MST Services. The mission MST Services is to provide high quality, highly responsive program development and training services to organizations establishing treatment programs using Multisystemic Therapy (MST). As a founding member of MST Services, he has been involved with the development of MST programs in over 30 states and at numerous sites internationally.

36. **Vincent Strully**, Founder and Executive Director of The New England Center for Children, has over 32 years of experience working with children with autism and challenging behaviors in the United States and Middle East.

37. **Leslie Tremaine**, PhD, at the time of interview was the behavioral health leader for New Mexico’s Human Services Department, Medical Assistance Division, where she is overseeing the purchase of mental health services through the newly instituted purchasing collaborative. She is the mental health leader for the SAMHSA.
Transformation Grant awarded to New Mexico. Dr. Tremaine has a distinguished career in public sector behavioral health, directing programs in Colorado, Louisiana, and Delaware. Recently, she announced her decision to accept the position of Mental Health Director, Santa Cruz County, California.

38. **Dave Wanser, PhD** is the Deputy Commissioner for Behavioral and Community Health at the Texas Department of State Health Services and is responsible for managed care procurement. He is also the Executive Director of the Texas Commission on Alcohol and Drug Abuse and the Chairman of the Texas Transformation Working Group.

39. **Claudia Zundel**, the lead for Colorado’s SAMHSA-funded system of care initiative Project BLOOM for Early Childhood Mental Health at the Colorado Division of Mental Health.
Appendix B

Interview Guides
## Family-Based Mental Health Services

**Question 1:** How do you make decisions about appropriate levels/types of intensive services for children and families?

**Question 2:** What types of formal screening and assessment protocols and tools are used to inform those decisions?

**Question 3:** How is screening and assessment data used in making decisions about appropriate levels/types of service for children and families?

**Question 4:** What family-based service options do you provide for children and families?

**Question 5:** Are any of the services evidence-based? If so, what type of evidence are they based on?

**Question 6:** If not specifically mentioned (either as services provided or as explicitly not provided), does your state offer any of the following?

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Wraparound Planning (with formal quality assurance/fidelity tracking protocols – these should be specified)
- Brief Strategic Family Therapy
- Other ________________________________

**Question 7:** What are the eligibility requirements for these services? (If not mentioned, prompt for age, payer, agency-involvement, and severity indicator variables)

**Question 8:** How are these services funded?

- Are there financial or other incentives to use them?
- Are there any performance requirements to guide the use of these services?

**Question 9:** Describe the quality assurance protocols, including any instruments, for family based services?
## 0-5 Mental Health Consultation

### Section A: Program and Managed Care Innovations

#### Question A-1: Does your state offer mental health consultation services in child care settings for children ages 0 to 5? If so, please describe how they are delivered. If not, please describe any plans to offer them. [Interviewer – be sure to prompt regarding the following points, if not brought up]

- How is consultation specific to an individual child’s behavior/needs delivered
- How is more general consultation to child care workers delivered
- How does access to mental health consultation vary by type of child care setting (for example, larger child care centers versus smaller family-run child care programs)?
- What linkages are there to more formal mental health interventions for children ages 0 to 5

#### Question A-2: Are any of the following services available in your state? If so, please describe how they are delivered:

- Mental health consultation in other settings (e.g., primary care, pre-school) for children ages 0 to 5
- Specific mental health interventions to address the mental health needs of children ages 0 to 5 (for example, Applied Behavioral Analysis)
- Other mental health services for children ages 0 to 5

#### Question A-3: Are any of the services just discussed available through Medicaid managed care programs?

- Mental health consultation in child care settings for children ages 0 to 5
- Mental health consultation in other settings (e.g., primary care, pre-school) for children ages 0 to 5
- Specific mental health interventions to address the mental health needs of children ages 0 to 5 (for example, Applied Behavioral Analysis)
- Other _________________________________________________________________

#### Question A-4: What types of provider organizations are delivering each of the services just discussed?

#### Question A-5: What types of individual providers are delivering each of the services just discussed?
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**Section B: Dissemination and Best Practices**

| **Question B-1:** | What have you done to promote competency in use of these types of interventions among providers? |
| - | Were there initial gaps in provider competency that needed to be addressed? How were they identified? |
| - | Was there any initial training of providers? |
| - | Is there certification/privileging of providers to offer the service? |
| - | Is booster training or retraining required or offered? |
| - | What have been the barriers to appropriate use of these types of services? How have you overcome them? |
PA OMHSAS – 0-5 MH Consultation White Paper Survey Tool

0-5 Mental Health Consultation

Section C: Funding

**Question C-1:** How are the interventions specified above funded?

- What sources of funds are used (Medicaid, state mental health, juvenile justice, child welfare, schools, other)
- Are there any funds used that are blended or braided across agencies?
- Are there financial or other incentives to use them?
- Are there any performance requirements to guide the use of these services?

**Question C-2:** Was there any effect on service utilization documented as a result of the introduction of these services?

- Increases in service use in targeted areas? Decreases in the use of less appropriate services?

Section D: Quality Management

**Question D-1:** Describe the quality assurance protocols used for any of these services, particularly for consultation in child care settings?

- Are any measures of fidelity or adherence used? If so, how is this done?
- Is there ongoing oversight of delivery of the services through audits or record reviews?
- Do you incorporate outcome assessment tools into the monitoring? If yes, how are results used (assess the system, provider profiling, case management at the case-specific level)?
- Are there other ways you have measured success for these programs?

Section E: Administrative Functions

**Question E-1:** What are the eligibility requirements for these services? (If not mentioned, prompt for age, payer, agency-involvement, and severity indicator variables)

**Question E-2:** What types of formal screening and assessment protocols and tools are used to inform those decisions?
**Question E-3:** How are screening and assessment data used in making decisions about appropriate levels/types of service for children and families?
## Question 1:
Please describe the use of services that promote recovery and resilience available to consumers in your mental health and substance abuse system? *(When necessary, use prompts below to identify specific strategies within each individual section heading and ask separately for children and adults)*

- What are the names of the services? What do the services involve?
- If you could estimate the percentage of providers that offer recovery- and resilience-oriented services in your state, county, network, what would that be?
- Does your state, county or MBHO pay for peer support services? To what extent?
- Do consumers have access to employment support?
- What are some of the barriers to implementation of recovery and resilience approaches you have encountered?

## Question 2:
What do you think is necessary for states, managed care organizations and providers to support recovery for adults? What do you think is necessary for states and management care organizations to promote resilience for children and families? *(Use prompts below to identify specific strategies when necessary and ask separately for children and adults.)*
### Question 2.1:

- Do you have any suggestions for how state and managed care organizations can promote a recovery/resilience culture that supports hope, high expectations, effective treatment and rehabilitation, and building a life outside of mental health treatment?
- Do you have suggestions for strategies to promote consumer-run services?
- Do consumers in your state/county have access to crisis alternatives such as warm lines and respite?
- Are coercion and involuntary treatment in use? Is seclusion and restraint still used in state/community/private psychiatric hospitals?
- Do you know if consumers have self-directed options such as developing advanced directives?
- Does your mental health system pay attention to fostering friends, participation in social events, community organizations and hobbies outside of the mental health system?
- Have any states or managed care organization been successful in implementing a single initial assessment accessed by multiple agencies? Is there a tool you’d recommend for this purpose?
PA OMHSAS – Recovery and Resilience White Paper Survey Tool
For Review and Discussion

Recovery and Resilience

Consumer Expert Questions

Section B: Dissemination and Best Practices

**Question 2.2:**

- Have you or consumers and family members you know participated in any training of State, Provider, or Managed Behavioral Health organization (MBHO) staff on recovery and resilience? What types of training do you recommend?
- Are you or other consumers/family members participating in a workgroup or transformation committee? Is this an effective strategy to promote recovery and resilience?
- How is information regarding recovery and resiliency best practices shared? Is there a website?

Section C: Funding

**Question 2.3:**

- Has your organization or other consumer organizations received funds to operate services? If so, describe scope and goals.
- In what settings have you seen consumers successfully employed (e.g. MCO, State, agencies)? How are they paid? Are the services reimbursable?
- Has your organization received any funds to promote implementation of recovery and resilience, including paid positions within your organization or paid consulting to help with implementation strategies?
- Are you aware of any provider contracts that have incentives or requirements to support recovery and resilience approaches?
- Can you estimate the percentage of peer support and consumer operated services available within your state/program compared to all services?
- To your knowledge, has the state/county or MBHO set any standards for achieving a certain number or percentage of peer support or consumer-run services?
## PA OMHSAS – Recovery and Resilience White Paper Survey Tool

For Review and Discussion

### Recovery and Resilience

**Consumer Expert Questions**

#### Section D: Quality Management

**Question 2.4:**

- Have you participated in a review of policies and procedures/medical records to strengthen recovery efforts and promote resilience? (e.g., personalized recovery plans?) How is this progressing?
- Are you involved in quality management approaches, including consumer and family evaluation initiatives?
- What is the feedback loop regarding the effectiveness of implementation of evidenced-based or promising practices?
- What indicators of success would you recommend a BH-MCO monitor that would provide a good early warning signal that the MCO needed to intervene in a service plan that appears not to be working? How should the BH-MCO intervene?
- What information should a BH-MCO collect to determine if the provider’s attitude and responsiveness (rather than the intervention) is not consistent with recovery/resiliency?

#### Section E: Administrative Functions

**Question 2.5:**

- Have consumers and family members been hired to help with transformation strategies? Other?
- In what settings have consumers been hired? What positions do consumers fill at the State, BH-MCO or provider agency? What supports were needed to facilitate success? What issues exist?

**Question 3:** What strategies do you think are working best? Not working very well?

- Is there a difference in strategies for children and families as distinct from adults/older adults?
### Recovery and Resilience Survey Tool

#### Industry Experts, States and Behavioral Health Managed Care Organizations Questions

**Question 1:** What strategies are you using to promote recovery and resilience?  
*When necessary, use prompts below to identify specific strategies within each individual section heading and ask separately for children and adults*

#### Section A: Program and Managed Care Innovations

**Question 1.1:**

- Promoting an expectation that people can and do recover, or in the case of children, emphasizing resilience?
- Involving consumers and families in promoting recovery and resilience. Describe.
- Providing access to consumer operated services? Can you estimate the percentage of these services available within your state/program compared to all services? Have you set any standards for achieving a certain number or percentage of peer support or consumer-run services?
- Promoting the availability of consumer-directed options such as developing advanced directives?
- Using utilization/care management approaches to support recovery and resilience? Are there specific policies, procedures, or tools you implemented or know about?
- Developing of recovery/resilience plans?
- Fostering participation in social events and friends outside of the mental health system.
- Providing access to crisis alternatives such as warm lines and respite? Minimization of coercive and involuntary treatment? Elimination of seclusion and restraint in hospitals?
- Offering employment support for the people you serve? How is this funded? Can you estimate the percentage of people that have jobs with health care benefits that your organization serves? Any job in the competitive workforce?
- Implementing Evidence Based Practices (EBPs) that promote recovery and resilience. Describe.
### Recovery and Resilience

**Industry Experts, States and Behavioral Health Managed Care Organizations Questions**

- Transitioning staff away from services that do not have as positive outcomes as EBPs?
- Identifying emerging practices that support recovery and resilience?

### Section B: Dissemination and Best Practices

**Question 1.2:**

- Designating staff, including consumers/family members or workgroup targeting recovery and resilience initiatives (specify).
- Training (staff, providers, consumers and families, administrators) on the recovery culture: recovery is likely, attention to basic needs, including housing, human and civil rights, income, healthcare, and transportation.
- How is information regarding these practices disseminated? Is there a website?
- Other

### Section C: Funding

**Question 1.3:**

- Targeting funding for consumer-run services?
- Providing/obtaining grants and other funding initiatives that promote recovery and resilience—describe scope and goals
- Incorporating incentives/requirements in provider contracts
- Implementing transition plans to finance and develop EBPs? Collecting cost effectiveness data on EBPs?
- Financing services that are part of an EBP through Medicaid? Please describe.
- Funding sources for recovery/resilience and EBPs? Do your financing plans include blended funding approaches, especially for children served by multiple agencies?
- If you could estimate the percentage of providers that offer best practices in your state, county, or network, what would that be?
### Section D: Quality Management

**Question 1.4:**

- Reviewing policies and procedures/medical records, e.g., personalized recovery plans?
- Reviewing clinical guidelines and treatment protocols to assess recovery and resilience focus?
- Using consumer and family evaluation approaches?
- Measuring fidelity to recovery/resilience and EBPs.
- Analyzing claims and encounter data to identify overall and provider-specific trends, establish benchmarks, and target areas for focused studies.
- Using other quality management approaches that promote recovery and resilience?
- What feedback loop exists regarding the effectiveness of the implementation of the recovery and resilience practices?
- How is the provider’s approach, attitude and responsiveness monitored?
- How does the BH-MCO know that intervention in a service plan is necessary? What interventions to they utilize?

### Section E: Administrative Functions

**Question 1.5:**

- Using Administrative set-asides to promote implementation of recovery and resilience, including consumer and family advocacy, consumer and family member positions?
- In what positions are consumers hired? How are they paid? What additional supports are provided or needed?
- Developing measures of success or penetration of recovery and resilience, e.g., (e.g., % of dollars spent on consumer operated services, specific consumer satisfaction items specific to recovery and resilience concepts and outcomes, etc.)
- What problems are the BH-MCOs, States and provider agencies having with hiring? Recruitment? What has been successful in addressing these problems?
<table>
<thead>
<tr>
<th>Question A-1</th>
<th>What managed care processes or practices help individuals avoid unnecessary State Hospital admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question A-2</td>
<td>What community resources exist to help individuals avoid unnecessary State Hospital admission?</td>
</tr>
<tr>
<td>Question A-3</td>
<td>What strategies does the BH-MCO or managing entity employ to facilitate community reintegration?</td>
</tr>
<tr>
<td>Question A-4</td>
<td>What community services/resources facilitate community re-integration?</td>
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<tr>
<td>Question A-5</td>
<td>What services does the State Hospital provide to prepare individuals for community reintegration?</td>
</tr>
<tr>
<td>Question A-6</td>
<td>What does the BH-MCO or managing entity do to maximize an individual’s tenure in the community (e.g. monitoring, testing, out-reach)?</td>
</tr>
<tr>
<td>Question A-7</td>
<td>Which strategies have been the most effective in increasing community tenure? What evidence do you have that they were effective?</td>
</tr>
<tr>
<td>Question A-8</td>
<td>If more than one county/geographic region refers into a State Hospital, is one county/region more successful than another diverting individuals from admission or reintegrating individuals into the community? If so, what differentiates this county/region from the others?</td>
</tr>
<tr>
<td>Question A-9</td>
<td>Have any counties moved away from reliance on state hospital beds, and if so, what strategies have they employed? What does the system of care look like?</td>
</tr>
</tbody>
</table>
### Reducing Reliance on State Hospitalization: Increasing Community Tenure

**Question A-10**: What is the role of the State Hospital in the system of care? What initiatives have reduced the State Hospital population or the average length of stay?

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**Section B: Dissemination and Best Practices**

**Question B-1**: How are consumers and family members made aware of community resources that prevent State Hospital admission or support community tenure?

**Question B-2**: How are network providers made aware of community resources that facilitate community tenure?

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**Section C: Funding**

**Question C-1**: How is treatment in the State Hospital funded?

**Question C-2**: At what point are Medicaid eligible individuals dis-enrolled when admitted to the State Hospital?
- When can these individuals re-enroll?

**Question C-3**: What financial incentives are in place to encourage State Hospitals to discharge individuals ready to be reintegrated into the community?

**Question C-4**: What financial incentives are in place for BH-MCOs to collaborate with State Hospitals in discharge planning into the community?

**Question C-5**: What incentives exist for BH-MCOs or other facilities to divert from State Hospital admission individuals who can be treated in a less restrictive environment?
## Section D: Quality Management

**Question D-1:** How does the BH-MCO monitor the progress and success of former State Hospital individuals in the community?

**Question D-2:** Based on outcomes monitoring, which sub-populations discharged from the State Hospital have the longest community tenure? What makes these groups more successful?

**Question D-3:** Do provider profiles include any measures of a provider’s success in helping individuals remain in the community? If so, how are providers paid/rewarded for supporting community tenure?

## Section E: Background Information

**Question E-1:** What populations (subpopulations) receive treatment in the State Hospital (e.g., involuntary/court-ordered for treatment, forensic, facility referrals for long term care, gero-psychiatric, sexually violent predators, children)?

**Question E-2:** What is the average length of stay at the State Hospital?

**Question E-3:** What is the State Hospital’s role in supporting recovery?

**Question E-4:** Which populations are the hardest to place in the community and why?

**Question E-5:** What is the process(es) for admission into the State Hospital?

**Question E-6:** Is there a waiting list for beds?
### Question E-7:
How many State Hospitals operate in your State? What are the number of beds available relative to the population served?

### Question E-8:
Have you ever closed a State Hospital? What strategies were effective in reducing reliance on that facility?

### Question E-9:
Are there specific requirements (regulations/settlement agreements/consent/decrees/court orders) impacting the admission or discharge of individuals treated by the State Hospital?
# Family Based Mental Health Services

## Interview Guide

### Family-Based Mental Health Services

**Section A: Program and Managed Care Innovations**

**Question A-1:** What intensive community-based service options do you provide for children and families?

**Question A-2:** Are any of the services evidence-based? If so, what type of evidence are they based on?

**Question A-3:** If not specifically mentioned (either as services provided or as explicitly not provided), does your state offer any of the following?

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Wraparound Planning (with formal quality assurance/fidelity tracking protocols – these should be specified)
- Brief Strategic Family Therapy
- Other _________________________________________________________________

**Question A-4:** To what extent are these services available (statewide, regions, individual county/city)?

- Are there any examples of best practices in managed care settings with interventions specified above?
- Are there any examples of best practices in other settings with interventions specified above?
## Family Based Mental Health Services
### Interview Guide

## Family-Based Mental Health Services

### Section B: Dissemination and Best Practices

**Question B-1:** What have you done to promote competency in use of these types of interventions among providers?
- Initial training of providers?
- Certification/privileging of providers to offer the service?
- Is booster training or retraining required or offered?
- What have been the barriers to appropriate use of these types of services? How have you overcome any of these barriers?

### Section C: Funding

**Question C-1:** How are the interventions specified above funded?
- What sources of funds are used (Medicaid, state mental health, juvenile justice, child welfare, schools, other)
- Are there financial or other incentives to use them?
- Are there any performance requirements to guide the use of these services?
### Family-Based Mental Health Services

#### Section D: Quality Management

**Question D-1:** Describe the quality assurance protocols, including any instruments, for intensive community-based services?

- Are any measures of fidelity or adherence used? If so, how is this done?
- Is there ongoing oversight of delivery of the services through audits or record reviews?
- Do you incorporate outcomes assessment tools into the monitoring? If yes, how are results used (assess the system, provider profiling, case management at the case-specific level)?
- Are there other ways you have measured success for these programs?

#### Section E: Administrative Functions

**Question E-1:** What are the eligibility requirements for these services? (If not mentioned, prompt for age, payer, agency-involvement, and severity indicator variables)

**Question E-2:** How do you make decisions about appropriate levels/types of intensive services for children and families?

**Question E-3:** What types of formal screening and assessment protocols and tools are used to inform those decisions?

**Question E-4:** How are screening and assessment data used in making decisions about appropriate levels/types of service for children and families?