

Assertive Community Treatment

Implementation Resource Kit



DRAFT VERSION

2003

Information for Mental Health Program Leaders

Background

Assertive community treatment (ACT) started when a group of mental health professionals at the Mendota Mental Health Institute in Wisconsin – Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D. – recognized that many people with severe mental illnesses were being discharged from inpatient care in stable condition only to be readmitted relatively soon thereafter. This group looked at how the mental health system worked and tried to figure out what could be done so that individuals with severe mental illness could remain in the community and have a life that was not driven by their illness.

This group recognized that there was an immediate decrease in the type and intensity of services available to people upon leaving the hospital. They also realized that, even when considerable time was spent in the hospital teaching people skills needed to live in the community, people were often unable to apply these skills once they were actually living in the community. Adjusting to a community setting was made worse by the fact that people who experience serious psychiatric symptoms may be particularly vulnerable to the stress associated with change.

The group also recognized that, because the mental health system was complex and services were fragmented, people often had difficulty getting the services and support they needed to prevent relapse. Many programs were only available for a limited time and, once a person was discharged, assistance ended. Sometimes people were denied services, or they were unable to

apply for services because of problems caused by the symptoms of their mental illness. Sometimes the service a person needed did not even exist and no one was responsible for making sure people got the help they needed to stay out of the hospital.

The group's response to these problems was to move inpatient staff into the community to work with people in the settings where they lived and worked. This multidisciplinary team provided people with the support, treatment, and rehabilitation services they needed to continue living in the community. The types of services that were provided and how long those services were provided depended on people's needs. Team members pooled their experience and knowledge and worked together to make certain people had the assistance they needed and that the treatment that was being provided was effective. The team met

each day to discuss how each person was doing and services were adjusted quickly when necessary. When people needed more support, team members met with them more frequently. Staff responded to people in the community 24 hours a day, 7 days a week. As people improved, the team decreased their interactions with them, but team members were available to provide additional support any time it was needed. After 30 years, the principles of this model remain the same.

Principles of Assertive Community Treatment

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

Who is ACT for?

Typically, people who receive services from an assertive community treatment program have not benefited from traditional approaches to providing treatment. People who receive ACT services are those who have the most serious and intractable symptoms of mental illness and experience the greatest impairment in functioning. Impairments may include difficulties with basic, everyday activities like keeping themselves safe, caring for their basic physical needs, or maintaining safe and adequate housing, unemployment, substance abuse, homelessness, and involvement in the criminal justice system.

Evidence of the effectiveness of ACT

Researchers have compared ACT to traditional approaches to care (usually brokered or clinical case management programs). Evidence shows that ACT is superior to comparison conditions in (1) reducing psychiatric hospitalization, (2) increasing housing stability and, (3) improving consumers' quality of life. Studies also show that consumers and their family members find ACT more satisfactory than comparable interventions.

The ACT team leader

The ACT team leader is responsible for program administration and clinical supervision and also provides direct services to consumers. The team leader's administrative responsibilities include hiring and training team members, scheduling, evaluating employee performance, monitoring the program's faithfulness to the ACT model, and various other financial and statistical responsibilities. The team leader is also responsible for clinical supervision. This involves monitoring each consumer's status, assessing team members' performance, and providing feedback to team members in the context of the team's day-to-day activities.

Team and caseload size

The team must have enough staff so that there is a comprehensive mixture of expertise and sufficient coverage for the hours of operation. At the same time, to operate as a team, the team must be small enough to communicate easily and allow each member to be familiar enough with each consumer's status that they can step in to provide care at any time. A team of 10 to 12 members with a total caseload of 100 persons is suggested, although teams serving a large number of individuals with acute needs may find that a smaller caseload is needed until the individuals stabilize. The cost of this more intensive staff may be recouped through a decrease in the use of more expensive inpatient services.

Team composition

Since an ACT team is responsible for providing a broad array of treatment, rehabilitation, and support services, team members must have a wide range of knowledge and experience. A staffing pattern for a team providing 24-hour coverage for 100 consumers might be:

- ▶ team leader – one full-time employed mental health professional
- ▶ one psychiatrist
- ▶ two or more nurses
- ▶ two or more employment specialists

- ▶ two or more substance abuse treatment specialists
- ▶ one full-time consumer/peer specialist
- ▶ mental health professionals and paraprofessionals (master level social workers, occupational therapists, rehabilitation counselors, psychologists)
- ▶ one program assistant

Team approach

An ACT team is not a consortium of specialists or a group of individual case managers. It is an integrated, self-contained treatment program in which team members work together collaboratively. While certain team members will work more often with some consumers than with others, all team members are familiar with each individual and are available when needed for consultation or to provide assistance. The team, as a whole, rather than any one member, is responsible for providing whatever is needed to assist individuals in their recovery from mental illness. This shared-caseload approach is an important component of ACT and is a characteristic that distinguishes it from other community-based programs. Elements that contribute to the shared-caseload approach include:

- ▶ collaborative assessment and treatment planning
- ▶ cross-training of team members to the maximum extent feasible
- ▶ daily team meetings
- ▶ open office layout
- ▶ availability of assistance 24-hours a day
- ▶ generalist practice, that is, regardless of their area of formal training, all members assist with activities that support individuals in the community such as going with an individual to talk to a landlord, calling about a lost check

Team development

When selecting individuals for an ACT team, team leaders will want to find individuals who not only have expertise in their particular specialties, but who can also work productively in a group. Pragmatism, street smarts, and an optimistic, "can do" attitude are also desirable. Individuals should be willing and able to actively involve consumers in making decisions about their own treatment and services.

Manuals and videos explaining the ACT model are listed at the end of this publication. These materials can provide staff members with an overview of the theoretical and operational principles of ACT. Once staff have a basic understanding of the model, it is recommended that they visit an existing, well-functioning team to observe how the team works with consumers and how they interact with each other. This is followed by several days of classroom instruction before consumers are admitted to the program. During the first one to two years of a new team's existence, there are periodic booster training sessions. Ongoing telephone consultation and side-by-side supervision by an experienced ACT team trainer are important in reducing the chance that staff members will revert to old, more familiar ways of operating.

Cultural sensitivity

Because team members work with individuals in community environments rather than in clinic or hospital settings, they are actively involved in the culture of the individuals they serve. Awareness of and sensitivity to cultural differences take on additional importance in this context. Teams should reflect the cultural diversity of the communities in which they operate and consider the need for bilingual team members. Members of the team should be familiar with and comfortable with the culture of the people being served.

Accountability

Each day the team is updated on the results of the prior day's contacts with people. The activities for the current day are then jointly planned. Throughout the day, team members are in and out of the office and interacting with each other. A nonproductive team member will quickly become obvious.

Administrative issues

Starting a new team means developing policies and procedures that fit the activities of the ACT model. These include establishing:

- ▶ a mission statement for the team
- ▶ a program budget
- ▶ a physical location for the team's headquarters
- ▶ admission criteria that clearly identify the population to be served
- ▶ a medical record management system
- ▶ procedures for managing medications

- ▶ management of consumer funds
- ▶ procedures for assessment and treatment planning
- ▶ policies covering transportation
- ▶ mechanisms for monitoring and feeding back outcome and process data

These issues are discussed in detail in *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-up* by Deborah Allness and William Knoedler. A copy can be obtained through www.nami.org

For more information

Information on implementing evidence-based practices

Evidence Based Practices Implementation Website

www.mentalhealthpractices.org

To locate programs to visit or to contact trainers

National Assertive Community Treatment Technical Assistance Center

National Alliance for the Mentally Ill
2107 Wilson Blvd, Suite 300
Arlington, VA 22201-3042
(866) 229 -6264
elizabeth@nami.org
www.nami.org/about/PACT.htm

Assertive Community Treatment Association (ACTA)

Assertive Community Treatment Association, Inc.
810 E. Grand River Ave., Suite 102
Brighton Michigan 48116
(810) 227-1859
cherimsixbey@actassociation.com
www.actassociation.com

Projecting the costs of ACT

The Lewin Group

The LewinGroup
3130 Fairview Park Dr., Suite 800
Falls Church, VA 22042
703-269-5500
karen.linkins@lewin.com

Helpful Books

“Assertive Community Treatment of Persons with Severe Mental Illness” by L. Stein & A. Santos, Norton Publishers

www.wwnorton.com

“PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up” by D. Allness & W. Knoedler, NAMI

www.nami.org
(866) 229-6264

Videos

“Assertive Community Treatment” (A Brief Introduction to ACT), Duke University, Department of Psychiatry & Behavioral Sciences

toolkit video

“Never Too Far” (describes an ACT program in a rural community), Duke University, Department of Psychiatry & Behavioral Sciences

pasip001@mc.duke.edu
919 684-3332

“Consumers Talk About ACT” (interviews with individuals who receive ACT services), Duke University, Department of Psychiatry & Behavioral Sciences

Elizabeth@nami.org
(866) 229-6264

“The Role of Advisory Groups”

Elizabeth@nami.org
(866) 229-6264

Family Psychoeducation

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What is family psychoeducation?

Family psychoeducation is a method of working in partnership with families to impart current information about the illness and to help them develop coping skills for handling problems posed by mental illness in one member of the family. The goal is that practitioner, consumer, and family work together to support recovery. It respects and incorporates their individual, family, and cultural realities and perspectives. It almost always fosters hope in place of desperation and demoralization.

Psychoeducation can be used in a single family or multi-family group format, depending on the consumers and family's wishes, as well as empirical indications. Single family and multi-family group versions will have different outcomes over the long term, but there are similar components. The approach has several phases, each with a specific format:

Introductory sessions

Family members meet with a practitioner, together or separately, and begin to form a partnership. These sessions explore warning signs of illness, the family's reactions to symptoms and behaviors, feelings of loss and grief, and goals for the future.

Educational workshop

Families come together in a classroom format for at least four hours to learn the most current information about the psychobiology of the illness. They learn important information about normal reactions, managing stress, safety measures. Families choosing single family psychoeducation may also wish to attend this session.

Problem-solving sessions

Consumers and families meet every two weeks for the first few months in a single or multi-family format while learning to deal with problems in a pragmatic, structured way. The best results occur when the work proceeds for at least nine months. Additional time of up to two years promotes improved outcomes.

Why should mental health program leaders consider family psychoeducation?

Increasingly, mental health facilities are feeling pressure to meet the demands of service and productivity. Mental health program leaders find they need to direct services that will satisfy these demands without sacrificing the quality of care being offered. At the same time, program leaders are concerned about practitioners' level of satisfaction.

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. Research has shown that there is a significant reduction in relapse rates (by at least 50% of previous rates) when family intervention, multi-family groups, and medication are used concurrently. Recent studies show promising results for bipolar disorder, major depression, and other severe mental illnesses.

What is the benefit of psychoeducation for practitioners?

Research has shown that psychoeducation provides practitioners with an opportunity to:

- ▶ Promote improved clinical outcomes, satisfaction, and higher rates of recovery amongst their clients
- ▶ Feel more supported in their efforts to manage the effects of illness
- ▶ Build relationships with families
- ▶ Experience improved cost-benefit ratios

In fact, many practitioners find that their work with families helps them develop their own professional skills. They describe an improved understanding of the effect of illness on family relations and an improved ability to shift their own perspectives from practitioner to partner.

Who is the target population?

The greatest amount of research has shown benefits for people with schizophrenic disorders and their families. Further, people who participate in family psychoeducation at an early stage of their illness have especially promising outcomes in terms of symptoms and employment. Increasing evidence shows that new versions for mood disorders, OCD, and borderline personality disorder are effective, as well for consumers who lack family support altogether. Thus, the population with the greatest benefit will be those with the most severe psychiatric disorders.

Family refers to anyone who cares about the consumer. It does not have to be a relative or a person sharing the same living space.

What can I do to implement family psychoeducation?

Mental health systems that have some psychosocial or psychotherapy services, can largely reallocate services toward family psychoeducation. If multi-family groups are established, total service efforts will actually decrease by the end of the first year. A recent cost-effectiveness study shows that the extra effort will be more than recouped in saved crisis/intensive treatment efforts and costs. Special arrangements may be needed to provide access to families from some cultural groups. It is very useful to consult with and involve the local or state chapter of NAMI.

This approach is designed to largely replace individual meetings with consumers. The most cost-effective approach is to simply include the family in most ongoing sessions, whether in single or multi-family group format. Most licensed mental health practitioners can learn to work within this model quite effectively. That includes social workers, psychiatric nurses, psychiatrists, psychologists, occupational therapists, and case managers. The usual steps toward establishing services include an agency-wide orientation and program consultation, intensive clinical training, and about one year of group supervision.

For more information

Information about family psychoeducation, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.



Improving Practices in Michigan's Public Mental Health System

Michigan Department of Community Health



**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
IMPROVING PRACTICES LEADERSHIP TEAM MEETING**

**MONDAY, NOVEMBER 5, 2007
LANSING COMMUNITY COLLEGE WEST CAMPUS**

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IMPROVING PRACTICES LEADERSHIP TEAMS IN MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

It is the vision of the Michigan Department of Community Health (MDCH) that: "Michigan's children, families and adults will have access to a public mental health and substance abuse service system that supports individuals with mental illness, emotional disturbance, developmental disabilities and substance use disorders by promoting good mental health, resiliency, recovery, and the right to control one's life within the context of the benefits and responsibilities of community."

Together with consumers, providers, families, advocates, community stakeholders, and policy makers, the MDCH is engaged in a system transformation process aimed at achieving the vision. In May 2005, the MDCH used federal Community Mental Health Block Grant funds to issue a request for proposals (RFP) to the state's 18 Prepaid Inpatient Health Plans (PIHPs) for Medicaid Specialty Mental Health and Substance Abuse Services and Supports. The RFP invited PIHPs to partner with MDCH and affiliate community mental health services programs to improve practices in the public mental health system. All 18 PIHPs responded to this invitation and agreed to use funding to convene Improving Practices Leadership Teams (IPLTs) and join in statewide practice improvement. The formation of the IPLTs is aimed at fostering a learning organization within the public mental health system so that emerging, promising and evidence-based practices can quickly become part of the choices available to consumers during the person-centered planning process.

The MDCH charged IPLTs to:

- Adopt a vision for a transformed system of care for adults and children;
- Establish leadership capabilities and organizational capacity to communicate the vision and lead the transformation;
- Create an environment or climate of working that is receptive and amenable to the transformation;
- Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system;
- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes;
- Develop an ongoing process to maximize opportunities and overcome obstacles; and
- Monitor outcomes and adjust processes based on learning from experience.

IPLTs are expected to:

- Align relevant persons, organizations, and systems to participate in transformation process;
- Assess parties' experience with change;
- Establish effective communication systems;
- Ensure effective leadership capabilities;
- Enable structures and process capabilities;
- Improve cultural capacity; and
- Demonstrate their progress in system transformation by implementing evidence-based, promising and new and emerging practices.

IPLT membership includes:

- An Improving Practice Leader
- Specialists in each of these areas: services for individuals with serious mental illness; services for children with serious emotional disturbance; and services for people with a developmental disability

- Finance
- Data
- Evaluation
- Consumer employed by the PIHP or subcontract agency
- Family member of a child receiving PIHP services
- An identified program leader for each practice being implemented by the PIHP
- An identified program leader for peer-directed or peer-operated services
- A peer support specialist

This document highlights some of the statewide accomplishments in fostering:

- A system of care based in recovery for adults with mental illness;
- A system of care for children; and
- Improved practices for delivering services and supports for people with developmental disabilities.

The MDCH leader for Improving Practices Leadership Teams is: Irene Kazieczko: kazieczko@michigan.gov

MDCH key contacts for IPLTs are: Patty Degnan: degnanp@michigan.gov, and Tison Thomas: thomasti@michigan.gov

MDCH PRACTICES IMPROVEMENT STEERING COMMITTEE

The Evidence-Based Practice Steering Committee was established by the Michigan Department of Community Health (MDCH) in 2004 to address how to implement evidence-based practices (EBPs) in Michigan's public mental health system. This initiative grew out of national mandates (e.g., President's New Freedom Commission and the resulting Federal Action Agenda, Institute of Medicine's Improving Quality of Health Care for Mental and Substance Use Conditions), federal Mental Health Block Grant (MHBG) funding requirements, and Michigan's Governor's Mental Health Commission that all called for using EBPs where they exist, and improving other practices that are currently being used by the public mental health system.

The Committee, later renamed Practice Improvement Steering Committee, is made up of representatives from universities, Prepaid Inpatient Health Plans (PIHPs), advocacy organizations, consumers and MDCH. It initially focused on identifying a small number of EBPs that would be implemented by PIHPs and supported by the MHBG dollars, and then become contractually required to be available at each PIHP beginning FY 08. The Committee selected two adult practices that already had free "toolkits" developed for the federal Substance Abuse and Mental Health Administration (SAMHSA): family psycho-education and integrated treatment for persons with co-occurring mental health and substance use disorders. One children's practice, Parent Management Training/Oregon model, was chosen for competitive opportunity to receive block grant funds to support its implementation. Subcommittees of the Steering Committee were established to oversee the implementation process, and an additional subcommittee was charged with identifying common measurements of success across the practices. Each EBP has an evaluation component that involves a university.

The Steering Committee also serves as a clearinghouse of information about, or provides advice on, efforts to adopt and train on other evidence-based, best, or promising practices, and on improving existing or usual practices. Examples of these are: Assertive Community Treatment, Developmental Disabilities services, Peer Specialists, Cognitive Behavioral Therapy, Multi-systemic Therapy, and Medication Algorithms. The Steering Committee has been supported in its efforts to implement EBPs, best practices and promising practices by the Michigan Association of Community Mental Health Boards (MACMHB) which has served as fiduciary and facilitator for the individual practice trainings, and has dedicated its last three spring conferences to providing training and information on improving practices.

For FY08, the Steering Committee advised MDCH to make MHBG funds available to two additional EBPs: supported housing and supported employment.

In the coming year, the Steering Committee is addressing how the improving practices initiative can be sustained at the state level and at the local level, once MHBG funds are not available for day-to-day implementation. In addition, the Committee is concerned about the practices maintaining fidelity to their evidence-based models and what measures can be taken to assure that.

Steering Committee Co-chairs are:

Judy Webb, (517) 335-4419, or webb@michigan.gov,

Irene Kazieczko, (517) 335-0252, or kazieczko@michigan.gov.

RECOVERY

It is the policy of the Michigan Department of Community Health (MDCH) to support systems transformation efforts to one based on the fundamental principle of recovery for persons with mental illness. The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), published a National Consensus Statement on Mental Health Recovery. The Consensus Statement defined recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." Michigan has supported a variety of initiatives that coincide with the release of the National Consensus Statement. Some of the major building blocks of recovery have been the creation of the Michigan Recovery Council and the availability of Certified Peer Support Specialists.

MDCH appointed the Recovery Council in December of 2005, with funding from a Center for Medicare and Medicaid Services (CMS) Mental Health Systems Transformation Grant. The Council meets every other month to assure rapid movement towards a public system of care based in recovery. To demonstrate the MDCH strong commitment for consumer participation in systems transformation efforts and policy development, the Recovery Council is comprised of over 75% primary consumer representation. Included in this large percentage are 18 individuals from each Prepaid Inpatient Health Plan (PIHP) who also serve on the Improving Practices Leadership Team (IPLT) for the region.

Recently the Recovery Council issued a Request for Proposals (RFP) to establish a statewide Recovery Center of Excellence (RCE). The RCE will serve as the platform for linking and supporting a virtual community of statewide change agents that will foster and support recovery initiatives. The RCE will utilize Certified Peer Support Specialists and consumers across the state to accomplish the goals. The RCE will also assist with MDCH efforts to measure recovery environments and individual recovery.

With consultation and partnership with the Human Services Research Institute (HSRI), the Recovery Council has selected the Recovery Enhancing Environment (REE) Measurement as the system-wide tool to evaluate individual and organizational performance indicators of recovery. Yale University Program for Recovery and Community Health, HSRI and the Recovery Council are working closely over the next two months to finalize implementation efforts of the REE.

Each of the state-level initiatives for practice improvement for adults with mental illness is being implemented in partnership with consumers and is aimed at supporting recovery. Information about each initiative is presented as a choice and option during the development and enhancement of the Individual Plan of Service completed through a person-centered planning process. Recovery Council members that serve on the Improving Practices Leadership Team provide the necessary link to ensure the MDCH vision for a system based in recovery.

**Recovery Council Contact Person: Irene Kazieczko -- kazieczko@michigan.gov
Contact Person for Recovery and Anti Stigma Initiatives: Colleen Jasper (517) 373-1255,
or Jasper@michigan.gov**

CERTIFIED PEER SUPPORT SPECIALISTS

Overview: Beginning in the late 1990s, the Michigan Department of Community Health (MDCH) began systems transformation efforts in promoting adults with mental illness to serve peers by working in local mental health agencies across the state. Positions as Peer Advocates and Case Management Assistants were areas applied for in the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant Request for Proposals.

These early initiatives led the way in developing and supporting a peer-trained workforce. One of the early barriers in maintaining peer positions centered on funding and reimbursement. This barrier was addressed on March 15, 2006 when Peer Support Specialists were added as a covered service in the 1915 b(3) waiver. Michigan was one of the first states to use Medicaid funding for Peer Support Specialists. Medical necessity criteria of community inclusion, participation, and/or independence are addressed by Peer Support Specialists in partnership with peers they serve when developing the Individual Plan of Service (IPOS) using a person-centered planning process. Some of the implementation areas include: plan facilitation, employment, housing, accessing entitlements, assisting with arrangements to support self-determination, Advance Directives, and crisis plans.

Education and Training: At the present time, Michigan is nationally known for educating and supporting a Certified Peer Support Specialist workforce. As of November 2007, 242 individuals have been trained and certified as Peer Support Specialists. To complete certification, peers apply for a week-long training program of 35 hours with over 26 modules developed from a foundation of recovery. Some of the modules include: five stages of recovery, effective listening, facilitating recovery dialogues, accomplishing recovery goals, facing one's fears, creating environments that promote recovery, problem solving, combating negative self-talk and power, conflict and integrity in the workplace.

After the week-long training, peers attend an 8-hour day follow-up training with additional modules that are specific to Michigan including: ethics, Advance Directives, person-centered planning and self determination, medical necessity criteria, documentation, encounter coding, housing and employment. Several weeks after, training peers are given a 4-hour examination. All of the follow-up training and testing is completed at Lansing Community College (LCC).

The training team consists of a partnership between the Appalachian Group of Georgia and Michigan trainers who are Certified Peer Support Specialists and are supported by their local agencies to assist as trainers. Information regarding Michigan module training is presented by MDCH staff in partnership with peers who have expertise in the subject areas.

A variety of topics are currently being offered for continuing education opportunities. MDCH has developed a partnership with the Copeland Center who offers certification for facilitation of Wellness Recovery Action Planning (WRAP). A Certified Peer Support Specialist in Oakland County with Master-level training status has been instrumental in providing 3-day introductory trainings to WRAP while co-facilitating the full-week training with the Executive Director of the Copeland Center. In partnership with Yale Program for Recovery and Community Health and Focus on Recovery United, a full-week facilitation training is offered for Peer Support Specialists in implementing the book "Pathways to Recovery." MDCH is committed to maintaining a quality trained peer workforce and will continue to work with others across the country to provide state of the art training. In July of 2007, a continuing education conference was held with over 150 peers participating. This conference will be offered annually and developed by Certified Peer Support Specialists.

Collaboration with Higher Education: MDCH has developed a collaborative relationship with LCC with activities moving towards a future agreement and a formal contract for training, testing, and certifying Peer Support Specialists. LCC is examining the full curriculum to move

toward awarding 3 elective credits for completion of training and certification. In 2008, the collaborative vision is that Michigan peers will receive certification from LCC, with follow-up continuing education trainings completed in partnership with LCC towards the goal of offering continuing education credits. When this process is completed, Peer Support Specialists who choose to further their education will be provided with career counseling and educational support to continue career paths of their choice.

Utilization and Effectiveness: According to the statewide encounter data of October 1, 2007, Michigan serves over 132,303 with a serious mental illness. Peer Support Specialists served 4,469 individuals totaling 3.38% of the total statewide population. This data points to the need for training and certifying more peers statewide to ensure that all individuals who have an Individual Plan of Service developed through a person-centered planning process are provided with the choices and options of Peer Support Specialists to implement goals and objectives.

To assist in promoting effectiveness and utilization, MDCH has scheduled meetings with liaisons from all CMHSPs for Certified Peer Support Specialists. Six meetings are scheduled throughout the year to focus on best practices, technical assistance, sharing agency forms, hiring practices and support models.

Peer Support Specialists have moved from Practice-Based Evidence, to a Promising Practice. National research is underway to evaluate this initiative as an Evidenced-Based Practice. Certified Peer Support Specialists are the keystone for Michigan's systems transformation efforts for adults with mental illness.

Contact Person: Pam Werner, (517) 335-4078, or wernerp@michigan.gov

ADVANCE DIRECTIVE FOR MENTAL HEALTH CARE

On January 3, 2005, Advance Directives for Mental Health Care became law in Michigan. The legal reference is contained in the Estates and Protected Individuals Code, PA 1998 No. 386, as amended by PA 2004 No. 532. The statutory citation is MCL 700.5506 et seq.

The Michigan Department of Community Health (MDCH) published a pamphlet that was written by Bradley Geller, Esq., in partnership with the Michigan Recovery Council. The document is based on providing information and forms to assist adults with mental illness in developing an advance directive that documents their wishes and choices about care provided. In Michigan, an advance directive for mental health care, also referred to as a durable power of attorney for mental health care, is a document in which you appoint another individual to make mental health decisions for you in the future. Individuals can choose to have a durable power of attorney for health care, an advance directive for mental health care or no durable power at all.

To provide additional technical assistance in conjunction with the pamphlets and brochures, MDCH, in partnership with Michigan Protection and Advocacy Services, completed a variety of trainings around the state for consumers, families, providers and other stakeholders. This includes six regional trainings for consumers, administrators, and staff this year; a workshop at the annual Consumer Conference which over 500 consumers attended; and the Upper Peninsula consumer conference also held a session on Advance Directives for consumers, families, and staff.

Michigan is one of several states nationally that has supported recovery by providing the right to have an advance directive. Specific information on each state is available at the website hosted by the National Resource Center for Psychiatric Advance Directives (PAD). This website provides an important voice with quotes from adults with mental illness who have chosen to develop an advance directive. Some of the listed quotes include:

- “it was really crowded in the ER so I showed intake my psychiatric advance directive and told them that I needed to go somewhere quiet....so that I could calm down....The intake nurse sat with me in a quiet room until I calmed down.”
- “I would recommend PADs because people can have you committed and you don’t have a say about anything, and at least this way you do have some say in your treatment, if it’s read and people see it and it’s legal.”
- “My therapist suggested I make copies of my PAD, so I did that, and gave a copy to everyone I wanted to. There is a copy of file at the hospital, just in case, along with my general healthcare directive. I don’t want any mistakes made...Those are my wishes and that’s a legal document, and it must be followed.
- This time, with a PAD, I did not receive any treatments that I did not want. They were respectful. I really felt like the hospital took better care of me because I had my PAD in fact, I think it’s the best care that I’ve ever received.

The quotes above are proof that developing an advance directive is beneficial and addresses freedom, liberty or independence that is central to dignity. For further information on advance directives in Michigan, visit the MDCH website at: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_41752---,00.html

Assisting individuals in determining choices and options of developing an advance directive during the person-centered planning process is a fundamental need for strengthening initiatives for practice improvement.

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INTEGRATED TREATMENT FOR INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Overview: To implement the Co-occurring Disorders: Integrated Dual Disorder Treatment (COD:IDDT) model evidence-based practice (EBP), Prepaid Inpatient Health Plans (PIHPs) need to look at the system as a whole. This means that the system must address the issues and barriers that consumers with complex needs face every day. In Michigan, the Michigan Department of Community Health (MDCH) uses the principles of the Continuous, Comprehensive Integrated System of Care (CCISC) model developed by Dr. Ken Minkoff and Dr. Chris Cline to effectively change the system. To develop a successful and sustainable change, the public mental health system must look at the entire system of care and develop a comprehensive plan that addresses co-occurring disorders and integrated treatment.

The COD:IDDT model is for people who have serious mental illness and have a co-occurring substance use disorder. This treatment approach helps people recover by offering treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. This means the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in an integrated fashion. The goal of COD:IDDT intervention is recovery from two serious illnesses. A wide variety of services are offered in a stage-wise fashion because some services are important early in treatment, while others are important later on. Individualized treatment is offered depending on what stage of recovery a person is in. Ultimately, the goal of integrated treatment is to help people manage both their mental illness and substance disorders so that they can pursue their own meaningful life goals.

FY 07 Accomplishments: All of Michigan's 18 PIHPs are involved in IDDT. At the program level, 17 PIHPs are currently in the process of developing or implementing the federal Substance Abuse Mental Health Administration (SAMHSA) EBP model. Twelve PIHPs currently have a charter/consensus agreement and/or a working document. Seventeen PIHPs did Co-FIT or COMPASS and developed action plans based on these assessments. Through FY 07, MDCH funded 11 PIHPs through block grants to develop integrated treatment capacity. During FY 08, 4 more PIHPs were awarded block grant funding. Michigan has more than 60 IDDT teams in different developing stages. MDCH, through block grant funding, is supporting a peer review process for fidelity monitoring and technical assistance for these 60 plus IDDT teams. This peer review process, called Michigan Fidelity Assessment Support Team (MiFAST), is coordinated by Wayne State University staff and is staffed by 15 trained clinicians from different Community Mental Health Services Programs (CMHSPs). At the clinical level, several trainings were provided through the Michigan Association of Community Mental Health Boards that focused on staff competency. Through the Subcommittee for Co-occurring Disorders, a regularly scheduled "Learn and Share" meets quarterly to share and learn information among all the PIHPs/CMHSPs and Coordinating Agencies (CAs) regarding resources, and learning from each one's experiences. Consumer involvement in integrated treatment is steadily improving. There are seven Dual Recovery Anonymous (DRA) groups that currently meet in different parts of the state.

Training Plans for FY 08:

A. Ken Minkoff/Chris Cline

1. Change Agent Trainings: Train a group of change agents from each PIHP/CA region that would become an enduring statewide team of clinical and administrative change agents to translate the implementation of co-occurring capability, integrated services, and co-occurring clinical competency into every layer of the public mental health system.

2. PIHP System Change Consultation: In addition, Drs. Minkoff and Cline will continue to provide a combination of on- and off-site training and technical assistance activities with PIHPs and CAs.

B. Ohio Coordinating Center of Excellence/Case Western University

Programmatic Consultation: Administrative consultation as required for PIHPs to develop and sustain services.

1. Training on certain fidelity items:
 - A. **Learn and Share:** Quarterly
 - B. **Wayne State University:** Will provide trainings on several IDDT fidelity items
 - C. **Fidelity Reviews:** Fidelity reviews and Readiness Assessments for the IDDT teams at no cost

Expected Outcome: Due to all these efforts, there is an increase in screening, assessment and treatment for individuals with substance use disorder in the public mental health system. There is also much more cooperation and coordination between the public mental health system and the substance abuse CAs. MDCH identified two modifier codes and issued instructions to both mental health and substance abuse system on how to report COD:IDDT and other integrated services. The co-occurring disorder measurement workgroup is discussing ways to collect accurate data of the number of individuals with substance use disorder in the public mental health system through the Quality Improvement data files.

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FAMILY PSYCHOEDUCATION

Family Psychoeducation (FPE) is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that practitioner, consumer, and family work together to support recovery. Common issues addressed through FPE include participation in outpatient programs, understanding prescribed medication, dealing with alcohol or other drug abuse, and managing symptoms of mental illness that affect the consumer. FPE respects and incorporates individual, family, and cultural perspectives. It engenders hope in place of desperation and demoralization and can significantly help people with a mental illness in their recovery process.

FPE services in Michigan have been implemented as an evidence-based practice (EBP) under our federal Block Grant consistent with the federal Substance Abuse Mental Health Administration (SAMHSA) FPE toolkit. Local Community Mental Health (CMH) agencies throughout the state have been funded to offer FPE consistent with the model developed by Dr. William McFarlane. This includes staff training, coaching and supervision through Dr. McFarlane or his associates to maintain model fidelity. FPE programs follow the McFarlane model with regard to consumer recruitment and joining activities, FPE facilitator's role, content of FPE sessions and other aspects of this proven method of intervention.

During FY 07, MDCH funded thirteen CMH agencies to provide FPE through the Block Grant. Ten CMH agencies (Central Michigan, Detroit-Wayne County, Genesee County, Lakeshore Alliance, LifeWays, Northern Affiliation, Oakland County, Pathways, Southeast Michigan and Venture) completed their second and final year of FPE Block Grant operation while three CMH agencies (Northwest Affiliation, Saginaw County and Southwest Affiliation) completed their first year of FPE Block Grant operation. Based upon quarterly progress reports submitted by the CMH agencies, a total of 61 FPE groups were in operation throughout the state serving a combined total of approximately 593 consumers and family members.

For FY 08, funding has been approved for three CMH agencies (Northwest Affiliation, Saginaw County and Southwest Affiliation) to complete a second year of FPE Block Grant operation. Four CMH agencies (Bay-Arenac/ Access Alliance, Clinton-Eaton-Ingham/Mid-Michigan Affiliation, Macomb County and network180) were also approved for year-one FPE funding, while Muskegon/Lakeshore Alliance was approved to provide an FPE enhancement project to complement their two-year FPE project.

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ASSERTIVE COMMUNITY TREATMENT

The challenge to the evidence-based practice (EBP) of Assertive Community Treatment (ACT) is not implementing ACT, but creating and sustaining an environment which looks at the practice, identifies needed improvements to attain the essential elements of ACT, implements and maintains them. Implemented in Michigan approximately 20 years ago, attention to adhering closely to the model has increased as the Improving Practices Initiative continues.

Originated in the 1970's in Wisconsin as a 'hospital without walls,' the Programs of Assertive Community Treatment (PACT) model, advocated by the federal Substance Abuse Mental Health Administration (SAMHSA), is difficult to fund and sustain. Few programs follow the model. An early adopter, Michigan made adaptations to address the treatment needs of consumers in our state. The primary differences between ACT and PACT are team size, team shifts, team qualifications and credentials and non-brokering of services.

To assist teams to self-assess and improve, the Flinn Family Foundation provided funding, and teams were evaluated. From the Flinn study, a tool, the draft Field Guide to ACT, was created. The Field Guide takes into account fidelity, Medicaid, best practice and feedback from the field visits. The Field Guide is not intended to be a fidelity check done by each team and reported as a fidelity measurement. Fidelity of each ACT team will be addressed in a different manner.

The Field Guide draft went out for public comments; feedback has been examined and some has been incorporated into the product.

The evaluation group will sample some state teams this year. Field visits will teach teams how to use the Field Guide and how to use the results of the findings to improve practice. Other training on the Field Guide will occur later in this fiscal year and will be provided by the Assertive Community Treatment Association (ACTA).

A crosswalk was developed to compare the Field Guide to Medicaid, Dartmouth Assertive Community Treatment Scale-draft and SAMHSA Minimum ACT standards. Since then, the crosswalk has been expanded to compare ACT, Integrated Dual Disorder Treatment (IDDT), and Supported Employment (SE) with Family Psychoeducation (FPE) to come. SAMHSA toolkits conflict between one another with some confusion within individual toolkits. The comparison will result in recommendation for Michigan practice and Medicaid revisions.

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MOTIVATIONAL INTERVIEWING TRAIN THE TRAINER MODEL

Overview: In a joint initiative, the Mental Health and Substance Abuse Administration and ODCP training projects are supporting six phases of Motivational Interviewing (MI) training that will be delivered regionally. The purpose of this initiative is to develop regional clinical staff/supervisor expertise in Motivational Interviewing.

Summary of Accomplishments: Phases 1 and 2 were completed in FY 07, and phases 3 to 5 are scheduled for FY 08. Phase 1 was targeted for Supervisors and Administrators to learn about MI and how to select participants for the following phases. Four Phase 1 trainings were provided. The trainings were open to staff from both the mental health and substance abuse provider networks. 128 staff from both mental health and substance abuse provider networks participated in the Phase 2 trainings. There are differences in participation, cost and resulting expectations depending on the provider network.

FY 08 Plans: It is expected that Phases 3 through 5 will be completed during this fiscal year. Phase 3 advanced training will start in November 2007. It is expected that once the individuals are trained in advanced MI techniques, they will submit individual tapes for coding.

Expected Outcome: Individuals successfully completing Phases 2 through 5 will gain a regionally limited, Michigan-specific Motivational Interviewing training credential. There is space for 128 individuals in the training, and it is expected that approximately 32 individuals will get the Michigan-specific training credential through Mr. Michael Clark.

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EVIDENCE-BASED SUPPORTED EMPLOYMENT

Evidence-based Supported Employment (EBSE) is an approach to vocational rehabilitation that emphasizes helping people obtain competitive work in the community, and providing the supports necessary to ensure success at the work place. The principles and critical elements of supported employment and practices involve rapid job search, jobs tailored to individuals, time-unlimited following supports, integration of supported employment and mental health services, and zero exclusion policy.

FY 05/06:

- EBSE was included in block grant RFP
- 2-day training with David Lynde from Dartmouth Evidence-Based Practices Center
- Three CMHSPs received block grant funds to implement EBSE

FY 06/07:

- Two 2-day trainings with David Lynde and Amy Miller
- EBSE was incorporated in Detroit-Wayne Comprehensive Project

FY 07/08:

- Block grant was allowed on a non-competitive basis for PIHPs who have already implemented both Family Psychoeducation and Co-Occurring Disorders: Integrated Dual Disorder Treatment
- 2 PIHPs received block grant funds
- Regional and statewide training will be provided
- Statewide workgroup will be developed
- Recommendations for Medicaid Provider Manual being discussed along with COD:IDDT and Assertive Community Treatment

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JAIL DIVERSION

Overview: The Michigan Department of Community Health (MDCH) has made a commitment to the principal of addressing the needs of the community and society to better serve persons with serious mental illness, serious emotional disturbance or developmental disability who come in contact with the criminal justice system but would be better served by the mental health system rather than incarceration. It is recognized that many of these individuals with serious mental illness have a co-occurring substance disorder. The MDCH Jail Diversion service programs are designed to serve those individuals who commit crimes of a misdemeanor or non-violent nature and voluntarily agree to participate in the diversion program.

Consistent with Section 207 of the mental health code, each Community Mental Health Services Program (CMHSP) shall provide services to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. The adult Jail Diversion Policy Practice Guidelines of February 25, 2005 reflects the commitment to the principles and conveys MDCH Jail Diversion policy and resources for CMHSPs.

FY 07 Activities: Three new Jail Diversion service programs were developed and funded through the federal block grant process. The focus for these programs was multi-faceted around staff hiring to coordinate Jail Diversion service delivery, cross-training of law enforcement, court, substance abuse and mental health professionals on how to recognize, access and screen individuals on the diversion system and how to recognize and treat individuals exhibiting behavior warranting Jail Diversion intervention. Education and outreach, along with the development of a broad array of community-based resources that address the fragmentation of services, are also made available through these CMHSP Jail Diversion programs.

MDCH sponsored a Jail Diversion mini-conference to convene mental health Jail Diversion program staff, law enforcement staff, and court personnel to provide a forum for information sharing and a review of successful Jail Diversion programs from around the state. This mini-conference was designed for CMHSP program staff and their partners who are involved at any level with Jail Diversion activities or are experiencing significant barriers to Jail Diversion programming. A statistical analysis of Jail Diversion data reports was given to address the need for accurate Jail Diversion numbers for evaluation and programming purposes its implication for practice.

FY 08 Plans: MDCH will fund three new Jail Diversion programs which focus on strengthening Jail Diversion services and coordinating participating partners who are needed to address the many areas of need for the at-risk population. MDCH will also monitor the development and implementation of two mental health courts operating within our state. In addition, MDCH will sponsor and participate in a train-the-trainer workshop developed through our federal block grant training contract with the Michigan Association of Community Mental Health Boards, in partnership with the Oakland County Community Mental Health Authority.

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DIALECTICAL BEHAVIOR THERAPY

Overview: Through this initiative, the Michigan Department of Community Health (MDCH) is supporting 16 Dialectical Behavior Therapy (DBT) teams who have no previous training or who have some training in DBT to develop increased clinical skills. The goal of the training and consultation is to systematically implement DBT and increase the availability of this treatment modality as a choice in the person-centered planning process. Sixteen DBT teams were selected for this three-year initiative. Each team consists of a maximum of 8 members, including peer support specialist(s)/consumer(s). The orientation training was held in Lansing in September 2007. Teams also received materials including DBT text book and skill manual.

FY 07 Accomplishments and Plans for FY 08:

Phase/Time Line	Description	Status
Phase I	Orientation training – Two day workshop followed by a day of consultation	Completed – September 2007
(2-3 months following orientation training)	Onsite Intensive Training Part I: 5 days	December 10-14, 2007
6 months between Intensive training and Advanced training	Consultation Services: 1 hour per team per month (x 6 months)	Phone consultation. start in January 2008
Online learning for Intensive Team Participants	20 hours of online learning focused on the skills component of the treatment (Intensive Training participants)	Started and ongoing September 2007
6 months post part II of Advanced training	Consultation Services: 1 hour per team per month (x 6 months)	Phone Consultation
6 months following Part II of Advanced Training	Advanced training for staff that completed Intensive Training– Review of team progress and program development. Review/refine content/delivery of treatment	TBD
Phase II – FY 08	Clinical Case Consultation 4 hours per team per month	Phone consultation
Advanced Training	Advanced training for staff that completed Intensive Training– Review of team progress and program development. Review/refine content/delivery of treatment	Part 1 May 5- 9, 2007 Part II June 9-13, 2007

Expected Outcome: Through this initiative, it is expected there will be a consistent statewide approach for implementation and support of DBT. It is expected that all 16 teams will complete this three-year initiative, and consumers will be able to receive DBT as a choice during person-centered planning throughout the public mental health system.

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INITIATIVES FOR INDIVIDUALS WITH DEMENTIA AND THEIR CAREGIVERS

The Michigan Department of Community Health (MDCH) is enhancing efforts to improve identification of older adults in all settings who exhibit significant changes and disturbances in mood, cognition, or behavior and to improve integration of services to persons with dementia and serious mental illness among primary, long-term, and mental health care. Family caregivers of isolated older adults with mental illness or progressive disabling medical conditions are also the focus of interventions designed to improve coping skills, mental health needs, reduction of stress, burden, depression, and family conflicts. Wraparound pilot projects have developed family teams that focus on strengths of natural supports and goals of the person with dementia and their family caregivers. Networks of support are developed for the families and with a Community Team, which is a collaborative group of community-based resources. These Community Teams have been tremendously successful at building relationships and sharing information and resources. Education on dementia care has been identified as a need for family members and respite care workers, and all pilot organizations have added this training to their regular programming. Two pilot sites are funded through federal mental health older adult block grants and two are funded by the Administration on Aging's Alzheimer's Disease Demonstration Grants to States; all four include rural communities. A model for a new target of adults with dementia who exhibit acute behavioral symptoms of distress and their family caregivers will be finalized in 2008.

Outreach strategies include traditional and innovative techniques to establish trust, rapport, acceptance, and increased use of mental health services by older adults at-risk. Case managers involved in Senior Neighbor programs and HUD public housing programs are receiving mental health training and consultation to increase linkages with CMHSP network of care and assist them in identifying the mental health needs of adults living in low-income housing sites. Staff of community and housing services assists their consumers, many of whom are reluctant to seek treatment. Another block grant program provides in-home assessment and treatment of elderly persons with severe mental illness who have not been able to meet their mental health needs due to living in a rural area. Local service providers, physicians, senior citizen programs, churches and nursing homes are educated to detect and refer elderly persons for mental health services. In addition, community education has focused on destigmatizing mental illness, developing support groups for elderly, and providing services in places that seniors frequent and trust.

Expertise is being developed to provide customized information, education, and case consultation to staff that work in health care and community services organizations, as well as increasing community mental health clinicians' knowledge and use of assessment tools and protocols. Two community mental health organizations (one rural, one urban) have designed seminar series on the use of cognitive impairment intervention protocols that help the professional assess a person's ability to process information, to express desires and needs verbally and nonverbally, and to perform tasks in the context of the environment and interactions with other people. A Train-the Trainer manual on dementia care for direct care workers has been updated and modified to include the newly released Dementia Core Competencies. Dementia care training for Home Help workers has been extended, particularly focusing on Detroit and Flint areas that have exhibited large needs. Printing of the manual, "Understanding Difficult Behaviors," is provided to family caregiver education programs throughout the state.

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COGNITIVE BEHAVIORAL THERAPY FOR OLDER ADULTS

Recognized as an underserved population in the public mental health system, older adults, aged 65 or older, with serious mental illness may be at risk of suicide, experience dementia with depressed mood, behavioral disturbances or delusions, or have co-occurring problems with substance use or dependency, and often there are other complicating factors that can include multiple medical conditions that may mask psychiatric conditions, multiple medication interactions, age-related changes to physical and mental functioning, and increasing isolation.

Older adults have greater mental health needs than are currently being served. The Michigan Mental Health Commission Report of 2004 stated that, "Special outreach efforts need to be targeted to older adults, persons with dementia, and their caregivers." The President's New Freedom Commission recognized the need for increased workforce development. This initiative addresses workforce development but not penetration rates or outreach or service efforts.

Cognitive Behavioral Therapy (CBT), modified for older adults, is an evidence-based practice (EBP) and a new initiative for older adult service providers. This is a block grant funded-FY 08 initiative, and it is in the final stages of planning.

Community Mental Health Services Program (CMHSP) older adult treatment staff will be identified; about one-half of the CMHSPs (about 20) will be able to have one treatment staff trained in CBT. Once identified, they will be invited by letter to participate. Training will be offered either in southeast Michigan or in Gaylord or Marquette, depending upon where the majority of recruits come from. Training includes an initial two-day session, monthly individual viewing of submitted tapes for supervision and feedback, with additional technical assistance available as needed, and one additional training day at the end of the year. The model has been adapted to older adults, and fidelity assessments occur within the supervision activities. Certification from the Beck Institute is also included and required.

Future potential: Using block grant money in one-year additional increments:

1. Group 1 training and supervision of Older Adult Mental Health (OAMH) therapists in EBP-CBT, as modified for older adults.
2. Group 2 training for additional CMHSP OAMH therapists (approximately 20).
3. Select OAMH therapists trained in CBT for older adults to participate in additional training in training others in CBT for older adults. Individuals selected for this additional training will need to agree to train another generation of staff to help expand this EBP statewide.

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SYSTEM OF CARE FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES AND THEIR FAMILIES

Overview: To improve outcomes for children with serious emotional disturbance (SED) and their families, the development of a community system of care is encouraged. *The system of care is to be comprehensive, family-centered, community-based, culturally and linguistically competent. It is a system that is developed for children/youth and their families that represents the organization of public and private services within the community into a comprehensive and interconnected network in order to accomplish better outcomes for all children. An integral part of the system of care development is the involvement of parents and youth. The process is to be family-centered where the family members (parents and youth) guide the development of the system of care.*

Communities were requested to utilize a system of care planning process in preparation for application for funding from the Children's Mental Health Block Grant (FY 07 and FY 08) and in implementing the 1915(C) SED Waiver. The Michigan Department of Community Health (MDCH) is particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth in Child Welfare (i.e., abuse/neglect and/or adopted children/youth) and Juvenile Justice who have SED.

Community Mental Health Services Programs (CMHSPs) were asked to take leadership and join with local stakeholders to identify all of the mental health services for children/youth and their families available in the community, the number of children/youth served in FY06, the capacity of the program/agency, total cost and funding source(s) as part of the environmental scan. Stakeholders were asked to determine if the services identified are an evidence-based or promising practice. Parents and youth were required members of the stakeholders group.

Accomplishments:

- ◆ CMHSPs utilized the system of care planning process as they developed their applications for Children's Mental Health Block Grant funding for FY07 and FY08.
- ◆ Children's mental health services planned for through the system of care process and submitted for Children's Block Grant funding were an evidence-based or a promising practice (Wraparound, Multi-Systemic Therapy, Therapeutic Foster Care, Infant Mental Health, etc.) and/or supported a systemic approach to screening/assessment or service provision.
- ◆ CMHSPs attended training in development of a system of care for children with serious emotional disturbance, and four CMHSPs have been funded to continue working with their partners to develop a comprehensive system of care through the implementation of evidence-based programs, a cross system screening process or the SED Waiver.
- ◆ Several of the CMHSPs applying for Children's Block Grant identified another agency/organization as providing a portion of the match funds for the block grant-funded service.

Plans for FY08:

Continue to utilize the system of care planning process as a precursor for the Children's Block Grant application.

- ▶ FY 08 mental health capitation for children has been increased and performance measures have been established for the Prepaid Inpatient Health Plans (PIHPs) to increase the number of children served and the expenditures for both children with SED and developmental disabilities with a special focus on children in the Department of Human Services (i.e., abuse/neglect, foster care).

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PARENT MANAGEMENT TRAINING-OREGON MODEL

Overview: The Parent Management Training-Oregon (PMTO) is a family-based intervention designed to empower parents by teaching them effective parenting practices. Research has demonstrated that when parents improve these skills, their children show commensurate increases in pro-social behavior and decreases in problem behavior. The PMTO method emphasizes identifying and building upon strengths already present in parents, children, and their environment. Professionals teach parents to shape their children's behavior with the use of positive and negative contingencies. Thus, professionals coach parents as they socialize their children. The key parenting practices taught are skill encouragement, limit setting, monitoring, problem solving, and positive involvement.

Parents are engaged in a collaborative process to strengthen their child rearing strategies. Common teaching approaches include the following: problem solving, eliciting goal behavior, assessing skills and filling in gaps, breaking content into teachable units, identifying obstacles and brainstorming ways to overcome them, role play, and exercises to assess and practice effective parenting practices. Professionals avoid didactic teaching and instead engage the parents in an active learning process.

Professionals follow an agenda with goals and objectives relevant to parenting skill development, use appropriate and sensitive pacing and timing, maintain leadership of sessions without dominating, are responsive to the needs of parents, and intervene in crises as needed. Sometimes the PMTO skills are applied to crisis situations, for example, use of strategizing through group problem solving. Sophisticated process or clinical skills are employed to help parents feel joined, understood, and supported during the change process. Common approaches include normalizing, reflection, use of humor, punctuating, mirroring, use of metaphors, use of movement, and use of drama.

Plans for FY 08: *Trainees from 2006 are finishing up, and Michigan will have 18 new specialists trained throughout the state. Another statewide training using some of these 18 individuals as trainers has also started, and 16 new therapists will be trained FY 07-08. In addition to the statewide training, the state has been divided into six regions for local training. Region 1 - North Care; Region 2 - CMH Affiliation of Mid Michigan and surrounding counties; Region 3 - network180, Lakeshore Behavioral Health Alliance, Southwest Affiliation; Region 4 - CMH for Central Michigan, Northwest Affiliation, and Northern Affiliation, Region 5 - CMH Partnership of Southeast Michigan and Region 6 - Wayne County.*

The regions are planning training as well. Region 2 and Region 5 have started their training that consists of 22 new therapists between the two regions. Region 1, 3 and 4 will begin training 28 new therapists in January 2008. Region 6 will be working with ISII and training 28 new therapists. All regions have been given block grant money to help set up their infrastructure to support additional training in PMTO. Kalamazoo CMH is also developing a database and video streaming to help with training, coaching, and fidelity monitoring.

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MULTISYSTEMIC THERAPY (MST)

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources, that promotes health. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring each week.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident. First, MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains. Second, MST programs have an extremely strong commitment to removing barriers to service access (see e.g., the home-based model of service delivery). Third, MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes). Fourth, and most important, MST has well-documented long-term outcomes with adolescents presenting serious antisocial behavior and their families. The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders.

Providers of Multisystemic Therapy: MST is available through the following Community Mental Health Service Programs (CMHSP's): Berrien Mental Health Authority, Summit Point, network180, Genesee County CMH Services, and Lifeways. In many of these CMHSP's, MST is jointly funded between the local court and the CMHSP.

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MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)

The goal of the MTFC program is 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
- reduced exposure to peers with similar problems

The intervention is multifaceted and occurs in multiple settings. The intervention 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
- psychiatric consultation and medication management, when needed

MTFC is currently available through AuSable Valley CMH Services. Macomb County CMH Services and CMH Authority of Clinton-Eaton-Ingham Counties are planning to develop MTFC.

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DEVELOPMENTAL DISABILITIES (DD) PRACTICE IMPROVEMENT TEAM

The Michigan Department of Community Health (MDCH) established the DD Practice Improvement Team (PIT) in the spring of 2005 for the purpose of identifying best practices and otherwise improving supports and services for people with developmental disabilities who are served by the public mental health system. The 50-member team meets monthly and is made up of advocates, family members, and staff from provider organizations, Community Mental Health Services Programs (CMHSPs) and the MDCH. The team crafted for itself a mission statement: *“to promote, articulate, encourage, provide leadership, and make recommendations to the Michigan Department of Community Health for improvements to supports and services that enable people with developmental disabilities to achieve the lives they envision wherever they reside in Michigan.”*

To that end, the team has focused primarily on educating the public mental health system about how to help people with developmental disabilities “get a life” in the community. It was successful in advocating for a Developmental Disabilities track of workshop sessions at each of the three annual Michigan Association of Community Mental Health Board (MACMHB) conferences; and for a community-based track at the annual Developmental Disabilities Conference sponsored by MDCH and Michigan State University; and has identified the content and presenters for all of these sessions. The team also assisted in the development of a series of day-long training sessions for mental health staff to be sponsored by the MACMHB on improving the lives of people with developmental disabilities. The topics include: addressing problem behaviors, interventions for co-occurring physical disabilities, planning for children and families, and measuring success. The sessions commence in November 2007 and continue through May 2008.

The team also developed a vision that *“adults with developmental disabilities have the supports and services necessary to be healthy and safe and successfully:*

- *contribute to their communities,*
- *earn an income in a non-segregated, community setting,*
- *live in their own homes,*
- *have full community inclusion, meaningful participation and membership,*
- *have friendships and relationships, and*
- *have a fulfilling life.”*

And, that *“children and their families successfully:*

- *live with a supportive birth or adoptive family,*
- *participate in their neighborhood community school,*
- *play an active role in the neighborhood and community activities,*
- *enjoy childhood and have friendships and relationships, and*
- *prepare for adult life.”*

In the coming year, the team will identify ways to measure the accomplishment of the vision through performance indicators, and possibly, standard measures of individuals' success.

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VIRTUAL TEAM

Purpose of Virtual Team:

MDCH has assembled a virtual consultation team composed of MDCH staff and external participants with recognized expertise in this area to assist CMHSPs and PIHPs in identifying support and service options to stabilize individuals with developmental disabilities during crisis situations. The team is aimed at developing the capacity in communities statewide for resolving challenging situations for persons with developmental disabilities with minimal disruption to the individual's life.

Examples of Challenging Situations for Virtual Team:

- Living situation jeopardized by:
physical aggression
property destruction
frequent elopement
self-injurious behavior
sexual offender issues
exacerbation of co-occurring DD/MI
- Overwhelmed/aging families
- Avoiding Mt. Pleasant admissions/assisting with discharges
- Identifying clinical expertise at local level, and targeting areas where expertise needs to be developed

Virtual Team Network:

- Central Office group - 17 individuals with varied experience and backgrounds
- Non-State of MI - experts from CMHSPs/PIHPs:
private providers - psychologists, therapists, etc.
DDI
consumers/families
advocacy groups - those with hands-on experience/expertise

Virtual Team Communication:

- Face-to-face meetings - decisions made for set-up, hypothetical situations, and protocol
- E-mail account - out of office correspondence to MDCH-Virtual Team
- Team Room – in-house discussion to formulate situational response

Plans for FY 08:

- Launch Virtual Team with memo to CMHSPs/PIHPs in mid-November
- Maintain database of types of requests
- Assess changes needed based on feedback from Satisfaction Surveys

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CULTURAL COMPETENCY

Culture is critical in determining what people bring to settings and services, the language they use, how they express and report their concerns, how they seek help, the development of coping styles and social supports, and the degree to which they attach stigma to mental health and substance abuse disorders. Culturally competent services are defined as “the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values.”

The Michigan Department of Community Health (MDCH) is working with the Michigan Association of Community Mental Health Boards (MACMHB) in developing a cultural competency plan to address cultural competency and diversity in the public mental health system.

Accomplishments during FY 07: MDCH and MACMHB are working with a group of stakeholders to address cultural competency and diversity in the public mental health system. The MACMHB issued a Request for Proposals (RFP) during FY 07 to address cultural competency and diversity. Four organizations submitted proposals; Wayne State University’s (WSU) Project Care was selected.

Plans for FY 08: As stated in the RFP, WSU will work with the workgroup to develop the following:

- Develop a statewide action plan for cultural competency in the public mental health system.
- Identify and evaluate models and instruments for organizational assessment.
- Research and present model cultural competency/diversity plans for use at the local level.
- Identify evidence-based assessments and training instruments.
- Produce an inventory of clinical best and promising practices.
- Survey the Community Mental Health Services Programs (CMHSPs) to identify best and promising practices currently used.
- Summarize policies of the federal Substance Abuse Mental Health Administration, National Association of State Mental Health Program Directors, MDCH and other sources that are current and relevant.
- Identify ways to improve knowledge and resources on a statewide basis.
- Develop a draft plan for statewide training and technical assistance including web-based training.
- Coordinate with MDCH and the Improving Practices Steering Committee.

Expected Outcome: Lead the system toward improved awareness, competency and proficiency around ethnic and cultural issues and assure that all consumers receive services and supports that promote community inclusion and participation, independence, productivity and recovery.

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HOUSING AND HOMELESSNESS PROGRAMS/PARTNERSHIPS

Supportive Housing Program and Ending Homelessness Partnership: This program is in its 9th year of existence and continues to produce more than 100 units per year in 9 counties through the use of low income housing tax credits used in tandem with other federal, state and local resources.

10 Year Plan to End Homelessness: This year's innovations include the Michigan State Housing Development Authority (MSHDA) focus of \$28,600,000 on creating community collaboratives, with housing resources targeted to end homelessness. Each area of the state now has a plan in place, and MSHDA resources will be targeted to help realize that goal. A project to provide 100 units of housing for veterans in Detroit has been effective in bringing new private partners to the table.

Michigan Department of Community Health (MDCH) Homeless Programs: These programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. This year's innovations include using PATH dollars to create a Housing Resource Center in Detroit.

Home Ownership: MDCH participates in a homeownership coalition for people with disabilities. Recent innovations have included making MSDHA down payment assistance available to people who are getting a USDA Rural Development loan to purchase a home.

2006 and 2007 Mental Health Block Grant-Supported Housing & Homeless Programs:

1. Macomb County CMH funded to provide recruitment, training, and implementation of a mental health outreach team for adults with SMI in Macomb County who are chronically homeless.
2. Macomb County CMH developed, piloted & evaluated a training program for peers, family members and agency staff so they could act with consumers to obtain & sustain independent living arrangements in the community. Peer graduates are able to serve as peer housing specialists.
3. Oakland County CMH funded to create a pre-transitional house targeted for the young adult population that provides support and guidance to learn the skills to live independently while working closely with core provider agencies and supportive services to access community resources.
4. Ionia County CMH funded to create a supported housing position to identify available housing opportunities in Ionia County, teach landlords and consumers how to work with each other, have landlords call CMH to intervene before evictions process begins.
5. St. Clair SMH funded to develop a local website that organizes and provides access to local, state, and national resources to obtain and maintain stable housing.
6. Detroit Wayne CMH funded to develop a training program that employs consumers to develop an apartment maintenance service to assist consumer tenants to successfully remain in independent living and avoid evictions.
7. Detroit Wayne CMH funded to include housing as part of a comprehensive systems change proposal.
8. Macomb CMH funded for a Housing Resource Center that will provide professional and peer support services for those seeking or working to maintain independent housing.
9. Northern Lakes CMH funded to provide Supported Housing services with peer support specialists and case management services for coordination and increasing focus on obtaining affordable and safe housing for adult consumers with severe mental illness.
10. Oakland County CMH funded to develop a comprehensive guide for adults with SMI and their families about transitioning from congregate living settings to independent supported housing.

11. Saginaw County CMH funded to provide supports to adults with SMI to facilitate their access and initial success with independent community housing.
12. Summit Pointe funded to collaborate with the SHARE Center, and the Greater Battle Creek Homeless Coalition to add Peer Support Specialists to its recovery initiative to increase the opportunity for persons with MI to remain in permanent supported housing.

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EVIDENCE-BASED PRACTICES MEASUREMENT WORKGROUP

Overview: This workgroup was convened in order to create a forum to discuss issues specific to the measurement of evidence-based practices (EBPs). The work of the Measurement Workgroup includes the development of performance indicators specific to EBPs, developing approaches for improved data collection of consumer characteristics and reporting of EBPs, and the discussion of the training and consulting needs specific to measurement. The work of the group has been based on the following set of guiding principles:

Guiding Principles:

- Measurement is an essential strategy for promoting systems change, informing learning organizations, and supporting implementation of EBPs.
- Measurement adds value to practice and management when it generates information that is useful for informing decisions.
- Measurement must be based on data that is explicitly defined, readily accessible, and on measurement instruments that are valid and reliable.
- Measurement methods must be standardized and implemented with consistency across systems.
- Measurement requirements must be designed to be efficient, minimizing imposition on the time and resources of consumers, providers, and managers while maximizing the utility of the information generated.

Tasks and Accomplishments of Workgroup:

- A review of data elements currently collected by the Michigan Department of Community Health (MDCH) for mental health and coordinating agencies.
 - The group routinely reviews the reporting of selected EBPs to the state's encounter data file including family psychoeducation, parent management training, and integrated dual diagnosis treatment.
 - The group has reviewed the completeness of reporting in numerous key demographic items including employment, residential living situation, and involvement with the criminal justice system. One demographic item that the group has focused on is the reporting of substance use disorder, which was shown to be substantially underreported. MDCH staff has worked with the Prepaid Inpatient Health Plan Information Technology staff to improve reporting of this item. Also, the workgroup has redesigned the approach for measuring substance abuse disorders as collected in the Quality Improvement data file reported to the state.
- Prioritized and selected 'key' measurements for implementation.
 - The workgroup compiled an extensive list of performance indicators for EBP that were taken from various sources including the state's performance measurement system, SAMHSA's National Outcomes Measures, and Substance Abuse Prevention and Treatment (SAPT).
 - Based on these indicators, MDCH has reviewed the relationship between the presence of co-occurring disorder and various demographic factors such as residential living situation, employment, and involvement with the criminal justice system.
- MDCH and Wayne State University have received a grant from SAMHSA for FY08-10 to develop training programs that provide education on how to use measurement in clinical decision-making, and provide instructions on how to implement measurement. This project will include a plan to obtain feedback regarding the utility and effectiveness of measurement.

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Illness Management & Recovery

Implementation Resource Kit



EVIDENCE-BASED PRACTICES
Shaping Mental Health Services Toward Recovery

DRAFT VERSION
2003

Information for Mental Health Program Leaders

What is the Illness Management and Recovery Program?

The Illness Management and Recovery Program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personal strategies for coping with mental illness and moving forward in their lives. This is a model for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression. It is appropriate for people at various stages of the recovery process. The program can be provided in an individual or group format and generally lasts between three to six months.

Practitioners for Illness Management and Recovery can come from a wide range of clinical backgrounds, including but not restricted to the following: social work, occupational therapy, counseling, case management, nursing, and psychology. All practitioners providing the program will need training and ongoing supervision.

Is the Illness Management and Recovery Program an evidence-based practice?

The Illness Management and Recovery Program is based on research which has shown that people who have experienced psychiatric symptoms can show improvements in:

- ▶ Knowledge about mental illness
- ▶ Reducing relapses and rehospitalizations
- ▶ Coping more effectively and reducing distress from symptoms
- ▶ Using medications more effectively

What is the role of family members and other supporters in this program?

With the person's permission, family members and other supporters may participate in one of more of the following ways:

- ▶ Read the educational handouts used in sessions
- ▶ Participate in selected sessions
- ▶ Assist in developing relapse prevention plans
- ▶ Participate in homework assignments
- ▶ Help the person pursue their recovery goals

What are the benefits for Community Mental Health Centers that provide the Illness Management and Recovery Program?

Mental Health Centers are under increasing pressure to provide interventions that have demonstrated positive outcomes for people who have experienced psychiatric symptoms. But it is often very time-consuming to locate and evaluate the research and to find user friendly, step-by-step materials that can be used implement and measure the outcomes of the intervention. The Illness Management and Recovery Program makes it possible to provide an evidence-based practice in a comprehensive and easy-to-use format.

What is provided in the Illness Management and Recovery Program?

- ▶ Educational Handouts for Illness Management and Recovery, written for people who have experienced psychiatric symptoms. These handouts contain practical information, summaries, check lists, and planning sheets for nine topic areas, as listed in the following section of this brochure.
- ▶ The Practitioner's Guide for Illness Management and Recovery, which provides practical suggestions for each handout, including how to help people develop and practice coping strategies, how to help people develop and pursue recovery goals, and tips for responding to problems that may arise during sessions.
- ▶ A fifteen minute introductory video.
- ▶ Informational brochures for people who have experienced psychiatric symptoms, family members and practitioners.
- ▶ A fidelity scale to measure whether the program is being implemented as designed.
- ▶ Outcome measures to assess whether the program is having a positive impact on participants.

What topic areas are covered in the program?

Educational handouts are provided for the following nine topics:

- ▶ Recovery strategies
- ▶ Practical facts about mental illness
- ▶ The stress-vulnerability model and treatment strategies
- ▶ Building social support
- ▶ Reducing relapses
- ▶ Using medication effectively
- ▶ Coping with stress
- ▶ Coping with problems and symptoms
- ▶ Getting your needs met in the mental health system

For more information

Visit our website: www.mentalhealthpractices.org

Co-Occurring Disorders: Integrated Dual Disorders Treatment

Implementation Resource Kit



DRAFT VERSION

2003

Information for Mental Health Program Leaders

Why are dual disorders important?

Dual disorders are common.

More than half of the adults with severe mental illness in public mental health systems are further impaired by co-occurring substance use disorders (abuse or dependence related to alcohol or other drugs).

Consumers with dual disorders are at high risk.

Risks include hospitalization, overdose, victimization, violence, legal problems, homelessness, HIV infection, and hepatitis.

Poor treatment for dual disorders is expensive.

Mental health systems spend most of their resources on a small percentage of individuals with difficult problems, often consumers with dual disorders. Mental health services for these consumers cost, on average, nearly twice as much as for clients with single disorders.

Integrated dual disorders treatment works.

Consumers with dual disorders have high rates of recovery when provided integrated dual disorders treatment, which means combining mental health and substance abuse treatments within the same team or program. Integrated treatment leads to dual recovery and reduces costs. Effective treatment is good public policy.

What is integrated dual disorders treatment?

Integration

Integrated dual disorders treatment differs from traditional approaches in several ways. The most important is integration of mental health and substance abuse treatments. One practitioner or one team in one agency provides both mental health and substance abuse treatments so that the consumer does not get lost, excluded, or confused going back and forth between two different programs.

Blending

Integrated dual disorders treatments also blend mental health and substance abuse treatments. For example, substance abuse treatments focus more on motivating people with two severe disorders to pursue abstinence, and mental health treatments are modified in light of the consumer's vulnerability to psychoactive substances.

Other features

- ↴ ↴ **Stage-wise treatment.** People go through a process over time to recover, and different services are helpful at different stages of recovery.
- ↴ ↴ **Assessment.** Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.
- ↴ ↴ **Motivational treatment.** Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse treatment.
- ↴ ↴ **Substance abuse counseling.** Substance abuse counseling helps people with dual disorders to develop the skills and find the supports needed to pursue recovery from substance use disorder.

What can mental health program leaders do?

Appoint a dual disorders program leader.

Implementation of a major program change requires that one person oversee planning, implementation, training, internal and external coordination, record keeping, and other sustaining activities.

Involve all stakeholders.

All stakeholders (consumers, families, clinicians, supervisors, program leaders, and policymakers) should be involved in planning, implementing, and sustaining an integrated service system for people with dual disorders.

Develop clinical skills.

Mental health practitioners often have not been trained to assess and treat substance abuse. Implementing an integrated dual disorders treatment program requires training staff to acquire new skills; it does not mean that additional staff must be hired.

There are four basic skills that all clinicians need:

1. knowledge regarding substances of abuse and how they affect mental illness,
2. substance abuse assessment skills,
3. motivational interviewing skills, and
4. substance abuse counseling skills.

Use established strategies for systems change.

Implementation of evidence-based practices entails a significant system change. Use well-known strategies, standardized models, and consultants.

Where can I get more information?

Integrated Dual Disorders Implementation Resource Kit.

See the *Tips for Mental Health Program Leaders*. This document identifies specific strategies, recommendations for reading, consultants, and implementation centers.

Contact national organizations.

We recommend the Center for Mental Health Services, at the Substance Abuse and Mental Health Services Administration (www.samhsa.gov), and the National Association of State Mental Health Program Directors Research Institute, Inc. (<http://nri.rdmc.org>).

Visit our website.

Information about integrated dual disorders treatment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

This document is part of an evidence-based practice implementation resource kit developed through a contract (no. 280-00-8049) from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and a grant from The Robert Wood Johnson Foundation (RWJF), and support from the West Family Foundation. These materials are in draft form for use in a pilot study. No one may reproduce, reprint, or distribute this publication for a fee without specific authorization from SAMHSA.

Supported Employment

Implementation Resource Kit



DRAFT VERSION
2003

Information for Mental Health Program Leaders

Many mental health agencies are confronted with the challenge of meeting the needs of consumers in an environment of limited resources. This brochure is one in a series on “evidence-based practices” to help inform agencies about the most efficacious service strategies available. Evidence-based practices are practices that lead to positive outcomes for consumers, based on a growing body of research.

While many mental health agencies are committed to assisting adults with severe mental illness improve their lives, relatively few offer up-to-date services with demonstrated effectiveness in their practice settings.¹

Making a decision to modify service delivery typically involves training and some programmatic changes. To assist agencies and administrators in this process, specific “resource kits” have been developed. These resource kits include introductory materials for consumers, families, and staff. Training information is delivered in a multimodal format. One of these resource kits pertains to supported employment. Supported employment provides a practice model that has demonstrated good outcomes in assisting adults with severe mental illness to obtain and sustain competitive employment.

¹ Lehman AF, Steinwachs DM: Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. *Schizophrenia Bulletin* 24:11-23, 1998.

People with mental illness have many strengths, talents, and abilities that are often overlooked, including the ability and motivation to work. Work has become an important part of the recovery process for many consumers. Research has shown that:

- ▶ 70% of adults with a severe mental illness desire work.
- ▶ 60% or more of adults with mental illness can be successful at working when using supported employment.

This sheet answers some common questions that you or your agency may have regarding supported employment.

How do we know supported employment works?

A recent review of 17 studies involving employment programs consistently demonstrated that supported employment programs showed significant advantages over traditional approaches.² Across these studies 58% of those in supported employment obtained competitive employment compared to 21% in traditional programs.

How do we know this model is right for this agency?

Findings support superior outcomes for supported employment following evidence-based principles compared to a variety of traditional approaches, including programs that emphasize considerable pre-vocational training before helping consumers to find competitive jobs, traditional psychiatric rehabilitation programs, and rehabilitative day treatment.

Why should our agency give priority to supported employment over other vocational services?

Surveys have consistently found that adults with severe mental illness and their families identify finding and keeping jobs as a top priority.

How will our agency be reimbursed for these services?

Financing mechanisms vary from agency to agency and state to state. The leaders of numerous agencies and systems have successfully established ways to fund supported employment programs using Medicaid, vocational rehabilitation funding, and other sources. In some states, agencies have worked out a mechanism to pool monies that can be used to reimburse the services of supported employment programs. Also, Medicaid rules have been rewritten to allow reimbursement for selected supported work activities. Consultation with agencies and system administrators who have been successful in this area can provide useful ideas and strategies.

² Bond GR, Drake RE, Mueser KT, et al: An update on supported employment for people with severe mental illness. *Psychiatric Services* 48:335-346, 1997.

How will our agency know what changes are necessary?

The supported employment resource kit includes information regarding effective program structures, tools for measuring fidelity to the model, and simple outcome measures. The extent of changes in any agency depends on the extent of services already provided in this area and other services that are being provided to adults with severe mental illness.

What are the core principles of the supported employment model?

- ▶ *Eligibility is based on consumer choice.* No one is excluded who wants to participate.
- ▶ *Supported employment is integrated with treatment:* Employment specialists coordinate plans with the treatment team: the case manager, therapist, psychiatrist, etc.
- ▶ *Competitive employment is the goal.* The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- ▶ *Job search starts soon after a consumer expresses interest in working.* There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like prevocational work units, transitional employment, or sheltered workshops).
- ▶ *Follow-along supports are continuous.* Individualized supports to maintain employment continue as long as consumers want the assistance.
- ▶ *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

How will our agency know if we are following the core principles?

A program fidelity scale has been piloted that measures adherence to supported employment practice. Programs that score higher on this fidelity scale were found to have higher employment rates in one study.

What training is available regarding the supported employment model?

Consultation and training from mental health services training institutes are available along with implementation resource kit materials that include: brochures, introductory and training videos, workbooks, and website support.

What does the training for supported employment include?

Some training institutes offer multimodal training that includes the implementation resource kit materials plus,

- ▶ introductory training to supported employment
- ▶ practice skills training
- ▶ job shadowing at agencies that have implemented supported employment
- ▶ post-training consultations
- ▶ post-training supervision
- ▶ post-training fidelity measures
- ▶ post-training outcome measures

Refer to the Supported Employment Implementation Resource Kit's *Implementation Tips for Mental Health Program Leaders* for more information.

Have other agencies successfully implemented supported employment?

Yes, the supported employment model has been successfully implemented by agencies in a variety of states, counties, and regions.

For more information:

Information about Supported Employment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

The Supported Employment Implementation Resource Kit contains copies of research articles and an annotated bibliography in the User's Guide. Some of these materials are also referenced on the website.