



MODERN COMMUNITY MENTAL HEALTH

An Interdisciplinary Approach

EDITED BY

Kenneth Yeager | David Cutler | Dale Svendsen | Grayce M. Sills

OXFORD

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Kenneth R. Yeager, PhD, LISW

David L. Cutler, MD

Dale Svendsen, MD, MS

Grayce M. Sills, PhD, RN, FAAN

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CONTRIBUTORS

EDITORS

Kenneth R. Yeager, PhD, LISW

Kenneth R. Yeager, PhD, is an associate professor, clinical, in the College of Medicine, Department of Psychiatry of The Ohio State University, and director of quality improvement for OSU Harding Hospital. Dr. Yeager has numerous publications in the following areas: Treating co-morbid substance abuse and mental illness; quality improvement and developing quality metrics; and evidence-based practice, including the Oxford University Press book titled *“Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services.”* He is a member of Oxford Bibliographies Online editorial board and a treating clinician for the National Football League Program for Substances of Abuse.

David L. Cutler, MD

Dr. Cutler has served since late 2004 as the medical director of the Mental Health and Addiction Services Division of the Multnomah County, Oregon, Department of Human Services. He is an auxiliary professor at The Ohio State University Department of Psychiatry, where, in 2005 and 2006, he was the visiting “professor of public psychiatry.” Before that, he was professor of psychiatry at the Oregon Health and Sciences University from 1977 to 2004, and director of the Public Psychiatry Training Program in the department of psychiatry (1985–2004). Dr. Cutler trained in psychiatry at the University of Washington and the University of California, Irvine. He served in the U.S. Air Force from 1971 to 1973 and was director of outpatient services at Southern Arizona Mental Health Center from 1973 to 1977.

He has published extensively on subjects ranging from training in public psychiatry, rural psychiatry, forensic psychiatry, and ethical issues in community mental health to the treatment of persons with severe mental illnesses. Between 1987 and 2005, he was editor in chief of the *Community Mental Health Journal*. Dr. Cutler’s career also includes stints on numerous editorial review boards, consultation posts, memberships on national and local task forces, and advisory boards and committees. Dr. Cutler was an early board member of the American Association of Community Psychiatrists (AACCP) and has remained a board member since 1989. He is a

Distinguished Life Fellow of the American Psychiatric Association and has received numerous awards from the National Alliance on Mental Illness (NAMI), the American Board of Psychiatry and Neurology (ABPN), and other national organizations.

Dale Svendsen, MD, MS

Dale Svendsen is currently the director of the Division of Public and Community Psychiatry at The Ohio State University Department of Psychiatry. Svendsen joined Ohio State after retiring as the medical director of the Ohio Department of Mental Health, where he worked diligently to build and implement best practices in public mental health across the state of Ohio. Svendsen has a particular interest in the integration of physical health and mental health care. He has served in numerous leadership positions and has completed publications in areas of comorbid health and mental health, and the implementation of best practices and evidence-based practices. Dr. Svendsen has received multiple awards for his leadership at the state and national levels.

Grayce M. Sills, PhD, RN, FAAN

Sills joined the Ohio State University faculty in 1964 as an assistant professor. By retirement in 1991, she had held a number of administrative positions, including director of the Advanced Psychiatric Mental Health Nursing Program, chair of the Department of Family and Community Nursing, director of graduate studies, and acting dean of the College of Nursing. Sills was a leader in shaping Ohio State's College of Nursing, including the development of the master's and doctoral programs and its acquisition of college status. Her commitment and skill as a teacher earned her a teaching and service award from the College of Medicine, and the Alumni Award for Distinguished Teaching, the university's highest honor for teaching. Sills is a nationally acclaimed scholar in the field of psychiatric nursing and has served on a number of local and state committees to improve services for the mentally ill. In 1988, Governor Richard Celeste appointed her to chair the Study Committee on Mental Health Services for the State of Ohio. A registered nurse, Sills holds a bachelor's degree from the University of Dayton. She earned her MS and PhD at Ohio State. She holds an honorary doctorate from Indiana University and is a fellow of the American Academy of Nursing.

CONTRIBUTORS

Robert W. Ahern, PhD, LISW-S

Clinical Director
Chief of Staff
Juvenile and Probate Court
Union County, OH
Instructor
College of Social Work
The Ohio State University
Private Practitioner
New Reflections Counseling Center
Marysville, OH

Anthony O. Ahmed, PhD

Assistant Professor
Department of Psychiatry and Health
Behavior
Georgia Health Sciences University
Augusta, GA

Elaine Alberti, MN, RN

Clinical Nurse Specialist
Eastern State Hospital
Medical Lake, WA

Jessica Levy Auslander, MA, NCC/NCSC, DCC

Instructional Development Specialist
Department of Psychiatry
College of Medicine
The Ohio State University Wexner Medical
Center
Columbus, OH

Carl C. Bell, MD

President & CEO
Community Mental Health Council &
Foundation, Inc.
Director
Institute for Juvenile Research
Director
Public and Community Psychiatry
Clinical Professor of Psychiatry and Public
Health
Department of Psychiatry
College of Medicine
University of Illinois at Chicago
Chicago, IL

Loretta Berti, PhD

Research Assistant
Section of Psychiatry and Clinical Psychology
Department of Public Health and
Community Medicine
University of Verona
Verona, Italy

David E. Biegel, PhD

Henry L. Zucker Professor of Social Work
Practice
Co-Director
Center of Substance Abuse and Mental
Illness
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Christopher D. Bowling, MEd, CLEE

Lieutenant
Crisis Intervention Team (CIT) Coordinator
Columbus, Ohio Division of Police
Columbus, OH

Daniel W. Bradford, MD, MPH

Director, Psychosocial Rehabilitation and
Recovery Center &
Inter-professional Fellowship on Psychosocial
Rehabilitation
Durham VA Medical Center
Assistant Professor
Department of Psychiatry and Behavioral
Sciences
Duke University Medical Center
Durham, NC

Peter F. Buckley, MD

Professor of Psychiatry and Health Behavior
Dean of the Medical College of Georgia
Georgia Health Sciences University
Augusta, GA

Joyce Burland, PhD

Clinical Psychologist
Author of the NAMI Family-to-Family
Education Program
Sante Fe, NM

Lorenzo Burti, MD

Professor of Psychiatry
Section of Psychiatry and Clinical Psychology
Department of Public Health and
Community Medicine
University of Verona
Verona, Italy

Elisabetta Canova, MA

Psychiatric Rehabilitation Specialist
Community Mental Health Service of
South-Verona
Verona, Italy

Philip Cass, PhD

Chief Executive Officer
Columbus Medical Association
Columbus, OH

Kevin Corcoran, PhD, JD

Professor
School of Social Work
Portland State University
Portland, OR

Christy Daron, MSW, LSW

Program Manager
Woman's SMD Residential Home
Southeast, Inc
Columbus, OH

Jean Dentinger, MPA

Diversion Courts Manager
Multnomah County Department of Human
Services
Portland, OR

Robert E. Drake, MD, PhD

Professor
Psychiatry, Community and Family
Medicine
The Dartmouth Institute
Dartmouth Medical School
Lebanon, NH

Benjamin G. Druss, MD, MPH

Rosalynn Carter Chair in Mental Health
Department of Health Policy and
Management
Behavioral Sciences and Health Education
Rollins School of Public Health
Emory University
Atlanta, GA

Ken Duckworth, MD

Medical Director
NAMI
Assistant Clinical Professor of Psychiatry
Harvard Medical School
Cambridge, MA

Hon. Charlotte Coleman-Eufinger

Juvenile and Probate Court
Union County, OH

Anita Everett, MD, DFAPA

Section Director
Community Psychiatry
Johns Hopkins School of Medicine
Johns Hopkins Bayview Medical Center
Baltimore, MD

Neil Falk, MD

Associate Medical Director
Cascadia Behavioral Healthcare, Inc.
Portland, OR

Marianne Farkas, ScD

Director of Training, Dissemination,
Technical Assistance
Clinical Professor
Center for Psychiatric Rehabilitation
Boston University
Boston, MA

Daniel B. Fisher, MD, PhD

Executive Director
National Empowerment Center
Cambridge, MA

Kamal Floura, MD

Medical Director
Eastern State Hospital
Medical Lake, WA

Rick Forbess, MSSW

Associate Director of Training,
Dissemination, Technical Assistance
Center for Psychiatric Rehabilitation
Boston University
Boston, MA

Michele Fornari, MA

Psychiatric Rehabilitation Specialist
Community Mental Health Service of
South-Verona
Verona, Italy

Fred Frese, PhD

Associate Professor of Psychiatry
Northeast Ohio Medical University
Rootstown, OH

Buddy Garfinkle, MA, MSW

Associate Executive Director
Bridgeway Rehabilitation Services, Inc.
Elizabeth, NJ

Julie P. Gentile, MD

Associate Professor
Wright State University
Dayton, OH

Rupert R. Goetz, MD, DFAPA

Chief Medical Officer
Oregon State Hospital
Salem, OR

Darcy Haag Granello, PhD, LPCC

Professor
Counselor Education
The Ohio State University
Columbus, OH

Patricia A. Griffin, PhD

Senior Consultant
SAMHSA GAINS Center
Pennsylvania Mental Health and Justice
Center of Excellence
Philadelphia Department of Behavioral
Health and Intellectual disAbility Services
Philadelphia, PA

Will Hall, MA, Dipl.PW

Director, Portland Hearing Voices
Host, Madness Radio
Co-Founder, Freedom Center
Portland, OR

Lisa Halpern, MPP, CPRP, CPS

Director of Recovery Services
Vinfen
Cambridge, MA

Michael Hogan, PhD

Commissioner
New York State Office of Mental Health
Albany, NY

Kevin Huckshorn, RN, MSN, CADC
Delaware Director
Division of Substance Abuse and Mental
Health
New Castle, DE

Carroll S. Jackson, LISW-S
Montgomery County Board of
Developmental Disabilities
Mental Health Clinic
Dayton, OH

David P. Kasick, MD
Assistant Professor of Clinical Psychiatry
College of Medicine
Director of Consultation-Liaison Psychiatry
The Ohio State University Wexner Medical
Center
Columbus, OH

Holly Kastan, MSW, LSW
Director of Planning, Development and
Outreach-OSU STAR Program
Department of Psychiatry
The Ohio State University Wexner Medical
Center
Columbus, OH

Kathleen Kemp, PhD
Postdoctoral Fellow
Institute of Law, Psychiatry and Public Policy
(ILPPP)
University of Virginia
Western State Hospital
Charlottesville, VA

Lenore A. Kola, PhD
Associate Professor of Social Work
Co-Director, Center for Evidence Based
Practices at Case
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Carol Kottwitz, MN, PMHCNS, BC
Clinical Nurse Specialist
Eastern State Hospital
Medical Lake, WA

Janice L. LeBel, EdD
Director of Program Management
Commonwealth of Massachusetts
Department of Mental Health
Boston, MA

Harriet P. Lefley, PhD
Professor
Department of Psychiatry and Behavioral
Sciences
University of Miami Miller School of
Medicine
Miami, FL

Jayme Lynch, CPS
Director
Peer Support and Wellness Center
Decatur, GA

Christopher T. Manetta, DO
Kirtland Air Force Base Medical Facility
Kirtland AFB, NM

Shané P. Marshall, LISW, LCDR III
Readjustment Counseling Therapist
Department of Veterans Affairs, Vet Center
Consultant
Shé Petite Management & Consulting
Columbus, OH

Dominica F. McBride, PhD
President
The HELP Institute, Inc
Director of Research
Community Mental Health Council, Inc
Chicago, IL

Bentson McFarland, MD, PhD
Professor of Psychiatry
Professor of Public Health and Preventive
Medicine
Oregon Health and Science University
Portland, OR

Patrick D. McGorry, AO, MD, BS, PhD, FRCP, FRANZCP

Executive Director
 Orygen Youth Health Research Centre
 Professor
 Centre for Youth Mental Health
 The University of Melbourne
 Director of Clinical Services
 Orygen Youth Health
 Melbourne, Australia

Ryan P. Melton, PhD, LPC, ACS

EASA State Clinical Coordinator
 Mid-Valley Behavioral Care Network
 Salem, OR

Kenneth Minkoff, MD

Senior System Consultant
 ZiaPartners, Inc
 San Rafael, California
 Clinical Assistant Professor of Psychiatry
 Cambridge Health Alliance Department of
 Psychiatry
 Harvard Medical School
 Cambridge, MA

Mark R. Munetz, MD

The Margaret Clark Morgan Foundation
 Chair
 Professor of Psychiatry
 Northeast Ohio Medical University
 Rootstown, OH
 Chief Clinical Officer
 Summit County Alcohol, Drug Addiction
 and Mental Health Services Board
 Akron, OH

Julie Niedermier, MD

Associate Professor of Clinical Psychiatry
 Director of Education
 Department of Psychiatry
 The Ohio State University Wexner Medical
 Center
 Columbus, OH

Bernadette Nunley, JD

Assistant County Attorney
 Multnomah County, OR

William Nunley, MD, MPH

Associate Medical Director
 CareOregon
 Corrections Health Consulting Psychiatrist
 Multnomah County Health Department
 Project Coordinator
 Bazelon Center for Mental Health Law
 Cascadia Behavioral Health Care
 Portland, OR

Donata Pavani, MA

Psychiatric Rehabilitation Specialist
 Community Mental Health Service of
 South-Verona
 Verona, Italy

Narsimha R. Pinninti, MD

Professor of Psychiatry
 UMDNJ School of Osteopathic Medicine
 Chief Medical Officer
 Twin Oaks Community Services
 Cherry Hill, NJ

David A. Pollack, MD

Professor for Public Policy
 Department of Psychiatry
 Division of Management
 Oregon Health and Science University
 Portland, OR

Alan Q. Radke, MD, MPH

Medical Director
 Department of Human Services
 State of Minnesota
 St. Paul, MN

Mark Ragins, MD

Medical Director
 Mental Health America-Los Angeles
 The Village
 Long Beach, CA

Jeffrey L. Ramirez, PhD, PMHNP, BC

Assistant Professor
 Gonzaga University
 Spokane, WA
 Clinical Nurse Specialist
 Eastern State Hospital
 Medical Lake, WA

Christina L. Rodriguez, MSW

Counselor
EASA Marion County
Salem, OR

Robert J. Ronis, MD, MPH

Douglas Danford Bond Professor and
Chairman
Department of Psychiatry
Case Western Reserve University School
of Medicine
Cleveland, OH

Sean N. Roush, OTD, OTR/L

Assistant Professor
School of Occupational Therapy
Pacific University
Hillsboro, OR

Tamara G. Sale, MA

EASA State Program Coordinator
Mid-Valley Behavioral Care Network
Salem, OR

Lisa T. Schmidt, PhD, CPRP

Associate Clinical Professor/Associate
Director
Department of Behavioral Health Counseling
College of Nursing and Health Professions
Drexel University
Philadelphia, PA

Phil Shapiro, MD, MPH

Medical Director
Central City Concern
Old Town Recovery Center
Portland, OR

James Sizemore, MDiv

Readjustment Counseling Therapist
Department of Veterans Affairs, Vet Center
Columbus, OH

Phyllis Solomon, PhD

Professor of Social Work
School of Social Policy & Practice
Professor of Social Work in Psychiatry
Department of Psychiatry, Medical School
University of Pennsylvania
Philadelphia, PA

Margaret A. Swarbrick, PhD, OT, CPRP

Director
CSPNJ Institute for Wellness and Recovery
Initiatives
Clinical Assistant Professor
School of Health Related Professions
University of Medicine and Dentistry of New
Jersey
Freehold, NJ

Gregory B. Teague, PhD

Associate Professor
Department of Mental Health Law & Policy
College of Behavioral and Community
Sciences
University of South Florida
Tampa, FL

Sharon Jenkins Tucker, MA, ITE, CPS

Executive Director
Georgia Mental Health Consumer Network
Decatur, GA

Craigian T. Usher, MD

Assistant Professor of Psychiatry
Director, Child & Adolescent Psychiatry
Residency Training Program
Oregon Health & Science University
Portland, OR

Vikki L. Vandiver, Dr.PH, MSW

Professor
School of Social Work
Portland State University
Affiliate Professor
Department of Psychiatry
Oregon Health and Science University
Portland, OR

**Suzanne Elizabeth Vogel-Scibilia, MD,
DFAPA**

Assistant Clinical Professor
University of Pittsburgh
Beaver, PA

Elizabeth Reisinger Walker, MAT, MPH

Doctoral Candidate
Department of Behavioral Sciences and
Health Education
Rollins School of Public Health
Emory University
Atlanta, GA

Laura Weisel, PhD

CEO, Clinical Director
TLP Group
Columbus, OH

Leslie A. Winters, JD

Assistant General Counsel
The Ohio State University Wexner Medical
Center
Columbus, OH

Robert M. Wolf, MD

Medical Director
Early Assessment and Support Team
Mid-Valley Behavioral Care Network
Salem, OR

Judy Wortham-Wood, MA

Executive Director
The Mental Health and Recovery Board of
Wayne and Holmes Counties
Wooster, OH

OPTIMIZING MEDICATION IN THE SERVICE OF RECOVERY

*Is There a Path for Reducing Over-Utilization of
Psychiatric Medications?*

NEIL FALK, DANIEL B. FISHER, AND WILL HALL

INTRODUCTION

There was a time when mines in the United States produced ores to go into blast furnaces to produce steel to go to factories that produced cars, radios, toasters, televisions, or other things we could buy at the hardware store or corner store. Now, instead of huge factories rising to the sky and puffing smoke from their furnaces making steel, we have huge medical centers rising above the hills, producing steam for their heating systems to warm their clinics where medical care is provided. There is a lot of momentum to this. There are treatments for all illnesses, and diagnoses to go with all treatments that can be billed to someone, and even though 50 million people in this country currently have no “official” access to health care, most of them—and the rest of us who have some sort of health insurance—still find a way to get pills from somewhere. Sometimes it seems like in America today the gross national product has become medical care: it is as if the purpose of our existence is to be patients so that perhaps we can help the economy recover. Truthfully, we are all consumers of healthcare products cradle to grave.

But what if we don’t want to be patients (and most of us really don’t want to be patients)? What if we are worried about the long-term effect of taking various chemical substances into our bodies (most research drug trials only last six months)? For each of us to be smart patients, we need to know the risks and benefits of receiving treatment and the risks and benefits of refusing treatment. Sadly, for some of us, remaining alive is a matter of accepting some kind of medical care. If we have a heart attack we usually want something done to fix the problem (a stent or a triple bypass, for example) so that we may live a while longer. If we become depressed and suicidal

there is still often a part of us that says, “I want some treatment that will help me feel better” (like a good therapist, or an antidepressant medicine, or both). But an even more subtle question is, At what point is treatment enough or no longer necessary? At what point may the treatment be worse for me than the illness? How do we know when? What happens if we get it wrong?

Wouldn't it be great if we could answer these questions? In this chapter we will raise these issues as food for thought, so to speak, although we doubt if anyone has the definitive answers as yet. Perhaps if we can shed light on this question, a new balance will be struck between the medical establishment and the community of patients, a balance that will give us a sense of equality and mindfulness as we decide what treatment we might need for whatever mental health problem we may have.

Our motivation for putting these thoughts into words comes from the fact that, of the three authors of this chapter, two of us have experienced extensive mental health treatment with medications. The other author provides treatment to a variety of people, including young persons experiencing symptoms of psychosis. All of us are mental health professionals involved in recovery or prevention services for people who suffer from severe forms of psychosis.

Each of us who suffers has a unique story to tell, with ups and downs. Although perhaps not typical of anyone else here, is a brief vignette of one of us:

Our family rarely talked about feelings. My sister and I underwent traumas our family did not discuss. So the chemical causation idea fit with our need for denial. From a sense of duty and guilt, I decided I should become a neurochemist and discover the pill to make my sister behave as she should. In the course of my post-doctoral research at the NIMH and in my own life, I felt betrayed by the chemical explanation of psychological issues. In the lab, the more deeply I examined the regulation of neurotransmitters dopamine and serotonin, the more I realized the futility of reducing our lives to a test tube. There were far too many factors involved in regulating the amounts of neurotransmitters. So I concluded that each of us was more than a machine and it was far more important to understand ourselves and our relationships than the behavior of our individual chemicals. This realization dissolved my sense of purpose in life.

I was diagnosed with schizophrenia and hospitalized on three occasions. I was given antipsychotic medications at each hospitalization. I tried to come off the Thorazine after my first hospitalization. However, I still thought mental illness was due to faulty chemistry, so I was fearful I might relapse. Indeed, one year later, after a failure in love, I did relapse and was re-hospitalized. After the second hospitalization I was convinced I had to make a major life change in my way of relating to people and in my profession. I realized that medication alone would not solve these problems. I fortunately had a psychiatrist who believed in my potential to recover. He saw a positive side to my psychoses. He described them as “regression in service of the ego.” This term was used by Dr. Ernst Kris, during his work in ego psychology, indicating the creative benefits of regression. He felt that the aims of the ego were sometimes enhanced by the ability of people to regress and use the irrational processes of the unconscious and the id to develop alternative ways of thinking, feeling, and behaving. While this is of obvious advantage to artists, he was thinking to of the wider benefits of such flexibility (Kris, 2000).

That time I was able to successfully come off all medication for a four-year period. During that period I worked as a peer counselor for people who came in distress to a free clinic. I entered a variety of group therapies and rap sessions. These experiences gave me the courage to share feelings, become more involved romantically and with friends, and enter a new career as a psychiatrist. (Fisher, 2008)

—D. F.

THE LITERATURE

While increased attention has been paid in recent years to non-medical models of approaching mental distress (Amminger, 2010; Brosse, 2002; Strohle, 2008; Gorkzynski, 2010; Karon and VandenBos, 1980; Miklowitz, 2007; Dickerson, 2000; Dixon et al., 2000; Dilk and Bond, 1996; Becker, 2004), the use of prescription mental health medications has risen. While an exploration of the factors behind this paradox is beyond the scope of this paper, it is striking that very little attention has been given to the issues involved in *discontinuing* medications. Specifically, the past 20 years have seen only sporadic publications in the medical literature of data reflecting how long we should continue treatment, when to attempt discontinuation of medications, or how to safely discontinue them. What has been published looks primarily at relapse rates of people who stop medications versus those who continue them, with an underlying assumption that relapse after stopping is at best common, and at worst inevitable. In addition, these studies assume that a recurrence of symptoms indicates the relapse of a chronic condition, and they do not address the question of whether the recurrent symptoms might actually represent long-term results of medication use (most of us, whether we take thyroid or Thorazine, notice side effects). These studies do not include data on what (if any) non-pharmacological treatments were used as adjuncts to, or replacements for, medication.

The studies do suggest a common theme, however: that slower discontinuation of medications (tapering off) carries a lower risk for relapse than a rapid or abrupt discontinuation. For example, a literature review from the mid-1990s (Baldessarini, 1996) concluded that people with a diagnosis of bipolar disorder who discontinued Lithium rapidly (within 1–13 days) relapsed five times sooner than those who discontinued their Lithium slowly (over 14 or more days). What was not overtly reported, however, was that 12% of people remained stable for 3½ years after discontinuing Lithium, with approximately 2% of the rapid discontinuers and 37% of the slow discontinuers remaining stable (with 30% remaining stable out to five years after discontinuing Lithium). One of the studies (Faedda, 1993) included in this meta-analysis pessimistically concluded that gradual discontinuation of Lithium delays but does not reduce risk of mania recurrence in bipolar affective disorder (BAD) 1, but delays and reduces risk of depressive recurrence in both BAD 1 and BAD 2.

Similarly, a mid-1990s literature review on discontinuing antipsychotics (Viguera, 1997) examined rapid (20 or less days, many within one day) versus slow (21 or more days) tapering of antipsychotics among people with a diagnosis of schizophrenia. While they reported that the relapse rate at six months among the rapid discontinuers was double that of the gradual

discontinuers, the data reveal that approximately 50% of those who abruptly stopped antipsychotics actually remained stable after six months, and 40% remained stable for a full 24 months. The best results were among those being treated in an outpatient setting who discontinued medications slowly, with over 50% of this group remaining stable four years after stopping medications. More recently, a longitudinal study revealed that 19% of people diagnosed with schizophrenia were in recovery 15 years after diagnosis, 67% of whom were off medication (Harrow & Jobe, 2007). Most of these people stopped medication one to two years after diagnosis, and remained in recovery for many years afterward.

More recently, a moderate-sized study looked at rapid (1–7 days) versus slow (14 or more days) discontinuation of antidepressants in people with various mood and anxiety diagnoses (Baldessarini, 2010). The primary conclusion was that people who stopped antidepressants quickly relapsed 2.3 times more rapidly than those who stopped gradually, and the study identified numerous issues correlated with more rapid relapse. However, the data reveal that 22.3% of the rapid discontinuers, and 40.9% of the gradual discontinuers, remained symptom-free after 12 months. These results are similar to a prior meta-analysis, which found that 59% of those who stopped antidepressants remained relapse-free after a modal study length of 12 months (Geddes, 2003).

It would appear that there are people taking psychiatric medications who could successfully discontinue them (Rappaport, 1977). Even Pepper et al. (1981) predicted in the “rule of thirds” that one third of those with a psychotic break would need medication but two thirds either did not need meds or would only require treatment if they experienced a relapse. This is consistent with naturalistic data from the pre-medication era. Multiple studies prior to 1955 revealed that roughly 50% to 70% of people diagnosed with schizophrenia were successfully living in the community between three and six years after release from state hospitals or similar institutions (Cole, 1959; Lehrman, 1961; Warner, 1985). Data from the early years of the medication era suggest that those who stop antipsychotic medication may in fact have better long-term outcomes than those who continue to take them long-term (Harrow, M 2007). Harrow found that the members of the cohort who were able to come off antipsychotic medication (39%) showed a greater degree of recovery than those who stayed on medication. He also showed that those who did not take antipsychotic medication during the 15-year period had a greater internal locus of control than those who stayed on medication (Harrow and Jobe, 2007). (However, it is unclear if this represents a negative effect of medication use, or a selection bias such that those with worse symptoms remain on medications longer.) Similar naturalistic studies in those diagnosed with depression suggest better long-term outcomes for those who did not use antidepressant medications than for those who did. Data reveal that those who did not take medication to treat their depression were 50% more likely to remain relapse-free (Weel-Baumgarten, 2000), had 42% less time feeling depressed (Patten, 2004), had better overall one-year outcomes (Goldberg, 1998), returned to work after short-term disability 27% faster, and were 50% less likely to develop long-term disability (Dewa, 2001). (Again, it is unclear whether these data describe a negative effect of antidepressants or a phenomenon that people with more severe pathology take medications more often.)

Unfortunately, there is scant scientific data on identifying those who are best treated without medications and those who would do better with only short-term use of medication. Likewise, there is a lack of scientific literature on how to support those who opt to go off medications. As poor pre-morbid functioning is the most common trait associated with higher risk for relapse

after stopping medication, it stands to reason that improving an individual's functioning and coping skills would help in his/her effort to stop or decrease medications (or not use them at all). This practice also supports the concept of not solely deferring or stopping medications, but finding alternate non-pharmacological methods to address symptoms (actual or potential). Many such methods are used concomitantly with medications when treating mental illness, and many can be used on their own without medications.

The most commonly used non-pharmacological treatment to address mental health symptoms is psychotherapy. Many studies support the use of several types of psychotherapy, including cognitive therapy, behavioral therapy, cognitive behavioral therapy, dialectical behavioral therapy, interpersonal therapy, and dynamic therapies (Dickerson, 2000). Most studies agree that medication and therapy offer similar success rates in treating depression, with therapy having more long-lasting benefits than medications after therapy is stopped, and with placebos playing an important role in antidepressant medication efficacy (Moncrieff et al., 2005). Similar data exist to support the use of psychotherapy as adjunctive treatment in bipolar disorder (Miklowitz, 2007) as well as schizophrenia (Miklowitz, 2007). Similarly, family therapy and psychoeducation are proven effective in supporting people diagnosed with bipolar disorder (Miklowitz, DJ 2007) and schizophrenia (Dixon, 1995; Dixon, 2000).

Addressing issues outside of a disease treatment model has also been proven helpful for those concerned about mental health symptoms. For example, supported employment has proven effective for people with a variety of psychiatric diagnoses (Becker, 2004) as has social skills training (Dilk & Bond, 1996). Courtney Harding's (Harding et al., 1987, 1994) well-documented Vermont State Hospital study of 269 persons diagnosed with long-term schizophrenia who were given hope and a recovery-oriented approach showed highly positive results. Forty percent of the group were able to get off meds completely, and another 28% showed marked recovery. In contrast, a comparison of Vermont's outcomes with those in Maine, where the state subscribed to a disease model and maintenance, showed there was a lower recovery rate in Maine (DeSisto et al., 1995). In addition, research into so-called holistic health approaches is suggesting the usefulness of some of these approaches. For example, an article in *Psychiatric News* (October 2011) features a psychiatrist in Washington, D.C., organizing free bikes and docking stations for his patients to ride around the city. Exercise has a demonstrated positive effect in affective disorders (Brosse, 2002; Strohle, 2008) and has shown promise in addressing symptoms in schizophrenia (Gorczyński, 2010). And many small studies address the role of food allergies and support the use of diet or specific herbal remedies, such as the use of hypericum for affective disorders (Linde, 2008) and Omega-3 oils for a variety of symptoms, including potentially emerging psychosis (Amminger, 2010).

Recovery philosophies regarding the cause and treatment of mental health symptoms, such as the Soteria House (Mosher, 1999) and Open Dialogue models (Seikkula et al., 2003), have also been helpful to those diagnosed with severe mental illness, with no or reduced medications. The Open Dialogue approach in Finland views extreme distress as social, rather than medical, in nature. Open Dialogue de-emphasizes American-style pharmaceutical intervention and instead establishes a dialogue with the patient, provides immediate help, and organizes a treatment meeting within twenty-four hours of the initial contact. The results consistently show that this way of working reduces hospitalization, lowers use of medication, and leads to less recurrence of crises when compared with psychosis treatment as usual. For

example, in a five-year follow-up (Seikkula, 2006), 83% of patients had returned to their jobs or studies or were job-seeking, thus not receiving government disability. In the same study, 77% did not have residual psychotic symptoms, and fewer than 20% were taking antipsychotic medication.

Soteria House, a residential hospital alternative, also demonstrated promising results. Director Loren Mosher wrote:

Results from 6-week outcome data for all Soteria House Ss and 2-year outcome data for the Ss admitted between 1971 and 1976 are discussed. The interpersonally based therapeutic milieu of Soteria House was as effective as neuroleptic drugs in reducing acute symptoms of psychosis in the short term (6 weeks) in newly diagnosed psychotics. Longer-term outcomes (2 years) were as good as or better than those of hospital treated control Ss in terms of independence, autonomy, and peer-based social networks. (Mosher, 1991)

The model of describing the problem and the approach to help was likewise interpersonal and recovery based, and the use of medication was lower and the relapse rate was much lower than hospitalization (Mosher, 1999).

Peer-run respites similar to Soteria House have also shown promising results. These alternatives to hospitalization are based on peer-support values, which rank the interpersonal as the most important element of assistance, and on recovery values of self-determination and holistic health. They show higher satisfaction rates than hospitals and a greater increase in self-esteem (see www.power2u.org/peer-run-crisis-alternatives.html).

Both the Soteria model and peer-run respites share a set of values very similar to SAMHSA's 10 components of recovery:

- I. The mental health conditions are approached holistically, and the psychosocial and spiritual factors of distress and recovery are given at least the same weight as the biological factors.
- II. There is always hope that the person will recover a full role in society.
- III. The person suffering's humanity is respected as being as important as that of the practitioner and other members of society.
- IV. Persons with mental health issues have the right to choose the form of therapy and support they are provided; i.e., self-determination is endorsed.
- V. Peer support is a vital component of recovery.
- VI. Having a greater internal locus of control is associated with recovery; i.e., empowerment is a component of recovery.

CASE VIGNETTE 1

Lisa was a 19-year-old college student who experienced the onset of paranoia, disorganization, and odd behavior during a campus festival weekend. She was presumed to have developed psychosis from substance use; however, her urine

drug screen was negative for all substances, and she denied any substance use besides alcohol. She remained hospitalized for two weeks due to symptoms that were slow to improve. She was discharged home with a diagnosis of schizophrenia, given her intense psychosis and development of prominent negative symptoms. Despite continued medication use and the eventual ending of her psychosis, she continued to have a flat affect and to isolate. She denied having depression, but clearly had little motivation for any social interactions or activity. She worked with an intensive treatment team, with a primary therapist who frequently visited her in the community and slowly worked to increase her activity level. Eight months after her discharge, she began to reintegrate with friends, and re-enrolled part-time in school. Twelve months after discharge, she expressed a desire to stop her medications, feeling she no longer needed them.

After a summer term class, during which she was stationed in a remote wilderness location, she returned to school full-time, and her medication was tapered off over three months. She did well at school, obtaining good grades similar to those she had in the past, working part-time in a restaurant, and volunteering at a community garden. While she intermittently had alternative and/or unusual ideas about her health and about environmental issues, she never had overt delusions, and remained highly active with friends and in the community. Her affect returned to full range, and she began dating again. As of this writing, she has been off medications for eighteen months without any recurrent symptoms or loss of social or academic functioning.

This example demonstrates a central tenet of the recovery model: that people can indeed recover from illnesses once considered chronic and debilitating (McGuire, 2000). In the past, individuals such as Lisa were told they would need to take medication for the rest of their lives, lest they have recurrent psychotic episodes. This can be devastating information, especially for individuals who have experienced their first and only episode of psychosis. In addition to consigning them to a medical model of illness and treatment to explain their experiences, it can discourage individuals from holding hope, and encourage them to not push themselves to excel. However, with early intensive treatment and adequate education, people can continue to have productive lives and experience minimal symptoms while off medications. While medications can certainly be helpful in acute psychosis, their use long term is not a given, presuming other methods of addressing symptoms are helpful.

In short, it is clear a subgroup of people taking psychiatric medications could do well without them, although there is no method to accurately distinguish this group from those who would benefit from long-term medication use. However, given the long-term risks associated with medication, and reasonable odds of any given individual doing well without medications, people should be given an opportunity to stop medications if they so desire. To do so safely, it is recommended that this titration off medication occur slowly (to minimize both the risk of future symptoms and the untoward effects of discontinuation syndromes), and that the person utilize one or more of any of the other treatment modalities proven effective in treating mental illnesses.

CASE VIGNETTE 2

Karla was a 24-year-old woman working in environmental sciences who became manic and psychotic while working in a remote forest. She experienced rapid onset of sleeplessness, expansive moods, delusions of space aliens trying to control her behavior, visual hallucinations of these aliens, and impulsivity. She responded well to the start of a mood stabilizer and an antipsychotic when hospitalized, but disliked the side effects of sedation, cognitive dulling, and weight gain. She agreed to stay on medications for six months, during which time she worked closely with a therapist to examine the general risk factors for relapse, explore her unique symptoms, and create a list of “early warning signs” indicating another psychotic episode might be developing. When such warning signs emerged, she increased her contact with her therapist and psychiatrist, and adopted appropriate behavioral responses, such as increasing her exercise, increasing her sleep, and taking one to two hours out of the day to play music or otherwise relax. She kept a small supply of an antipsychotic drugs on hand as a “safety net” should her behavioral interventions not be as helpful as she hoped.

Over the ensuing two years off medications, she had numerous episodes of “early warning” symptoms, all but two of which responded within three to five days to behavioral interventions. On these other two occasions, she used her medication in low doses for five to seven days, each time reducing her symptoms to manageable levels. She maintained part-time employment throughout these two years, needing to take time away from work only once for a few days. As of this writing, she continues to work successfully and play music in small clubs, and has established a long-term romantic relationship.

This vignette demonstrates that long-term use of medications is not always a necessity, especially when alternative methods of addressing symptoms are successful. However, many individuals opt to use medications intermittently when symptoms re-arise, in cases when these alternative methods of treatment prove ineffective for a specific episode. Unfortunately, it is impossible to know after a first episode of illness if the individual will be able to stop medications, require intermittent use of medications, or have need of medications over the long term.

However, in the interest of limiting the exposure of individuals to their long-term adverse effects, psychiatric medications should be used only after proven necessary for that individual’s recovery.

APPROACHING DISCONTINUATION: TOWARD BEST PRACTICES

What should our response be when a client questions continuing psychotropic medications, or when a prescriber is concerned about short- or long-term risks associated with continuing

medications? When do medications no longer become useful, and when is their usefulness outweighed by their risks? In addition to the limited research on the topic, developing any specific protocols for reduction and discontinuation faces an additional challenge: the subjective nature of medication therapeutic response. Assessment of and preparation for the discontinuation process will therefore begin with attention to the *therapeutic relationship* and to broader social support for the client. Once this attention is in place, clinicians can begin a careful consideration of the client's medication history and the current nature of medications' adverse effects, as well as an assessment of the subjective usefulness of the medications to the client; and from there we can consider a reduction process, at each step working with the client on their response. The most important attitude for both client and providers is that this is a mutual learning process. (Hall, 2007)

Assessing therapeutic usefulness of a client's medication profile is difficult to do from a purely pharmacological standpoint because, other than obvious psychotic symptoms or disorganized thinking, psychiatric medication response and side effects are mostly subjective, particularly once the person no longer exhibits positive symptoms. As Cohen writes, "No single theory in psychopharmacology addresses how drugs produce 'therapeutic' effects. There is no theory of 'drug response.' This is because the perception of a drug effect as therapeutic depends on human motives within particular social contexts." (Cohen, 2001) The reduction and discontinuation process will depend therefore on the attention to the therapeutic relationship, the education of the client about the nature of their diagnosis and condition, and the creation of new life possibilities around reduction and discontinuation.

With limited time and resources, prescribers may not themselves be able to give the required attention to the relationship; a team or an individual such as a case manager, peer specialist, therapist, or nurse practitioner will be important. For our purposes, let us call this person a "wellness coach": someone who unconditionally supports and advocates for the client. The role of the wellness coach would be to ensure communication between prescriber, client, and others involved with providing care such as families; create a pattern of continuity and regularity in the process; support client education and the client's decision-making process at each step of the way; discover and utilize support resources for the client; and provide the emotional support and recognition needed to foster greater autonomy and engagement with the recovery process. The U.K. Charity MIND study found that doctor-patient relations *re: coming off meds* are frequently very poor. Of patients interviewed, 40 percent saw their prescribers as "not helpful" in the process, making them the least helpful source of advice and support. (Read, 2005) Without a good relationship and the role of wellness coach who is "on the side" of the client in place, it will be difficult to effectively monitor the client's progress, address problems early, cultivate non-medication wellness tools, and avoid problems.

Rather than focus primarily on medications, at each step we should address the entirety of the client's life experience, to best understand the place of medications and discontinuation or reduction decisions within it. Priority should be put where it is needed, rather than following a preprogrammed schedule for medication changes, with flexibility to pause or resume the process as the client's overall life situation indicates. Emphasis should be not on medication reduction/withdrawal as an end in itself, but rather on the life goal the individual has and how the medication reduction can serve that. This reinforces the recovery-based understanding of medications as a tool in life, rather than a necessary treatment for disease.

The wellness coach will also coordinate an education process that sets the context and tone for reduction and discontinuation. Education is directed at the client as well as the client's larger immediate social network, such as family members, friends, and healthcare providers, and is a

mutual education process, with the wellness coach seeking to learn and understand the clients' experience and needs and to help educate any providers and professionals involved. The cornerstone of this education is the values and perspectives of the peer recovery movement and its emphasis on self-determination, to foster the emergence of autonomy and responsibility in the client.

While at each step of the way prescription and medication reduction are client-centered, the prescriber also maintains a clinical and ethical responsibility to monitor the process from the standpoint of their skills and experience, with the aim to "Do No Harm." Following a prescription is the purview of the client; writing a prescription is the purview of the clinician, and the process is collaborative. Each brings their unique perspective and has the freedom to question the other, and if needed disengage from the relationship if they feel their perspective is not adequately addressed in the collaboration. For example, clients may be willing to take risks clinicians advise against, such as the risk of hospitalization or tolerance of experiences defined as symptoms, because from their experience adverse effects have become intolerable; while clinicians may be unwilling to go along with a medication requested by the client because of their assessment of medication toxicity risks. Each has a responsibility to voice their concerns and to reach compromise where possible, and prescribers are ethically and professionally bound by their role as prescribers and have the added responsibility to be aware of the power differences with their client. Where medication optimization and reduction are new to the prescribers, they will need to approach the process as a learning experience and have an attitude of humility and tolerance for the unknown.

To begin preparation, clients should be supported in examining their history with medications, any previous attempts at reduction or discontinuation, their relationships with providers, the client's desire to begin the reduction/discontinuation process, and their motivations, goals, and challenges. Comprehensive laboratory tests and tests for medication toxicity, as indicated by each medication, should be up-to-date to suggest discontinuation priorities and to consider any medical need for abrupt withdrawal. Once an initial assessment of medication adverse effects is done, an overall physical health assessment should be conducted, including from a holistic standpoint, to clarify what factors are influencing the client's quality-of-life concerns. Many clients experience quality-of-life limitations that arise from unaddressed physical issues, which have been overlooked by previous providers or mistakenly attributed to a diagnosed mental disorder. Many emotional and psychological complaints can have hidden physical origins. While there is a great range of possible considerations, some things to consider are thyroid functioning; adverse effects of other medications such as steroids; encephalopathy; vitamin deficiency; or gluten intolerance, any of which could be playing a role. Physical health assessment encourages the client to take a more active stance in their wellness and to overcome past relationships of passivity and dependence toward their treatment. To catch the earliest signs of adverse effects, clinicians should consider using the most comprehensive testing available.

A discontinuation plan then usually begins with a slow incremental taper, such as a 10 percent reduction from baseline dosage in two- to three-week increments. This can be adjusted based on the length of time the client has been on the drug and on the client's level of preparedness, motivation, and support. As reduction begins, prescriber and client check to ensure the process is tolerable, and the prescriber supports the client in waiting out withdrawal symptoms using non-medication approaches, with the option of increasing back to the previous dosage at any time that the process feels overwhelming or too fast. Clients who have been taking

medications long term may need to consider an even slower rate, such as continuing the reduction every few months or longer, unless side effects are too severe. Often clients have good ideas as to where to begin, such as medications with the most troubling side effects or with those felt as not useful or necessary; the prescriber may also recommend a starting point based on the toxicity indicated by laboratory tests and observed adverse effects. In the case of polypharmacy and redundant medications, a faster taper may be successful since the client has other medications to rely on. Some medications such as for anxiety and sleep can be transitioned to an as-needed basis. Meds with shorter half-lives may be switched to those with longer half-lives, especially in the case of antidepressants. Liquid formulations may make precise control of the dosage easier.

While this slow and tapering approach to reduction and discontinuation is generally advisable and has a growing body of research evidence in support of it, in practical settings this is only a guideline. For example, clinicians and clients sometimes face circumstances where abrupt withdrawal is indicated. Medication toxicity such as liver and kidney problems, signs of tardive dyskinesia, rash associated with lamotrigine, neuroleptic malignancy syndrome, serotonin syndrome, or acute reactions such as heart arrhythmia, suicidality, self-injury, or mania call for either immediate withdrawal or transfer to another medication with a different adverse effect profile. In such instances the risks associated with withdrawal are outweighed by the physical danger posed by medication continuation. Abrupt withdrawal should be cautiously considered, however, as some medications, such as benzodiazepines, can be life-threatening during abrupt discontinuation (Ashton, 2005). Clients may also choose abrupt withdrawal when adverse effects are subjectively experienced as intolerable. In these cases, clinicians should ensure that clients are informed about the possible consequences of abrupt withdrawal, while also acknowledging the motivation and concerns behind it, and any difficulties encountered are treated as a learning process.

As the process is underway, the client will explore and discuss their experience. Key areas of client education include the effectiveness of non-medication symptom management, the way medications work as psychoactive substances, the considerable research uncertainty about the nature of mental illness, the success of others who are able to reduce and go off medications, and the importance of being open to the outcome (Jacobs et al., 1999; Moncreiff, 2005; Vastag, 2001). Not everyone becomes completely medication free; therefore, the goal is improved well-being and the optimal use of medications, not necessarily *no* medications. Expectation of recovery and hope for success are the most crucial ingredients, and should be conveyed by the wellness coach and all providers involved, while emphasizing the need for patience and flexibility.

As the client will be learning to rely on non-medication tools for managing their distressing experiences, the coach makes an inventory of their existing capacities and resources. Understanding early warning signs, using person-directed planning, the Wellness Recovery and Action Plan, and psychiatric advance directives can all be helpful, and the client should be directed to opportunities to discover new wellness resources, understanding that their unique interests determine what role a specific tool may or may not play in their life, rather than imposing one method over another.

Symptom management will have two aspects in the process: the capacity to respond to withdrawal-related symptoms and emotional distress previously suppressed by medications; and the client's attitude toward those symptoms and distress. Physical symptoms such as headaches and flu-like discomfort should be met with reassurances they will usually pass as the

withdrawal and detoxification process continues, while if these symptoms persist or become intolerable, presenting the option of returning to previous levels of medication until the symptoms abate and the reduction process can be resumed, perhaps at a slower pace. Wellness tools will be useful at the earliest signs of increased emotional symptoms, especially sleeplessness and anxiety. Lack of sleep is the single most important symptom to be watchful of, with quick intervention to prevent escalation. Anxiety leading to social and emotional withdrawal is the second most important symptom. The close relationship with the wellness coach is central to addressing these issues successfully.

At the same time, the client facing renewed symptoms of distress may need to learn that these are not indicators of the return of a disease process that must be medicated, but may be met on their own terms as human experiences like any other. Clients whose emotions have been limited by medications may not be familiar with the ups and downs of life from a non-pathologizing standpoint, and therefore be too quick to judge renewed fear, sadness, anger, or elation as signs of returning illness. The unique sensitivities and expression of the individual's personality should be supported, rather than assuming that what is "normal" is to be "asymptomatic" at all times.

Recurrence of emotional distress and physical withdrawal symptoms should be weighed carefully, to strike a balance between challenging and overwhelming the client. Where the process goes too fast or risks becoming unmanageable by the clients' personal resources, options such as resuming previous dosages should be considered, but only with the opportunity presented to learn and discover new ways of coping. This gradual transition to non-medication approaches requires patience and openness to meeting the client where they are at each step of the way.

If hospitalization is an option in the face of distress, a liaison with hospital staff should be created so that medication protocols while the client is an inpatient complement the continued overall reduction process, rather than just returning to or raising the levels of medication prior to the start. Any crisis should be considered transitory and part of a long-term learning process, rather than a failure and indication that the process cannot continue. Hospitalization is not a surrender of autonomy but presents opportunities for the client and their coach to be engaged with decisions and options on how to best serve the client's needs.

WHEN DISCONTINUATION IS NOT INDICATED

Unfortunately, some individuals prove to need medication long term, and quickly experience recurrences and relapses when off medications, even after a long-term and gradual reduction. It is indeed unfortunate that often there is a sort of Hobson's choice between mental health and side effects for some folks. All of our treatments, despite our best intentions, do not always work. Many individuals cannot tolerate the side effects of effective medications, or may get only limited benefits from tolerable medications. A good client-provider relationship can help you to continually assess whether medications are effective and tolerable, or if adjustments are required. These continuous assessments and adjustments are best and most safely done when alternative supports are present as well. In such cases, the road to recovery may be long and difficult. The following vignettes demonstrate examples of when medications should be continued if possible, even when clients are ambivalent at best about their usefulness.

CASE VIGNETTE 3

Lee was a 19-year-old male who was mandated to mental health treatment after assaulting his 14-year-old brother in the middle of the night while the boy was sleeping. Prior to this incident, Lee had other episodes of violence at home, including yelling at other family members, causing property damage to the home and vehicles, and attempting to hit his parents. He also often threw away food from the refrigerator, claiming it was poisoned. His violence was often associated with alcohol or marijuana use, but not always.

He began working with an intensive outreach and support team, who helped him obtain partial sobriety. While his violent behavior stopped during his two- to six-week periods of sobriety, he continued to display paranoia, throwing away food and bathroom products and accusing neighbors of persecuting his family due to their non-citizen status. He also remained isolated from his family and friends. He reluctantly began taking fish oil on the recommendation of his psychiatrist, as he refused medications, and continued to be partially adherent with this treatment for four months. When his paranoia and isolation did not improve, he agreed to try a low dose of antipsychotic. His partial adherence improved, mostly due to the efforts of his mother, resulting in decreased symptoms. He recognized the medication was somewhat helpful, and accepted a higher dose. This higher dose resulted in his paranoia's ending. He became more social with his family, and began attending substance-abuse treatment groups (while he started these due to a court requirement, he eventually came to look forward to these groups). As of this writing, he remains mostly adherent with medication, sometimes not refilling his supply for two to seven days. He recognizes that he has more difficulties thinking and interacting with others when off medication, and hopes to stay on it.

Many people, especially younger folks experiencing a first episode of psychosis, have little awareness about how their thoughts and behaviors are flawed or unreliable. As such, it may be difficult for them to view themselves as having a condition that needs treatment. In addition, confounding factors, especially substance use, may make it difficult to clarify if a mental disorder diagnosis is indeed warranted (and if medication use would thus be appropriate). In such cases, if no acute danger is present, it is best to take time to tease out these other factors, to ensure any suggested medication use is appropriate. If so, a slow introduction of medication in an environment of multiple supports helps improve long-term adherence and long-term life success for the individual.

CASE VIGNETTE 4

John was a 20-year-old male training to be a mixed martial arts fighter who came to the clinic at his parents' request. He was barely able to tolerate an interview, frequently getting up to show martial arts moves or quote from his Eastern philosophy texts. He initially refused medications, seeing no need for them. However, at his parents' urging, he agreed to take them, explaining that his body and will

were so strong no medications could contain them. He intermittently took medications over the next month, and was hospitalized after he was removed from his college campus by security staff for agitation. He stabilized after 10 days of medication use, but quickly became significantly depressed. He responded well to the addition of an antidepressant, and gained insight into his recent manic behavior. He viewed this mania (and subsequent depression) as a factor of his martial arts training's raising his energy level too high, and stopped medications three months later, agreeing to restart them if asked. However, when he had recurrent mania six months later, he deferred on medications when they were encouraged by his psychiatrist. He was hospitalized two weeks later, stabilizing quickly again and becoming depressed shortly thereafter. His depression responded again to the addition of an antidepressant; however, he became hypomanic when he started taking an herbal weight loss supplement as part of his training. His supplement was stopped, and his mood stabilizer changed due to side effects of weight gain and sedation. He did well for eight months, eventually having recurrent mania despite medication adherence. A change in mood stabilizers and addition of low-dose antidepressants resulted in a stable mood, which has been stable for seven months as of this writing. He currently is working part-time, slowly reintegrating with friends, and contemplating a return to school. However, his confidence is shaken by the events of the past few years, and he remains unsure of how to proceed in his life.

Except when the individual is legally mandated to treatment, each person must decide if medications are an option they wish to use in their recovery, and if their use is a primary element of their recovery plan or a secondary adjunct to other options. However, as mental illnesses can sometimes affect one's judgment, some individuals may not recognize the benefits they gain from the use of medication. Similarly, sometimes medication can itself limit the capacity of the individual to recognize adverse effects. In such cases, a good client-provider relationship is helpful in helping the person gain understanding and better consider these benefits and risks.

APPENDIX: MEDICATIONS AND RECOVERY

RECOVERY-ORIENTED PSYCHIATRIC PRACTICE GUIDELINES

In 2010, a group of psychiatrists met to propose a recovery-oriented approach to provision of psychiatric medication:

- 1a. The development of a therapeutic alliance is essential for both informed choice and for more successful reduction of medication. This relationship between prescriber and consumer is enhanced by a "wellness coach" (Swarbrick et al., 2011) and is based on all parties' subscribing to four basic ground rules of engaging in dialogue (as have been tested in business: Isaacs, 1999):

- a. Listening together: giving equal consideration to all sides of the conversation (these principles are vital to effective networking meetings)
 - b. Respecting differences: building a positive, respectful relationship between the psychiatrist and the consumer is essential
 - c. Suspension of belief: it is particularly important that both parties be able to suspend any dogmatic beliefs of either extreme—that medications are always required for recovery, or that medications always interfere with recovery
 - d. Authentic voicing: the consumer should be encouraged to voice their true opinion about their medication
- 1b. Mental health consumers have the right of informed choice and shared decision making with regard to their medication
 - 2a. Their psychiatrist and wellness coach should inform them and their immediate significant supports of the benefits and risks of medications, as well as non-medication alternatives that have been helpful for other persons with their mental health issues.
 - 2b. Part of the education should involve informing the consumer of person-directed recovery planning, WRAP, and advance directives.
 - 2c. The person should also learn that many of the symptoms such as insomnia and anxiety are often the expression of the withdrawal process or due to the normal ups and downs of life.
 3. Based on this information and consumers' own reactions to the medications, they have the right to choose which medication(s) to take, how much to take, when to take it, whether to stop taking it, and how to stop taking medication.
 4. Informed choice is renegotiated at each meeting between consumer and their psychiatrist and wellness coach on each visit.
 5. If a consumer chooses to discontinue their medication, we recommend that the decision be collaborative, enabling the consumer to remain in treatment during the period of withdrawal.
 6. Maintaining a relationship between the psychiatrist and the consumer is an important element in responsible tapering-off of medication.
 7. Power shared in ways that encourage the autonomy of the consumer; the concept of collaboration be reinforced by the psychiatrist having power together in the relationship, and this relationship be mirrored in relationship between the person and their pills. A psychiatrist using this collaborative approach might prescribe a pill and say, "This pill will not cure you, but you can collaborate with it so that you can take increasing control of your life."

We recommend that consumer choice to stop a medication be respected that they and their prescriber and team of mental health caregivers follow these guidelines:

- a. Taper medications carefully and very gradually.
- b. Be aware that every psychotropic medication may be associated with withdrawal reactions, which should be necessarily discussed but not be mistaken for relapse.
- c. Agree that mental distress is best approached holistically, such that attention is paid to the bio-psycho-socio-spiritual dimensions of living and recovery.

- d. Support social well-being by helping develop a personal network of supportive people who are understanding of recovery plans and supportive of the individual consumer.
- e. Attend to psychological well-being by encouraging, learning, and practicing self-soothing and stress-reduction skills such as meditation and affirmations.
- f. Attend to physical well-being by having a healthy diet, engaging in regular exercise, and getting sufficient sleep.
- g. Spiritual dimensions, involving finding meaning and purpose in life, are supported and encouraged.
- h. Be trauma-informed by maximizing connections and empowerment while minimizing unnecessary life stresses and trauma. Develop a positive working relationship with a nearby hospital, clinic, and/or respite center so they can continue the appropriate medication regime and plan for medication optimization when a consumer is using their services.

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SUPPORTED HOUSING, SOCIALIZATION, EDUCATION, AND EMPLOYMENT

MARGARET A. SWARBRICK AND ROBERT E. DRAKE

As the President's New Freedom Commission (2003) emphasized, recovery entails living, learning, working, and participating fully in one's community. This chapter addresses four approaches to helping people achieve these important outcomes: supported housing, supported socialization, supported education, and supported employment. These interventions share common theoretical and practical orientations. Each assumes that people know themselves and their personal recovery goals, have personal strengths, and can make use of professional as well as natural supports to live be successful in community environments of their choice. Each starts with the person's phenomenology: How do they see themselves, their situations, their needs, and their goals? Each approach assumes that people have strengths that can be identified, reinforced, and enhanced rather than deficits that must be corrected, or problems to be solved. Each assumes that people can take control of their own lives and recoveries more easily if they have access to relevant information and choices, and opportunities to learn, practice, and take risks. Each entails direct access to valued adult roles rather than stepwise training approaches. Each assumes that integrated, natural settings are preferable to segregated settings (i.e., only other people living with disabilities). Each empowers the consumer or client as *the central* member of a multi-disciplinary team. Finally, each relies on natural supports of the person's choice as well as professional supports.

We begin with a vignette to illustrate how these interventions can be combined and individually tailored. We then describe each intervention, including principles, details, research, and training. Finally, we discuss the commonalities of these approaches.

A YOUNG MAN WITH PSYCHOSIS AND DRUG ADDICTION

Manuel R. was a 23-year-old man when he came to the mental health center. He began struggling with drug use and intermittent psychotic episodes during his freshman year of college and flunked out of school the following year. Afterward, he had numerous admissions to psychiatric hospitals and addiction treatment centers, was unable to hold a job, and experienced increasing acrimony with his parents and siblings. A public altercation eventually led to his arrest and conviction on assault charges.

When he joined a multidisciplinary dual diagnosis team, Manuel was experiencing paranoia, cravings, and severe regrets regarding his school and work failures and the problems he had caused his family. His goals were to live independently, to repair relationships with his family, and to return to school and work. He initially entered a residential dual-diagnosis facility for three months, in which he became stabilized on lithium plus an antipsychotic medication, learned to manage his paranoia and cravings in cognitive-behavioral sessions, received education about his dual disorders, bonded with other young men in the residence, and began to attend Alcoholics Anonymous meetings each evening in the community with mentors (experienced AA members who were hired to help others learn about and join AA). He also applied to take one course at a local community college.

As Manuel transitioned to an apartment in the community, the dual diagnosis team helped him set up his apartment, learn to use public transportation, and enroll at the community college. They also continued to support him and his peers in attending AA meetings. When Manuel completed his first college course in accounting, with help planning his homework schedule from the team, he enrolled in another course and also began looking for a job. The team helped him find a part-time job as a bookkeeping assistant. Weekly telephone meetings with Manuel's family resulted in respectful communications and clear agreements about responsibilities. He feels that they understand his illnesses better, and they feel that they are taking care of their own needs as well as helping Manuel.

Manuel believes that his quality of life is immensely improved. He has an apartment, a job, several friends in AA, a better relationship with his family, and confidence about completing his college education. The team checks with Manuel bi-weekly and provides supports, but his needs are less each month as he begins to rely more on his friends and his own capacity to manage his life.

Manuel's story illustrates how supported housing, employment, education, and socialization are woven together and highly individualized by the same team. We next describe each intervention separately.

SUPPORTED HOUSING

Supported housing combines supports for independent housing with flexible mental health interventions and other services (Rog, 2004; Tabol, Drebing, & Rosenheck, 2010; see <http://www.socwel.ku.edu/mentalhealth/projects/promising/supporthousing.shtml>). It can be located in different living settings, including self-contained accommodations with professional services on site (at least during office hours) and scattered-site arrangements with regular visits by a support team.

Supported housing emphasizes several principles:

- client-centeredness—the consumer’s values, goals, and preferences
- housing choice—type, housemates, supports
- tenancy—lease held by the consumer
- integrated community-living settings—not segregated enclaves
- affordable decent housing—professionals may help to locate
- permanence—do not have to move on once completing a program
- education regarding rights—tenant role rather than consumer/patient role
- separate housing supports—not linked with other services
- personal preferences—use of mental health treatment and other services
- agency oversight—many tasks related to housing
- services in the community—not in mental health settings

Teams of all kinds (assertive community treatment, intensive case management, community support, housing teams, and so on) can deliver supported housing. Members typically have expertise, not only on housing issues, but also in regard to benefits, mental health, addictions, employment, and other resources and services that may be useful or relevant. Services are usually available 24 hours a day, seven days a week. Much of the team’s work entails basic support: acquiring furniture, shopping for groceries, making and keeping healthcare appointments, obtaining public benefits, paying bills, preparing meals, keeping a clean and safe home, and so forth.

People with limited education can deliver basic housing supports. Social workers are usually involved in coordination, counseling, and supervisory roles. People with specialized training may be needed to provide skills teaching, addiction counseling, peer advocacy, supported employment, or other interventions. A person with a graduate degree in some area of mental health usually leads the team. These teams may serve one or more specific populations, requiring specialized team training or skills. Examples include teams serving people with co-occurring mental health and intellectual disabilities, people with significant physical health issues, or people who are raising children.

Many supported housing programs deviate from the basic model (Tabol, Drebing, & Rosenheck, 2010). Alterations may involve required treatment, required financial management, multiple units in the same building, or shared living of some kind. Some programs diverge so far from the model that they are called “supportive housing” rather than “supported housing.” The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes permanent supportive housing; see http://store.samhsa.gov/product/SMA10-4510?WT.ac=AD20100918HP_SMA10-4510.

Research on Housing First and other models of supported housing has shown positive outcomes in terms of maintaining residence, especially for people who have experienced homelessness (Tsemberis, Gulcur, & Nakae, 2004; McHugo et al., 2004). In addition to housing supports and mental health services, successful models usually emphasize harm reduction rather than immediate sobriety, also client choice, personal recovery goals, and financial services to ensure rental payments.

Dependence is a central challenge with supported housing. People easily become accustomed to having extensive assistance, and staff may also find it easier to do tasks for people than to teach them the skills they need to take care of themselves.

SUPPORTED EMPLOYMENT

Supported employment is an approach to vocational rehabilitation that helps people with psychiatric disabilities attain and succeed in competitive jobs (Becker & Drake, 2003). The Individual Placement and Support (IPS) model of supported employment (see www.dartmouth.edu/~ips) is the only nationally and internationally recognized evidence-based approach to vocational rehabilitation for this population.

Several principles define IPS:

- zero exclusion—all clients who want employment are eligible
- competitive employment—client's goal
- client choice—all aspects of selecting, finding, and maintaining employment
- job development—professional approach
- rapid job search—training on the job rather than prior to employment
- service integration—vocational plus housing, mental health, addiction, physical health
- follow-along supports—as long as needed

In IPS, employment specialists help with all phases of vocational services: assessing, planning, developing, acquiring, mastering, retaining, and changing jobs. An employment specialist typically works with 18 to 20 clients at a time. The client makes all decisions; e.g., choosing a type of job, how to find the job, how many hours to work, disclosure of their status, types of support, and so on, through a process of shared decision-making, in which the employment specialist provides information and options.

IPS supported employment is a team-based model. The employment specialist joins one or more multidisciplinary teams: case management, assertive community treatment, intensive case management, supported housing, or other types of teams. Rather than providing the vocational services alone, the employment specialist galvanizes the team to consider work as an essential part of recovery, one needing everyone's attention. The doctor may need to reassure the client that he or she can work and may need to adjust medications to reduce side effects. The social worker may need to educate the family about Social Security rules regarding insurance and income support when people are working. The therapist may need to help the client learn coping skills to manage anxiety on the job. The case manager may need to help the client learn to use public transportation to and from work. The addiction counselor may need to make sure the workplace supports abstinence (e.g., does not serve alcohol).

The entire team is involved in helping the client select a good job match and sometimes in finding a job also. As an example, consider a young man, Albert, who had never worked and was anxious and fearful around people. The team helped Albert identify his interests and strengths in taking care of animals. All members of the team thought of their own contacts with pet stores, farms, veterinary clinics, pet owners, and so on, to identify potential employers. Each team member made contacts to help develop a part-time job. Within a month, Albert had three job offers. He chose a job on weekends taking care of recovering animals at a veterinary clinic. The employment specialist visited him regularly at work. Albert gradually expanded his time to weekday evenings, gained confidence in his ability to do a good job, and made friends with other employees at the veterinary clinic.

People with a variety of backgrounds—business, vocational services, mental health, lived experience—can become employment specialists. They can learn basic IPS skills via an online course (at www.dartmouth.edu/~ips/page26/page26.html) and can develop their skills through the mentoring of an IPS supervisor. Books, training courses, videos, training, and fidelity tools are available: see www.dartmouth.edu/~ips.

IPS has been developed and refined for over 20 years, based on continuous research. The model has a clear procedural manual, a fidelity scale, and defined training procedures (Swanson & Becker, 2010). In some states, reimbursement, licensing, or accreditation is tied to fidelity. IPS is widely used in several American states, several European countries, Canada, and Australia.

Extensive research on IPS includes 16 randomized controlled trials and numerous other studies around the world. Recent summaries of the research (Drake & Bond, 2011; Bond, Drake, & Becker, in press) show that about two-thirds of clients who enroll in IPS achieve competitive employment within 12 to 18 months. The rate is slightly higher in North American countries than in other countries, possibly due to different workforce, economic, and regulatory factors. Long-term follow-ups show that clients tend to remain employed and be steady workers for at least 10 years. When working, clients tend to improve in terms of self-esteem, quality of life, and symptom control. Current research aims at improving outcomes for the one-third of clients who are not benefiting from standard IPS; for example, by providing compensatory cognitive strategies or cognitive training.

Federal disability benefits from Social Security can be discontinued proportionately or stopped suddenly when people return to work. Health insurance can also be tied to disability status. In addition, many states tie public benefits and rents to earned income. Despite some of the challenges people may face returning to work being employed is a key to helping people to realize their full potential and helping them to be contributing members of their community and society.

SUPPORTED EDUCATION

Supported education assists people with psychiatric disabilities in pursuing academic goals in integrated post-secondary schools (Anthony & Unger, 1991). Services are individualized and flexible with an emphasis on student choice, self-determination, and career development. People are helped to manage post-secondary education, to achieve their academic goals, and to gain meaningful employment. Supports are highly variable but might encompass applying to school, gaining financial support, planning classes, negotiating with teachers, completing assignments,

managing test anxiety, controlling symptoms, compensating for cognitive problems, and learning how to cope socially in an academic environment. Though most colleges offer disability services, students with psychiatric disabilities are often reluctant to access traditional disability services due to fears regarding disclosure (Collins & Mowbray, 2005).

Principles of supported education include:

- client choice—educational goals and services
- educational assessment—informs individually tailored educational plan
- career counseling—education linked with employment
- coping skills—for managing stress and symptoms
- access school resources—enrollment, financial aid, and campus resources
- time management skills—homework, papers, preparing for tests

Supported education has not been standardized by research in the same way as supported employment. Thus, models vary widely in terms of where students attend classes, where they receive supports, what types of supports are available, who provides the supports, the amount of supports, and the linkage with mental health services. For example, supports may be delivered in the classroom, at the school, at a clinic, or in one's residence. Several manuals on different approaches to supported education are available, and different groups are also working on fidelity measures. Until the basic approach is standardized and empirically validated, however, these efforts may be premature.

Supported education is sometimes offered by individual practitioners but at other times as part of a team-based approach. Many newly developed supported education services are operating in a team environment to ensure students have seamless services. The mobile team works with students in different educational settings or modes (local community college, local full-scale college or university, vocational-technical school, and home learners studying via distance learning). The current worldwide emphasis on early intervention involves working with younger people, many of whom have had their education threatened or interrupted by the early phases of mental health problems. Early-episode teams are typically multidisciplinary and include a specialist in supported education and employment (Nuechterlein et al., 2008; Rudnick & Gover, 2009). The team works together to prevent further episodes of illness and disability. Clients often pursue a mixture of education and employment, and usually the same person provides both services.

The skills and training needed to provide supported education are unclear. Experience suggests that supported education practitioners should complete some sort of formal educational or vocational training program, but in reality practitioners come from many backgrounds. Understanding psychiatric rehabilitation principles might also assist practitioners in the areas of situational assessments, direct skills teaching, resource planning, supportive counseling, and using natural supports. An important role of a supported education practitioner is to establish and maintain ongoing relationships between the supported education program and educational institutions in the community (e.g., the school's offices of disability services, admissions, and financial aid).

Supported education so far lacks rigorous research, but non-experimental studies show reasonable rates of enrollment, completion of classes, and obtaining degrees (Unger et al., 2000; Goulding, Chien, & Compton, 2010; Best, Still, & Cameron, 2008). A large, randomized controlled study is underway now, conducted by investigators at Temple University and the University of Medicine and Dentistry of New Jersey, School of Health Related Professions Department of Psychiatric Rehabilitation and Counseling Professions.

Supported education may be even more vulnerable than supported employment to funding difficulties. The current financial climate emphasizes “medical necessity” rather than people’s desires to be functional citizens.

SUPPORTED SOCIALIZATION

Supported socialization, though seemingly a natural analogue of supported housing, employment, and education, has neither a consistent definition nor a consistent methodology. People with mental health problems often report loneliness, isolation, and a desire for friendships. Traditional approaches to improving social connections involve social skills training, group activities within mental health programs, clubhouses, and peer support programs. But these efforts may not transfer to new relationships outside of the mental health system.

Supported socialization aims to help people develop and sustain relationships in the community, apart from the mental health system. It emphasizes the concept of community integration rather than mental health segregation. Supported socialization involves a direct effort to help people participate in natural social, organizational, and recreational activities in the community (Davidson et al., 2004). Thus, social experiences and training groups within a day treatment center would not qualify as supported socialization; helping a participant to join a church, a softball team, or a stamp collecting group in the community would be considered supported socialization.

Other aims are often added to the concept of supported socialization; for example, to enhance the depth and quality of relationships (Davidson et al., 2004) or to facilitate exchanges of tangible goods and problem-solving opportunities (Wong, Matejkowski, & Lee, 2011). But these extensions of the concept often revert to traditional mental health efforts to change people rather than to help them find satisfying friendships and social niches in the community.

Emerging principles of supported socialization might include the following:

- highly individualized—based on personal interests, preferences, and goals
- building on strengths—rather than changing personality or skills
- relationships in the community—not in the mental health system
- community opportunities—consider many potential activities
- supports as needed—types, amounts, and durations

No consensus exists on how supported socialization should be delivered. In theory, lay-people, peers, or professionals could deliver supported socialization. Several programs partner community volunteers with mental health consumers to develop permanent supportive friendships. A small team might include a community volunteer and a mental health or rehabilitation professional to oversee the process (McCorkle, et al 2008). Alternatively, teams involved in other interventions, such as assertive community treatment teams, supported employment teams, or supported housing teams, could also provide supported socialization.

The process and skills for delivering supported socialization are also unclear. Discussions and guides on topics as varied as leisure, parenting, dating, and intimacy are widely available (see, e.g., www.tucollaborative.org). The following vignette illustrates a possible process and suggests relevant skills.

John lives alone and complains of loneliness. He currently stays mostly in his apartment but wants to socialize more. He has revealed that he used to bowl and enjoyed the social aspects of bowling. A supported socialization intervention for John might be a stepwise process like the following:

- John and a staff member go bowling together.
- The staff member helps John examine the bulletin boards at the bowling alley for a bowling team or league that he might join.
- The staff member meets with John to address practical issues (e.g., transportation and buying or renting bowling shoes) and to discuss strategies for managing his anxiety about bowling on a team with unfamiliar people.
- The staff member accompanies John during his first league night, observing from a distance and available to help if needed.
- John goes bowling on a next league night without the staff member, who is available by cell phone.
- The staff member meets with John monthly to solve problems until John feels comfortable that he is making friends on the team.

Little research exists on supported socialization. Because many clients reject or fail to benefit from other approaches to finding desired social relationships, supported socialization models need to be constructed, piloted, refined, measured, and tested. To be consistent with other supported approaches, supported socialization should emphasize natural social settings in the community rather than relationships that are paid for by the mental health system.

DISCUSSION AND CONCLUSIONS

People with mental health difficulties identify functional goals such as independent housing, education, employment, and friends as essential to the recovery process. Supported approaches to helping them to achieve these goals share several features. They begin with the consumer's perception of needs, goals, and preferences. They offer consumers choices in terms of pathways, timing, steps, and types of supports. They aim directly and rapidly at integrating in one's community and using natural supports. They encourage independence from the mental health system.

People from many different backgrounds, including people in recovery, can deliver supported services. To ensure that different types of supports are combined, individually tailored, and linked with other services, team-based approaches are usually optimal. The consumer is always the central member of the team as the director of services. The variety of supported service models usefully informs the recovery vision and outcomes.

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RECOVERY AND COMMUNITY MENTAL HEALTH

MARK RAGINS AND DAVID A. POLLACK

This chapter is intended to introduce and clarify the concept of recovery, the revolutionary qualities of the recovery movement, the what and how of recovery-oriented services, and how mental health organizations can and should transform to become compatible with recovery principles. The recovery movement has emerged with much energy and enthusiasm in community-based mental health programs throughout the United States and around the world. Recovery brings hopeful, value-based transformational concepts and practical skills to effectively serve people who have been difficult to serve and whose experience with the treatment system has left them frustrated, demoralized, and alienated.

The following case description, which is interspersed throughout the chapter, will be used to demonstrate key points about these challenges and the various responses to them.

CASE EXAMPLE

Robert served in the army in Korea, but long after the fighting was done. He mainly remembered using drugs sold to him by his sergeant. When he left the military, he was lost, confused, isolated, using drugs, and increasingly wrapped up in a religious guilt feeling that God was punishing him. He wandered the country and became suicidal. He went to a Midwestern Veterans Administration hospital for help, but was locked in a barren ward, deprived of any means to hurt himself. After two weeks, he promised not to kill himself, so they let him out. He hated the experience and never returned to the VA for any services or benefits.

He spent the next decade traveling around, doing odd jobs and learning some construction skills. Occasionally homeless, he often lived in hotels or shelters as he moved about. He never held a steady job or an apartment of his own, and had no long-term relationships or connections with his family.

Then a terrifying thing happened. He fell asleep on a bus and two undercover military agents sat behind him and implanted a receptor in his head so they could transmit satellite messages to him. These messages were very disturbing and crazy-making, telling him to kill himself or hurt other people, especially black people. When he saw a newspaper report that his old sergeant had been made a general, it all made sense to him. He was being discredited so he could never testify against his old sergeant.

He went to hospitals to get X-rays to find the implant and remove it, but instead was told he was crazy. He was given medications that confused him. He felt unable to “fight the machine.” He struggled mightily against these messages, but sometimes did attack people. He developed headaches, severe anxiety, and insomnia. He learned that alcohol calmed him and helped him sleep, but also dulled his mind and reduced his vigilance. Speed seemed to work better, because it helped him think fast enough to outsmart the machine, but then the headaches, insomnia, and anxiety returned. He isolated himself to avoid hurting anyone, and ended up living under a bridge.

Our discussion begins by comparing and contrasting the two most common mental health treatment models—the medical model and the rehabilitation model—with the recovery model.

The *medical model* is predicated on the notion of diagnosing psychiatric illnesses, treating their symptoms, and helping persons with these conditions return to health and more productive and meaningful lives. However, it is a paradigm that fails to address some concerns for persons with mental illnesses. Many people with mental illnesses do not agree that they have an illness, at least not in the way it is defined by the medical model, and they are often difficult to engage in treatment. Even with excellent treatment, many do not experience sufficient symptom relief from treatment alone to feel healthy enough to return to life. After most symptoms are relieved, many continue to have substantial disabilities from other factors (e.g., trauma and loss, personality issues, low intelligence, poor relationship skills, poverty, lack of education, social ostracism), not to mention the immediate and longer-term impacts of involuntary and coerced treatment interventions. This leads many to seek additional, often equally insufficient, medical treatments and/or to give up on the mental health system entirely.

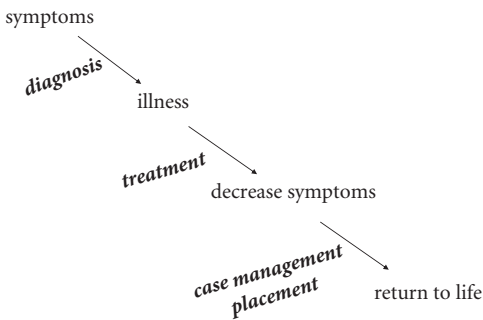


Figure 26.1 Medical Model

ROBERT'S MEDICAL MODEL SCENARIO

Robert was hospitalized and was diagnosed with a co-occurring mental illness and addiction disorder. The hospital staff explained to him in a compassionate, psychoeducational manner that there wasn't any machine. They explained that he had a chemical imbalance in his brain, probably exacerbated by substance use. The brain disorder was causing his mind to misperceive reality, and the "machine" was a delusion. The good news was that medications could restore his brain's chemical imbalance so he wouldn't be delusional anymore.

Unfortunately, Robert refused to believe this explanatory model, even though the staff were kind and compassionate. He refused the medications and never went to the outpatient clinic they referred him to. Since Robert lacked insight and was struggling to meet his basic needs, he was repeatedly hospitalized on an involuntarily basis and forcibly medicated. When not hospitalized and removed from society for his protection and public safety, he would often return to a life of alienation, homelessness, loneliness, and little hope of returning to a productive life.

The *rehabilitation model* focuses more on functioning than on symptoms. A functional assessment leads to training to reduce deficits and build strengths. When persons are sufficiently supported and perceived as likely to succeed, they are assisted in using their new and restored skills to return to life. However, this model also fails for a significant number of people. It is almost always used sequentially with the medical model, based on the presumption that symptoms must be treated and stabilized before skills training and support efforts would be effective. If symptoms cannot be controlled, such people are often deemed not ready for rehabilitation. This vulnerability is being actively addressed with various supportive rehabilitation techniques (e.g., supported employment, housing, education). The need for symptom control is not necessarily a prerequisite for effective functioning, but our system often reflects social stigma and rejection by not giving people with overt symptoms a chance to build functioning. The rehabilitation model depends on sufficient opportunity: that if someone has job skills, there is a job available, or if someone is able

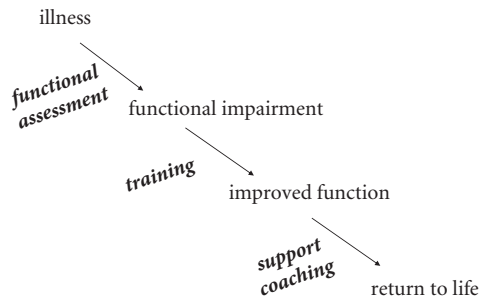


Figure 26.2 Rehabilitation Model

to live independently, there is an affordable apartment available. To be effective, rehabilitation has to be supplemented by community development to build such opportunities.

ROBERT'S REHABILITATION SCENARIO

After he was discharged from the hospital, the outpatient rehabilitation program staff told Robert that they would help him with supportive housing and employment after he was stabilized. When he became compliant with medications (by taking medications) and maintained sobriety (by completing a drug treatment program), he would be ready for rehabilitation. Alternatively, if he felt that such an approach was too difficult, they would help him get on Social Security disability. They would then offer him housing and services in a residential program where he would receive the treatment, structure, and supervision that he needed until he could again function safely and independently. When offered these choices, he refused all services and eventually wandered off and out of contact with the treatment program.

The recovery model emphasizes changes that persons make in and for themselves. When people first come for services, they often feel their illness has swallowed them up. They have struggled to overcome it on their own for quite a while, but with little success. They have experienced substantial loss, destruction, and rejection, as well as self-doubt. They often feel crippled by the illness and their life is a constant all-consuming struggle. Recovery engages the part of the person that is struggling, that may still have hopes and dreams, and aligns with that part. The recovery approach helps by decreasing the impact of the illness and by restoring or expanding the rest of the person's life. Recovery requires building meaningful roles in life.

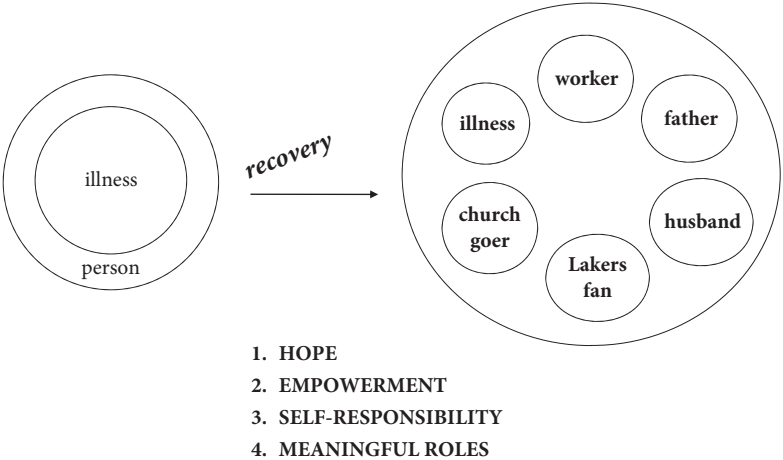


Figure 26.3 Recovery Model

ROBERT'S RECOVERY SCENARIO

The staff guided Robert toward recovery step by step. They helped him rebuild hope by having him work with an outreach worker who used to be homeless and hopeless himself. "If I could make it, so can you." They helped him create an image of a better future dealing with the "implant" and other frightening thoughts and to get back to work. They helped to empower him and build up his belief in himself. They gave him self-help coping tools, including medications he could manage and administer himself. They insisted on his taking responsibility for not hurting anyone, no matter what the "satellite" or other entities would tell him. They invited him to contribute to their program in meaningful ways, making lunches for homeless people and earning money to pay rent. As he struggled to rebuild, they stuck with him to find ways to overcome the barriers that emerged.

Recovery is both a destination and a journey. Meaningful goals mark progress along the way:

1. Functions may be recovered—the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
2. External things may be recovered—an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, a TV, educational programs, etc.
3. Internal states can be recovered—feeling good about oneself, satisfaction, self-confidence, spiritual peace, self-responsibility, a sense of identity other than as a mentally ill person, etc.

The journey of recovery is a very personal process. In the same way that Elizabeth Kübler-Ross described a set of stages that people go through as they struggle with impending death, Mark Ragins described a set of stages (hope, empowerment, self responsibility, and achieving meaningful roles) that people go through as they struggle to overcome serious mental illnesses (Ragins, 2002). Even as hospice has been developed to assist people in their journey to die with dignity, mental health is developing recovery-based programs to assist people in their journeys to live with dignity.

We will return to Robert and more details of what happened to him, later in the chapter.

THE RECOVERY REVOLUTION

In his book *The Structure of Scientific Revolutions*, Thomas Kuhn describes the process of revolutionary change in science as resulting from the failure of a dominant paradigm to explain or address the issues for which it was originally intended. A scientific revolution is a "non-cumulative developmental episode in which an older paradigm is replaced in whole or in part by an incompatible new one." Such a change is analogous to a political revolution.

The conditions that have led to the current "revolution" to transform the mental health system to accommodate the notion of recovery clearly match those described by Kuhn. Persons

who had been recipients of mental health services came to feel that they were not getting better, would complain that their needs were frustrated or unmet, and often felt harmed by the system that was allegedly there to help them. They also went in and out of the system (or avoided it because of the negative experiences they had grown accustomed to) into other niches of society that were neither prepared for nor able to deal with them, reflecting the failure of the mental health system; for example, jails and prisons, safety-net health clinics, or the streets. As more persons with lived experiences in the mental health system shared their stories with peers and members of their social and support networks, a growing sense emerged that things had to change and that alternative approaches must be developed (Davidson et al., 2010; Spaniol & Koehler, 1994; Warner, 1985; Becker & Drake 2003).

Over the past 20 to 30 years, the recovery movement has progressed from being an outsider revolutionary movement to being an insider reform movement. This has been a difficult personal and tactical progression for many people in the movement. Angry advocacy is easier and more immediately satisfying than collaborative compromise. Criticizing is easier than constructive collaboration. Nonetheless, the shift is occurring, supported by a growing army of consumers, advocates, clinicians, policy makers, and influential community members. As the recovery movement has progressed, new challenges and applications have emerged. The full implications and impact of recovery are ahead of us.

Malcolm Gladwell, in *The Tipping Point* (2000), has hypothesized that a number of factors are essential for revolutionary ideas to become fully realized. These include:

1. **The Power of Context:** This is the realization that maintaining the status quo or incremental change is unsustainable and will fail, leading to system collapse and much worse outcomes. The evidence is mounting that the current paradigm is failing:
 - Many persons do not get better with traditional medical or rehab treatment approaches.
 - Many have become alienated from the mental health system and its coercive and sometimes harmful interventions.
 - For many who remain in the mental health system, the illness has become their identity and their lives are filled with hopelessness and passivity.
 - Unrecognized trauma has emerged as a major issue, but the system often fails to help without triggering old traumatic feelings or creating new ones.
 - The mental health system fails to recognize that many persons have significant strengths, want to take on more self-responsibility, and want to go on with their lives in the “real world.”
 - Budgets for mental health services have been slashed and often disproportionately allocated to more intense forms of treatment.
 - The lack of meaningful community support contributes to more trans-institutionalization of persons with mental illnesses into the criminal justice system.
 - The lack of a welcoming and caring system results in horror stories about persons with mental illness behaving in violent ways in the popular press (even though they are much more often the victims of various forms of brutal behavior), leading to more stigma and demands that we “lock up the mentally ill.”

When these failures of the usual care become more widely observed, the system is undeniably destabilized, and a new paradigm must emerge.

2. **The Power of the Few:** This entails developing and supporting connectors, mavens, and salesmen. Passionate and assertive champions who advocate for change make such changes happen. The primary instigators of the recovery movement have come from the consumer/survivor movement. These are people who describe themselves as having survived not only their mental illnesses, but also the traditional treatment for those illnesses. They angrily and painfully describe traumatic experiences associated with coerced treatment, institutionalization, restraints, and excessive medications, as well as social ostracism, stigma, and isolation. They actively promote system transformation through real consumer inclusion—"nothing about us without us," including choice, empowerment, increased opportunities, decreased stigma, and direct participation in all aspects of the mental health system. Over time, the recovery movement has found champions scattered throughout the field, including the 12-Step recovery movement, rehabilitation professionals, civil rights advocates, staff "doing whatever it takes" with challenging populations like homeless people, transitional-age youth, and minority cultures, and spiritually based treatment providers. Many mental health professionals have found recovery practice a return to their core personal and professional values. Many have been doing recovery-oriented practice already, although sometimes "in the closet."
3. **The "Stickiness" Factor:** This means compelling ideas presented in unconventional and unexpected ways and contrary to conventional wisdom. Approaches that attract attention and interest, that are "sticky," involve imagining a dramatically new vision of what we do and how we do it. Our system has incorporated a pervasive view that serious mental illnesses are chronic and deteriorating. The default position is that most people with serious mental illnesses have impaired insight, poor judgment, lack of self-responsibility, and overall inability to function effectively in society. This view stresses stabilization of symptoms, which leads to controlling and coercive interventions, lifelong social isolation, and dependency.

Two sets of data sharply challenge this "default" position: First, longitudinal outcome studies of persons with schizophrenia have shown that many have been able to substantially recover. (7,8,9). Second, there is an overwhelming number and variety of first-person accounts of persons who have achieved recovery from major mental illness. More and more people are "coming out of the closet," including celebrities, mental health professionals, leading citizens, and ordinary people everywhere, and they are sharing their stories of successful struggle and hope (Balter & Katz, 1987; Chamberlin, 1988; Saks, 2008; Jamison, 1997).

Unfortunately, both the longitudinal data and the personal stories of recovery have failed to gain much attention within the professional clinical consciousness. Actively counteracting these hopeful views has been the "clinician's illusion" that the worst outcomes are typical and to be expected, often based on the skewed experience that many clinicians have had in their training or in the failing systems in which they work; in other words, a self-reinforcing conclusion, or what Gerald Caplan would call "theme interference." (Caplan & Caplan, 1993). In recent years, this negative expectation has been increasingly replaced by the more hopeful and positively reinforcing vision that the outcome studies and personal accounts imply. The emerging descriptions of recovery have a compelling power that has attracted and inspired many people.

WHAT IS RECOVERY AND HOW DO WE MAKE IT PRACTICAL?

Recovery has been variably defined, which can be very confusing. However, some consensus was achieved in two recent initiatives.

The President's New Freedom Commission on Mental Health created a plan in 2003 to transform the entire mental health system refocusing it on recovery, and declared that

"recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery."

In 2004, SAMHSA convened a panel of professionals, consumers, and families who agreed that *"recovery is 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."* They described 10 fundamental components of recovery: "Self direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope" (National Consensus Statement on Mental Health Recovery, 2004).

In 2011, SAMHSA went a step further, bringing together mental health and substance abuse representatives to create a unifying Working Definition of Recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" with four major dimensions—health, home, purpose, and community (SAMHSA, 2012).

Recovery is not the same as cure. For acute illnesses, recovery often results from symptom elimination and cure, but for persistent illnesses, recovery more often results from:

- Achieving self-management of the illness
- Maintaining hope and self-image
- Carrying on with life through rehabilitation and adaptation
- Replacing professional supports with natural supports
- Building strengths and resilience to handle future illness

Many people, including consumers, families, staff, and our communities, will be reluctant to give up the path of pursuing a medical cure for mental illnesses, but if taken together, those objectives offer us a realistic, practical route to recovery for almost everyone.

Successful recovery does not conclude with the person thanking the treatment providers for all their great understanding and help, but also remaining dependent upon them: "I'm so glad I met you. You really understand me. You gave me the right medications. You took care of everything. I know I can always rely on you to solve any problem for me. I'm going to stay in treatment with you and count on you forever because I'll never be well enough to handle things on my own." Instead, successful recovery leads to more self-knowledge and self-reliance: "I wouldn't have wished this illness on my worst enemy. The pain and suffering have been enormous, but in a strange way it has been a blessing in disguise. I've found and developed strengths I never knew

I had. I've learned what's really important in life. There have been deep gifts from my deepest wounds. It's made me into the person I am today." To get to that endpoint, we must change our initial response from, "You did the right thing coming to see me. I'm a good doctor. I'm going to be able to help you," to "I can already see strengths you are going to use to overcome this terrible illness." The hope in recovery is that they will develop, not that we will "cure" them.

HOW DO RECOVERY-BASED SERVICES WORK?

1. Recovery-based services are "person-centered" instead of "illness-centered."

A homeless outreach worker, himself a veteran with a history of mental illness and alcoholism, began stopping by Robert's encampment, bringing him sack lunches, sharing stories, and listening quietly. After several months, Robert agreed to come into a drop-in center to shower and get some clean clothes.

After another week, Robert was introduced to the team psychiatrist, to "see if our doctor can help you." As he listened to Robert's story, the doctor didn't ask many diagnostic questions. He asked Robert about the story of his life instead of the history of his illness. He learned that Robert was a very moral man, that he missed working, and that he was getting sick and tired of living on the streets. When the psychiatrist shared pictures of his own family, Robert said that he still hoped he could marry and have a family some day. Rather than providing corrective insights that "the machine" wasn't real and that he had a psychotic disorder that would probably respond to medication, the doctor met Robert where he was. He said he knew nothing about military satellite technology, but a lot about strengthening brains and dealing with overwhelming stressors. He was interested in Robert's efforts to strengthen his brain with alcohol and amphetamines and thought he could offer a better alternative. He offered him a prescription for a pill that "combines the effects of alcohol and speed that might calm you and focus your thinking. Would you be willing to try it instead of alcohol and speed to see if that helped you fight the machine better?" He agreed.

Put simply, the goal of recovery is not to treat mental illnesses, but to help people with mental illnesses to have better lives. However, this transformative approach ultimately affects the entire clinical process.

2. Recovery-based services are built on consumer strengths, leading to resilience, rather than on the clinical mastery of the professional treating the consumer's deficits.

The psychiatrist told Robert that he was more vulnerable to the "machine" by staying alone under the bridge than in a hotel room, and that he'd probably cope better if he was doing something positive instead of sitting worrying about this

all day long. To take advantage of his work ethic, Robert was offered “work for a day—house for a day.” He could work two hours a day in the program’s café lunch-room making hamburgers and sandwiches to earn a nightly hotel voucher. He was assured there would be people there who could help if he felt overwhelmed or violent and who wouldn’t lock him up. They began working together on his goal of fighting off the machine and rejoining society. They invited him to become a member of the community program (The Village).

Over the next few months, he improved. The machine quieted down enough so he could relax and sleep; the headaches went away. When he worked, the machine didn’t affect him at all. He began driving the van on catering jobs. The program staff were encouraged and offered him a permanent job and help getting a subsidized apartment.

Strengths are not people’s skills or talents or things we like about them. They are the resources they will use to overcome their illnesses. Strengths can be internal qualities like determination, hopefulness, self-awareness, self-responsibility, pride, a strong work ethic, family values, and spiritual faith. Strengths can be external resources like money, family, community, stable and safe housing, mentors and friends. Strengths can be discovered (or

Table 26.1 A comparison of person-centered and illness-centered approaches to care

Person-Centered	Illness-Centered
The relationship is the foundation	The diagnosis is the foundation
Begin with welcoming—outreach and engagement	Begin with illness-assessment and diagnosis
Services are based on personal suffering and help needed	Services are based on diagnosis and treatment needed
Services work toward quality-of-life goals	Services work toward illness-reduction goals
Treatment and rehabilitation are goal-driven	Treatment is symptom-driven and rehabilitation is disability-driven
Personal recovery is central from beginning to end	Recovery from the illness sometimes results after the illness and then the disability are taken care of
Track personal progress toward recovery	Track illness progress toward symptom reduction and cure
Use techniques that promote personal growth and self-responsibility	Use techniques that promote illness control and reduction of risk of damage from the illness
Services end when persons can manage their own lives and attain meaningful roles	Services end when the illness is cured
The relationship may change and grow throughout and continue even after services end	The relationship only exists to treat the illness and must be carefully restricted to maintain professional boundaries

rediscovered) or newly developed. When someone has enough strength to overcome the next symptom increase, drug relapse, relationship breakup, job loss, family disappointment, or even tragic loss without falling apart, without becoming homeless or jailed or hospitalized, without losing everything they have worked so hard for, then they have resilience. Our goal is not to protect them from tragedies but to help them build enough resilience to handle the inevitable crises when they come.

As people grow, they move along a continuum from “unengaged” to “engaged but poorly self-coordinating” to “self-responsible.” People who are “unengaged” generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are “engaged, but poorly self-directed” might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are “self-responsible” can collaborate in their recovery and usually can coordinate it by increasing their resilience, self-sufficiency, and community integration.

These three levels of engagement are not exclusively related to consumer traits. System traits, primarily “ease of engagement” and “ease of coordination,” also affect the level of engagement. Programs that are more welcoming and accessible, with few barriers to treatment and that integrate multiple coordinated services at one site instead of scattered in several separate systems, are more likely to attract or retain consumers whose level of engagement had previously been marginal.

Table 26.2 Differences in approaches between Caretaking Services and Growth Oriented Services across four stages of recovery

Stage of Recovery	Caretaking Services	Growth Oriented Services
Extreme risk	External controls—locked environment, seclusion, restraints, 1:1 monitoring. Forced sedation. Reduce external interactions and stress.	Support to increase internal controls and self-responsible problem solving. Help to reduce internal sources of distress and loss of control. Trauma sensitive interactions.
Unengaged	Forced treatment Protection Benefits establishment Acute stabilization	Outreach and engagement Peer bridging Concrete quality-of-life goals Relationship building
Engaged, but poorly self-coordinating	Structure Making decisions for people Case management Chronic stabilization Board and care	Supportive services Skill building Personal service coordination Collaboration building Halfway house
Self-responsible	Benefits retention Maintenance therapy and medication Support groups	Community integration Self-help Peer support Wellness activities Growth promoting therapy

Most consumers need both caretaking and growth-promoting services at different times in their lives and in different combinations. However, the more a program emphasizes or relies upon caretaking services, the less likely it is to promote growth, personal strength, and resilience.

Readiness is a key concept in standard mental health services and is generally understood to mean “prepared and likely to succeed.” Traditional programs spend a lot of time assessing readiness and trying to create it so that people will be “ready” to leave the hospital, get a job, go to school, become their own payee, get off conservatorship or court-ordered treatment, get their own apartment, or effectively use or even get off medications. From a recovery perspective, “ready” means “motivated and excited,” and the focus is on exposure and building motivation. “Prepared and likely to succeed” comes from learning by doing, sometimes with guidance, but often as a result of trial and error. The job of staff is not to prepare ahead of time, but to actively support while the client learns by doing. Instead of trying to prevent or avoid suffering, the recovery goal should be to help consumers learn as they go, building strengths and resiliency for when they will be on their own.

3. Recovery-based services are “client-driven” instead of “professional-driven.”

Robert disappeared back under the bridge. The treatment team suspected that he'd either relapsed on speed or stopped taking his medication and was more psychotic. The peer outreach worker looked for him and found that neither of those things had happened. Robert was just scared and thought they were pushing him too fast. He agreed to return to “work for a day—house for a day.”

Six months later, he chose to move on to permanent work and an apartment. By the time the team celebrated his achievement with a housewarming party, he'd gained so much confidence dealing with the machine that he stopped his medications. The psychiatrist continued to see him and, although his old religious guilt returned, the machine remained very quiet. He worked on his shame and guilt without meds. He began volunteering by providing homeless outreach with his old peer counselor as a way to give back to others.

Robert felt proud of himself and the emotional closeness he had developed with the community of staff and program members, who reminded him of his lost family. The program helped him find his sister on the Internet and to visit her in a distant city. She welcomed her long-lost brother. Six months later, he decided to move to be with his sister, realizing that he was strong enough to make it without the treatment program.

Client-driven approaches were developed primarily to increase engagement and motivation in treatment. Traditional approaches incorporate a big differential in the relative power of the treatment transaction: a strong professional helping a weak person by doing something to or for them, which conveys a subtle, sometimes overt, message that the client/patient needs the professional in order to get better. A truly amazing array of client-driven approaches has been developed, primarily by non-clinicians, especially consumers in recovery. Here are some notable examples:

1. Personal Assistance in Community Existence (PACE)—A comprehensive approach to recovery built on self-directed, empowered usage of proven recovery beliefs, relationships, skills, identity, and community, especially useful for people who are not motivated by a medical approach for their “so-called mental illness.” (Ahern & Fisher, 1999)
2. Shared Decision Making—People are more likely to be motivated to work on plans they have had a part in creating and that reflect their contributions. (Davidson et al., 2010)
3. Motivational Interviewing—We can “meet people where they are” in the normal process of making difficult life changes (pre-contemplation, contemplation, planning, action, and sustaining), supporting them in their inevitable ambivalence with its “ups and backs.” This is likely to be more effective than always prescribing action and then getting frustrated, even coercive, and blaming them when they don’t follow through. (Miller & Rollnik, 2002)
4. Wellness Recovery Action Plans (WRAP)—People can create their own plans in a notebook for maintaining mental health, dealing with moderate stressors, and serious crises. WRAP can be done individually or in groups and can be facilitated by trained peer counselors. (Copeland, 2002a,b)
5. Advance Directives—Serious mental illness can lead to times of losing control and the ability to make competent decisions, even for people who are generally doing well in recovery. Just like people prepare for medical deteriorations by creating advance directives to make their choices known ahead of time and to appoint a surrogate, people can create advance directives for future psychiatric crises. Many states have legal supports for advance directives (Backlar, 1997; Fisher, 2000).

True collaboration requires understanding how other people view themselves and their lives, rather than just teaching them our point of view. It requires understanding their goals instead of ours, looking for shared goals that both parties can value and enthusiastically pursue. It requires clinicians to be compliant with consumers’ plans as much as expecting consumers to be compliant with professionals’ plans. It requires sharing power and actively empowering people. In particular, it requires mutual trust.

WHAT ARE “RECOVERY-BASED” SERVICES?

A typical set of services that promote engagement, self-responsibility, and community integration, while incorporating self-help activities that facilitate recovery, would include the following:

1. *Engagement and welcoming*—Focus on relationship- and trust-building services, not on requiring diagnosis or insight or medication; “meeting people where they’re at”; harm reduction; “housing first”; peer engagement; outreach; and charity.
2. *Person-centered planning and goal-driven services*—Develop a shared story of the person’s life instead of a history of illness, identify strengths to be used in recovery, assist in formulating goals to pursue collaboratively, identify potential barriers and develop

shared plans to overcome barriers, develop goal-setting skills, and use a menu of services supplied by an integrated team and community.

3. *Sharing decision-making and building self-responsibility*—Develop collaborative relationships, describe service choices in understandable language and as it impacts the consumer's goals; "client-driven services," advance directives, assist clients in learning from consequences of decisions to learn to make new choices—learn from mistakes; define respective roles in achieving goals; increasing self-responsibility and self-reliance.
4. *Rehabilitation-building skills and supports*—Do things with people instead of for them; use "teachable moments," *in vivo* skill building; assist with entitlements, supports, and opportunities; psychiatric rehabilitation and psychosocial rehabilitation; clubhouses and learning roles; peer support.
5. *Recovery-based medication services*—Consider treatment optimization approaches that balance judicious use of medications with other treatment, rehab, and recovery interventions, with particular emphasis on patient/client/consumer preference. Align use of medications with the consumer's goals, instead of symptom control. Getting patients to take their medication to improve their symptoms needn't precede rebuilding lives. Medications can initially be for "short-term" effects until a "customer relationship" is built. Getting off medications happens when they're no longer needed to attain and maintain goals, not when symptoms are relieved. Medications enable self-help coping techniques, rather than competing with them. (Muesser et al., 2002)
6. *Peer support and self help*—Cultivate opportunities for outreach and engagement, peer counseling, shared stories and humanity, peer advocacy, peer bridging, acceptance, "giving back," peer support groups, 12-Step groups, coping skills, self care, WRAP. (Georgia Mental health Consumer Network, 2003; Jonikas & Cook, 2004)
7. *Adapting and integrating therapy and healing*—Provide therapeutic relationships without excessive structure or rules. Emphasize engagement, relationship building, "corrective emotional experiences." Create a healing environment—sanctuary, counterculture of acceptance, "therapeutic milieu," group therapy without walls, Carl Rogers' client centered approach that emphasizes providing empathy, authenticity, and caring to help people grow without needing a formal therapy structure.
8. *Trauma-informed care*—Increase trauma awareness, empathetic relationships, trauma healing and recovery, personal safety and boundaries. Avoid retraumatization cycles and traumatization by staff, including reducing coercion, seclusion, and restraints.
9. *Spirituality and alternative approaches*—For some persons, healing and recovery requires attention to their spiritual life. Faith and communing with others who share similar spiritual beliefs, without proselytizing or requiring participation in formal religious activities, can be a very powerful and supportive adjunct to feeling whole; inclusion of spiritual strengthening practices and healing.
10. *Community integration and quality of life support services*—Identify needs and gaps in social supports, and provide benefits assistance, re-documentation, "supported services"—housing, education, employment, medical care, community development; finding "welcoming hearts" in the community; finding a niche; meaningful roles; community inclusion; rights and responsibilities; avoiding "failures of community integration"—hospitalization, homelessness, imprisonment.
11. *Graduation and self-reliance*—Build strengths and resilience, protective factors, gifts from their suffering, overcoming fear of losing benefits and illness roles, replacing

professional supports with self-help and personal supports, developing community treatment resources, “coming out” to fight stigma and discrimination.

RECOVERY CHANGES EVERYTHING: RELATIONSHIPS, TEAMS, CULTURE, AND SYSTEM

To implement recovery-based services, there must be substantial transformation of treatment relationships. These changes are often threatening to staff who feel effective and safe within the bounds of traditional professional standards and ethics. Items like sharing bathrooms, giving choices to psychotic people, treating people without relying on medications, taking people in staff cars, eating lunch together, and encouraging relevant and ethical staff self-disclosure are lightning rods for staff resistance to recovery.

Recovery-oriented programs usually provide volunteer and staff positions for peers and family advocates. Persons with lived experiences of mental illness can provide specialized peer-based services, such as positions that involve outreach, peer-to-peer engagement, case management, life-rebuilding skills, and community development, and they can be hired in any position that they are qualified to do. The inclusion of such persons in the staff of a program can be disruptive to the traditional professional staff, who may worry or complain about risks associated with boundaries, ethics, or safety.

Recovery is not an “anything goes” model. One must be attentive to safety and ethics. Traditional ethics and safety rules evolved in a very risky and dangerous treatment arena: the isolated, secretive, individual private practice settings. It may be surprising and paradoxical, but activities that may not be safe, ethical, or appropriate within a private practice context can be provided and may be preferred in the context of a cohesive recovery-based team and program culture. Clinical rules regarding safety and ethics, and their rationale, must be reexamined and aligned with the goals of treatment and recovery: lowering boundaries and barriers, sharing power and responsibility, and engaging the community. Patricia Deegan has provided detailed guidance for the creation of new rules for new teams (Deegan, 2003). The Los Angeles County Department of Mental Health created a set of bureaucratic “Parameters for Service Relationships in a Recovery-Based Mental Health System” reconciling recovery values with existing policies and parameters (2006).

Team-based care is becoming the norm throughout all areas of health care. The relatively recent emphasis on patient-centered primary care homes and the integration of mental health and primary care are obvious examples of this rapidly growing trend. A recent report has identified the key core competencies for persons involved in collaborative care (Interprofessional Education Collaborative Expert Panel, 2011). In addition to the specific competencies associated with the person’s specific clinical discipline, this report specifies collaborative care abilities in four domains: values/ethics for interprofessional practice, roles/responsibilities, interprofessional communication, and teams and teamwork. Although most community-based mental health programs have provided some form of team-based care for decades, many have failed to truly develop teams to meet the aims of a quality health system; that is, to be patient-centered, effective, efficient, equitable, timely, and safe. These collaborative care competencies are relevant and underscore the shortcomings of traditional practices, whether individual or team-based.

Recovery programs need to be team-based and to cultivate these competencies because:

- We need to integrate a range of quality-of-life services beyond any one person's competence.
- People at different stages of recovery require different staff skills—engagement, building skills and support, moving on.
- None of us is Mother Theresa, but between us we can create “one Mother Theresa”: a broad “counterculture of acceptance” welcoming and engaging everyone in need.
- To safely and ethically lower boundaries and adopt multiple roles, we need to support and keep each other honest.
- To maintain staff morale and avoid our own trauma and burnout, we need to stick together and take care of each other.

Recovery-based programs are more readily differentiated from traditional programs by the values embedded in their culture than by the services they provide. Mental Health America of Los Angeles has created a recovery-culture progress report that rates programs from the perspective of consumers, families, line staff, and supervisors/administrators on seven key dimensions: Welcoming and accessibility, growth orientation, consumer inclusion, emotional healing relationships and environments, quality-of-life focus, community integration, and staff recovery and morale (Ragins, 2010). That final dimension is crucial and often overlooked: Staff should be treated in a recovery-based way, if only to increase their ability to treat their clients the same way. In many programs, staff morale is too low to allow a recovery-based culture. On the other hand, when a recovery-based culture is promoted, staff burnout diminishes and morale improves.

Recovery-based programs need to align all of their processes with recovery-based values and principles. Boston University's Center for Psychiatric Rehabilitation states that “A ROMHP [*recovery-oriented mental health program*] is characterized by program structures such as mission, policies, procedures, record keeping and quality assurance that are consistent with fundamental recovery values. Similarly, staffing concerns such as selection, training and supervision are guided by the fundamental values of recovery.” The BU document identifies four fundamental values: person orientation, person involvement, self-determination/choice, and growth potential (32). As the recovery movement matures, additional refinements are emerging, such as recovery-based supervision and mentoring, recovery-based administration, recovery-based funding, and recovery-based accountability.

IMPLEMENTING RECOVERY-BASED TRANSFORMATION

It is easier to create a new recovery-based program with selected staff than to transform an existing program. Resistance to change is common (Farkas et al., 2005). Keys to transformation include: Sustained coordinated leadership, creating “learning cultures” in the programs, improving connections between programs and administration, including and hiring consumers, and moving from a predominantly crisis-response mode to a proactive, team-based, planned mode.

The American Association of Community Psychiatrists created a policy document that is intended to facilitate the transformation to recovery-oriented services and to provide direction to organizations or systems that are engaged in this process. They should be useful to systems that have already made significant progress in creating services that promote recovery by providing a systematic way of thinking about quality improvement and management for these services.

The guidelines are organized divided into three domains of service systems: administration, treatment and supports. Each domain is composed of several elements and recovery-enhancing characteristics for each of these elements are described. Some suggestions for measurement of achievement/progress in each of these areas are included. (2003)

The revolution is still in progress:

Successful revolutions are rare in social systems and not all revolutions succeed, even if they should. True revolutions often take a generation or more to fully unfold and actualize. Progress can be tracked through stages of development; moving from innovators and early adaptors to growing acceptance to broad-based implementation.

Looking back at the history of the recovery movement thus far, there is clear evidence of progress.

1980s: Recovery Is Possible

- Longitudinal studies of recovery
- Individual stories of recovery
- Recovery doesn't have to mean cure—Recovery can occur with chronic illnesses
- Recovery is something the person does, not the illness—recovery is “person-centered”

1990s: Recovery Services Are Better

- Quality-of-life outcomes from model programs
- Inclusion of challenging populations who were dropping out, frustrating, and without recovery services, who “needed” coercion
- Improved staff morale and satisfaction
- Enhanced employment outcomes

2000s: Recovery Is Coming

- Widespread recovery transformation proclamations—President's New Freedom Commission, Veteran's Administration, California's Mental Health Services Act, SAMHSA's transformation states, other state initiatives
- Widespread persistent transformation efforts. “It's not just a fashion—you can't wait this out”

2010s: Recovery Is Practical

- Widespread development of recovery-based practices, programs, tools, and systems of care
- Recovery requires an integrated team—including psychiatrists and consumer staff
- Recovery is reasonably cost-effective compared with standard services—and probably even compared to neglect and cost-shifting
- Moving from recovery as an add-on for “outliers” to the core of the entire system

FUTURE CHALLENGES

In this chapter, we have:

- Outlined the roots of the recovery movement in mental health,
- Compared recovery to the prior two dominant models of care, the medical and rehabilitation models, and

- Described what recovery services are and how to implement them.

As recovery-based programs continue to emerge, develop, grow, and learn from their own and others' experiences, it is essential that the providers and consumers who endorse these approaches continue to improve the quality of the programs they create. We must also keep the "tipping point" process active by spreading the news that this is the effective and preferred way to meet the needs of the populations we serve, especially persons with severe and persistent mental illnesses and addiction disorders.

In order to sustain this revolution, we must apply recovery to the administration of programs; for example, through recovery-oriented leadership, mentoring, supervision, and accountability. Programs must manage their workload and avoid excessive caseloads, by creating efficient methods for allowing clients to flow through and graduate from programs. We must expand the effort to create and provide "strengths-based" services to build resilience and a sense of community into all of our lives, whether we are providers, recipients of services, or both. As the health system changes to one that is more primary care-based, we need to make sure that recovery principles and practices are a central part of the overall integration of mental health and addiction services with primary care. History suggests this will not be easy, because health integration means "medical model." But whether our revolution succeeds is up to all of us. There will be much more work yet to be done, some of which will involve educating our colleagues.

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MILITARY VETERANS AND FAMILIES

JAMES SIZEMORE AND SHANÉ MARSHALL

Since September 11, 2001, many military personnel have been deployed to various regions around the world to engage in combat. This has brought the effects of these deployments on service members and their families to the attention of people within the larger society. The primary mental health issue most people focus on with military veterans is post-traumatic stress disorder (PTSD) (Department of Veterans Affairs, 2011b; Department of Defense, 2011; National Association of State Alcohol and Drug Abuse Directors and Abt Associates, Inc. 2009). While this focus is valid, it is not the sole concern of mental health care needs among veterans. Other issues affecting military veterans are:

- Readjustment to civilian life (from military life or combat situations)
- Marriage and family: Changes in family dynamics, broken bonds, etc.
- Divorce
- Parenting skills
- Family issues involving PTSD
- Depression
- Anxiety
- Sleep disturbances
- Suicide
- Military sexual trauma (MST)
- Impulsive behaviors
- Grief/bereavement
- Post-traumatic stress disorder (PTSD)
- Traumatic brain injury (TBI)
- Alcohol and other drug (AOD) issues
- Legal issues

- Housing/homelessness
- Employment/unemployment
- Service linkage and availability
- Financial troubles
- Crisis management

CASE EXAMPLE

Daniel W. is a 28-year-old married Caucasian male who has two children. He was admitted to the emergency room after a traumatic car accident and was soon taken to the intensive care unit and then the medical step-down unit. In the assessment he indicated he possibly had thoughts of self-harm prior to the accident. We also learned that Daniel is a military veteran who served two tours of duty in Southwest Asia in support of Operation Iraqi Freedom and Operation Enduring Freedom. Daniel was discharged from the military a year ago.

He attended college for a year prior to enlisting into the Army; which was soon after the 9/11 attacks. Daniel felt he should do his part in defending the United States, so he had a desire to serve in the military. Upon completion of his initial training, he was assigned to a military unit stationed in Germany that deployed to Iraq shortly after his arrival. He spent 15 months in Iraq on his first deployment. When his unit redeployed to Germany, he married a woman he met on line while taking online college courses. He deployed again two years later, to Afghanistan, for 12 months, during which his first child was born. He redeployed back to Germany after 12 months. Daniel's next tour of duty was an unaccompanied tour to Korea. During this time his wife returned to the States to live near her family, and his second child was born. Because he wished to spend more time with his family, Daniel reluctantly got out of the military upon completing his enlistment. Since getting out of the Army, Daniel doesn't feel he fits in with his family or the civilian community. He and his wife are fighting more often, and because of his absence for over half of their lives, he doesn't feel he knows his kids (ages six and three years old). Overall, he doesn't feel he fits anywhere anymore.

In the midst of this readjustment, Daniel does not have personal health insurance. While he qualifies to receive health care through the Department of Veteran Affairs (VA) Health Administration, he is reluctant to seek assistance. Therefore, he has not enrolled in the VA healthcare system, and is not certain of how to get assistance.

THE VETERANS' PERSPECTIVE

MILITARY CULTURE

When a person wears a military uniform, they and others within the military community know their role and position. The style of the uniform is different for each branch of service: Army,

Navy, Air Force, Marines, or Coast Guard. But on each uniform a service member wears their rank, combat patches, awards, and badges. When they walk into a room in uniform with other people in uniform, they know where they fit and can size up the other personnel with a quick look. Personnel have clearly defined positions within the military, and become identified by that role. For example, a person who is in a combat military occupation skill (MOS) trains to seek out and engage the enemy. While a person who is in a combat support or service support MOS is also trained to engage the enemy, if they are engaged, they typically don't try to find them.

The military has a clearly defined process for personnel to advance in their career or gain rank. There are clearly defined test scores to achieve and schools to attend in order to move up through the rank structure, and the community is designed to help them achieve these goals. If the service member does not advance in rank over a period of time, they will be discharged from military service (see afterdeployment.org). When military veterans are separated from the service, they are not afforded the necessary time or training to make an easy transition or readjustment to civilian life. Therefore, some of the most immediate feelings experienced may be becoming:

- Overwhelmed by the need to make choices
- Anxious due to a lack of structure
- Unsure where they fit in society
- Uncertain about the future
- Frustrated about starting over

SPIRITUALITY

Within the military, often the first person someone in need of mental health care will interact with is the chaplain. Whether the person is a Protestant, Catholic, Wiccan, Buddhist, or atheist is not a qualifier or disqualifier for seeing a chaplain. Chaplains are more than spiritual counselors; they also serve in the role of advisors regarding interpersonal matters and personal issues affecting people. Spiritual concerns should not be overlooked. The veteran's experience in other cultures, environments, and war zones may cause them to have personal spiritual conflicts. Veterans are often exposed to human suffering that most others do not experience. This is not all due to being in combat. Military personnel will often provide humanitarian assistance in regions of the world that are very poor or politically unstable, and will often assist during or immediately following natural disasters. Some draw upon their faith or spiritual beliefs as a source of strength, but others have their belief structures challenged or shattered by what they have seen or done. Some experiences that may bring about spiritual discord are:

- Seeing human suffering in combat zones or Third World nations
- Killing other human beings
- Survival after those nearby were violently killed
- Lacking relief from combat-related trauma
- Asking why would God do this? (Hurricane, volcano, tidal wave, tornado, etc.)
- Questioning if there is a God
- A desire to be forgiven
- A desire to be at peace within

READJUSTMENT TO THE CIVILIAN WORLD

Upon leaving the military, a veteran and his/her family are in a world of many decisions and limited community support. While they were on military posts or bases, the social service supports were easily accessible, and the loss of military structure can be difficult to handle. In addition to this, all of the friends who were their support are no longer nearby, nor are they easily accessible (Afterdeployment, 2011). They are now living in a community of people who don't understand them. When returning to the civilian community, the military veteran and their family must adapt to a whole new system of life (Duckworth, 2009):

- From a military community to one with very few veterans
- From having major responsibilities for the lives of others to very little responsibility
- From specialized training to the very beginning of a new career
- From secure employment to seeking employment in a questionable job market
- From being highly skilled and qualified to having military skills that may not be useful in the civilian job market

SEEKING HELP

One of the reasons military veterans are reluctant to seek help is because it is viewed as an admission of weakness. This reluctance is not just involving mental health concerns, but is also for physical health issues as well (Lanham, 2007). Military members may hide or downplay physical injuries when they think it will separate them from their unit or keep them from deploying with the unit. They are even more likely to hide mental health issues, due to issues of stigmatization. The fear of seeking mental health care is compounded by the belief they will lose their security clearance and possibly be discharged from the military, or not be able to pursue a civilian career. Additionally, veterans are reluctant to seek mental health care because they hold some of the following beliefs:

- It means they are weak or “crazy”
- They should be in charge of the situation
- It implies they are unable to “get it together”
- They are not dependable in tough situations
- They can tough it out till it is over
- There is no reason to bother . . . it takes too much time and paperwork to get help
- They don't want everyone to know their business

MILITARY FAMILIES

Often the family will identify themselves as being “in the military” along with the service member. A spouse's status in the community is tied to the military members' rank (e.g., an officer's wife rises in status as her husband rises in rank). As a result, the spouses will see themselves as having to maintain a role as a military spouse. Military families form support networks to assist one another while their service-members are deployed, and it is typical for the spouses of the highest-ranking members to be the leaders of the family support system. The families will

develop strong bonds among themselves, just as the military members will during a deployment (Duckworth, 2009). The spouses are expected to maintain the household so the service members can maintain focus on the mission and not be distracted by household concerns. Military families may experience the following:

- Long periods of separations
- Infidelity
- Parenting difficulties
- Fear of death or severe injury to the service member
- Strong reliance on extended family and friends
- Guilt for feelings of detachment
- Questioned loyalty
- Fear of changes upon the service-member's return
- Single parenthood
- Lack of social support
- Feelings of loneliness
- Development of a strong connection within the military community
- Stress of maintaining a household alone
- Neglect
- Financial strain

A service member will often make more money when they are deployed, but this is not always the case. Some Reservists and National Guard members take a pay decrease when they are activated for military service. An additional financial burden is that a military spouse will often have to pay to have things done around the household that the service member would have done when at home (e.g., lawn care, home repairs, etc.), and if there are children in the household, they need additional childcare support.

RECOMMENDED STEPS OF CARE

In the case example noted, Daniel's injuries resulting from the car accident were identified as the immediate concern, but these injuries were the result of underlying mental health issues. The car accident appeared to be a veiled attempt to commit suicide. With the compounding effects of Daniel's troubled family life and reintegration into the civilian community, he began to view suicide as a solution to his problems. In the healthcare community, adding the question, "Are you a military veteran?" to the assessment process provides a way to identify veterans and opens a process to begin identifying underlying issues and linking and/or referral to needed resources.

STEP ONE—ASK "ARE YOU A MILITARY VETERAN? DID YOU SERVE IN A COMBAT ZONE?"

Adding this question to the assessment process opens up possible sources of the issues affecting the patient, and identification of resources available to them. There are some considerations

when interacting with a veteran (especially a combat veteran). As a result of military and combat experiences, veterans can seem aggressive to those who are not familiar with military personnel. A loud voice or use of harsh or vulgar language does not mean they are posturing or escalating to violent behavior. Showing respect, remaining calm, and using an appropriate tone of voice is often the best way to defuse tension that may arise in the moment. Some consideration and tips for interacting with military veterans are as follows:

- Be professional
- Be respectful
- Relax
- A priority is building rapport and trust for the life of the therapeutic relationship
- Allow the veteran time to share their experience; try to avoid rushing the process
- Avoid aggressive and authoritarian attitudes, as they can trigger an aggressive response
- Avoid use of demeaning or condescending tones or language
- Avoid minimization of their experiences and significant events
- Keep in mind the veteran does not know you, how much they can trust you, or your intentions as a mental health professional
- Obtain information related to pre-military/military/post-military experiences/homecoming
- Assess for religious and cultural factors that may impact their views of orders they carried out while on active duty

STEP TWO—IDENTIFY THE ISSUES OR PRESENTING PROBLEM

Some of the possible cultural and family concerns to consider during the assessment are identified above. For Daniel's case, there are multiple issues that are interconnected, which is likely to be true in many other cases. Nevertheless, taking the time to listen to Daniel is necessary for the exploration within the complexity of his situation. Upon review and as noted before, Daniel gave up a career he enjoyed to be with his family. But once he was with his family, he began to feel he did not fit in with them and was letting them down. He no doubt began to feel this way regarding his fellow service members because he was not able to be there for them, either. Issues that military members often experience related to their families are:

- Disconnectedness
- Infidelity
- Anger
- Feelings of abandonment and/or betrayal
- Change of family roles and loss of responsibilities
- Communication difficulty
- Concern about how much of their experiences they reveal to their family
- Don't want to burden their family with their problems

Daniel's family issues are also compounded by events experienced during his two combat tours. During these tours, one of the soldiers in his charge was killed and another was severely

injured when his leg was amputated during an attack. Daniel had several other soldiers injured in enemy attacks and vehicle accidents as well. Symptoms that may be associated with exposure to combat environments such as these are:

- Stress/anxiety: for safety, experiencing full range of emotion, reactions to surroundings
- Hypervigilance: being on alert may mean the difference between life or death
- Guilt: for being alive or not being able to protect those who were injured or killed
- Dissociation: to patrol for increased arousal or triggers
- Intrusive thoughts: regarding events that occurred
- Nightmares: regarding events that occurred or are associated with fear of actual behaviors while awake
- Hallucinations: seeing, hearing, or smelling things that were present during combat
- Physical pain: both from actual injury or of a somatic nature as associated with experience(s)

STEP THREE—IDENTIFY THE RESOURCES AVAILABLE

The Veterans' Administration has many sources of healthcare and other benefits that may alleviate underlying concerns and are available to veterans. However, the complexity of qualifications for them can be overwhelming. It is then necessary to understand that the primary means for a veteran to gain access to these benefits is by having a "DD214" (pronounced *dee-dee-two-fourteen*). A DD214 is a Department of Defense Form #214 which indicates the veteran's military service and identifies where and when they served. It also indicates the type of discharge the veteran obtained from the military (e.g., honorable, general, dishonorable, etc.). All of these items will identify various resources available to the veteran. Also, there are additional state and local government agencies and nonprofit organizations that provide assistance to veterans. These organizations will require the DD214 as proof of military service as well. Accessing these agencies will be discussed below.

Some states have developed systems to connect veterans and their families to behavioral healthcare. This network can be accessed through the Department of Mental Health or the Department of Alcohol and Drug Addiction Services and the Army National Guard. These networks also provide training to the providers on the issues affecting veterans and their families, and on treatment options.

STEP FOUR—STRUCTURING THE TREATMENT ENVIRONMENT

Military veterans are used to having task lists to complete, and they are seeking answers or solutions to solve their problem. Yet, as they may want to vent regarding these problems, they remain in need of guidance on how to overcome these issues. Ways that assist in fostering an appropriate environment for care are as follows:

- Provide adequate space within the treatment environment to minimize discomfort and prevent triggers

- Explain the difference between “psychiatrist,” “psychologist,” “social worker,” “counselor,” and all the other mental health professionals they may encounter so veterans know what treatment to expect from each provider
- Educate the veteran on your scope of practice and/or influence
- Explain the treatment process, expectations, rights, confidentiality, and responsibilities
- Have clear and concise instructions and/or steps throughout the treatment process
- Ask them to repeat back what you have instructed them, for clarity and understanding
- Learn something about the culture/military/history of the war
- Foster a sense of trust, at their pace
- Provide structure throughout the life of treatment
- Assist in medication management to reduce excessive and/or debilitating side effects
- Empower the veteran for ongoing mental and medical health care maintenance
- Advocate for the veteran as needed and/or requested

STEP FIVE—FOLLOW-UP (CASE MANAGEMENT)

Veterans with PTSD or TBI often have difficulty maintaining schedules or meeting appointment schedules. They often become overwhelmed with anxiety and frustrated with multiple schedules and appointments. As a result, they will drop out of treatment or not consistently attend scheduled appointments. Therefore, it is important to assist veterans with meeting appointments. A case manager is helpful in maintaining appointments with counselors and psychiatrists. It is sometimes helpful to have a social worker accompany a veteran to appointments to ensure they communicate effectively the symptoms they are experiencing. There are times when it is helpful to involve the spouse or family in the treatment process. Family members will often reveal symptoms the veteran does not notice or is not willing to reveal. A family member will also help a veteran remember appointments and will encourage a veteran to follow through with the treatment (Department of Veteran Affairs, 2011a). Some means to help veterans make appointments or commit to the treatment process are:

- Assign a case manager
- Involve a family member
- Call to remind them of appointments
- Encourage the usage of a smartphone to maintain appointments

ACCESSING HEALTHCARE IN THE DEPARTMENT OF VETERAN AFFAIRS

The Department of Veteran Affairs (VA) Healthcare System is available to veterans who meet certain criteria. One of which is that within five years of being discharged from the military, a veteran can receive healthcare at a VA facilities for little or no cost to them. To access this system, the veteran will need a copy of their DD214, as mentioned before. If the veteran does not have a copy, one can be requested from the military, though it often takes six weeks or more for the document to arrive. There are several ways for a veteran to get a copy of the DD214 if they do not have one already. These include:

- Requesting a copy of the DD214 on the Web or by phone from the military
- Requesting the assistance of a Veteran Service Officer
- Requesting the assistance of VA Benefits Advisor
- Visiting a veteran service organizations where assistance is provided to gain access to benefits
- Calling or visiting a Vet Center

Once the veteran has a copy of his DD214, he can go to a VA hospital or clinic to enroll into the healthcare system and determine his eligibility through the Enrollment Department. The veteran can also speak with a benefits advisor to determine his eligibility for other veteran assistance programs. While many people assume a veteran has free healthcare at any VA healthcare facility, this is not always the case. Due to the complexities of eligibility, it is best to connect the veteran with a Benefits Advisor. Vet Centers are an agency within the VA that provides counseling and assistance on navigating the VA and various agencies and programs. A veteran can be directed to one of the Vet Centers to get assistance. This can be done in person or over the phone.

ADDITIONAL VETERAN SERVICE ORGANIZATIONS

The VA is the federal agency that provides assistance to veterans. There are state agencies, county agencies, city agencies, and civilian nonprofit organizations that provide assistance to veterans and their families as well. Some of these are listed below.

- State agencies
 - Governor's Office of Veteran Affairs
 - Veterans Service Commission
 - Veterans Benefits Office
- County agencies
 - Veteran Service Officers are trained to assist veterans accessing benefits
 - Areas with larger populations will offer more services
 - These agencies can provide emergency funds for rent or medications
- Civilian nonprofits
 - Veterans of Foreign Wars (VFW)
 - American Legion
 - Disabled American Veterans (DAV)
 - Marine Corps League
 - Vietnam Veterans of America
 - Iraq Afghanistan Veterans of America (IAVA)

Some veteran service organizations provide assistance for specific needs, such as:

- Amputees
- Traumatic brain injury (TBI) survivors
- Widows and orphans of service members killed in action
- Bereavement support for families (TAPS)
- Military kids

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MENTAL ILLNESS AND INTELLECTUAL DISABILITY

JULIE P. GENTILE, CHRISTOPHER T. MANETTA, AND
CARROLL S. JACKSON

There is universal agreement that all individuals with intellectual disabilities might present with behavior and interaction skills of a chronologically younger child and might maintain these characteristics throughout the lifespan. Thus, any judgment about symptom presentation must be evaluated within the context of developmental delay. (Szymanski and King, 1999)

CASE EXAMPLE

Anne is a 21-year-old female with a history of mild intellectual disability, borderline personality disorder, and obsessive compulsive disorder who is hospitalized for self-injurious behavior and elopement from her sheltered workshop setting. She also has a medical history significant for seizure disorder, esophageal ulcers, and gastro-esophageal reflux disease. During the mental health hospitalization, she is restarted on her medication regimen, which includes valproate (Depakote), quetiapine (Seroquel), fluoxetine (Prozac) and temazepam (Restoril). The precipitant of the hospitalization was the patient's feeling of abandonment when her biological mother was to pick her up for her birthday and did not show up. This has happened on numerous occasions, and Anne's fractured relationship with her mother consistently causes significant disruption in her life. At the time of the disappointment, the patient began to refuse her medications and eloped from her sheltered workshop the following day. Local law enforcement was notified of the elopement, and within several hours, the patient was located and taken to the emergency department of a local hospital for admission to the behavioral health unit.

INTRODUCTION

Mental illness and intellectual disabilities (ID) have been intimately interlaced for centuries. Individuals with either of these conditions have been marginalized, institutionalized, or left to their own devices, particularly if their families were unable or unwilling to provide appropriate care for them. In more recent years, deinstitutionalization has become more widely accepted; placement in the least restrictive environment is the norm, but the success of individuals in community settings is dependent on multiple factors, including collaboration of mental health and intellectual disability systems, as well as appropriate transition and community supports.

Many mental health professionals lack specialized training in ID, and yet persons with ID frequently present to mental health professionals with behavior problems that may or may not be related to mental health issues. The current prevalence rate of ID in the general population is approximately two to three percent, and it has also been found to be 1.5 times more common in males than in females. The prevalence is slightly higher if intelligence quotient (IQ <70) is used as the only criterion (Larson et al. 2001).

In this chapter, the unique challenges encountered by providers treating the ID patient population will be reviewed, and relevant nuances for prescribers that distinguish individuals with ID from others will be described. No evidence-based practices exist specific to individuals with ID; therefore, the clinician is left to utilize expert consensus guidelines in combination with evidence-based practices for the general population.

MENTAL HEALTH ASSESSMENT

Individuals with ID experience and suffer from the same entire range of psychiatric disorders as do those with typical cognitive functioning; in fact, behavior and psychiatric issues occur in individuals with ID at three to six times the rate of the general population (Aman et al. 2003). It is therefore vital that community organizations collaborate and work in partnership to effectively serve the ID population to avoid duplicating services, but more importantly to keep individuals from falling through the cracks.

According to the Centers for Disease Control and Prevention (CDCP), ID is characterized by both a significantly below-average score on a test of mental intelligence and by limitations in the person's ability to function in areas of daily life such as communication, meeting basic needs, and navigating social settings. Communication is the foundation of every relationship; most individuals with ID have limited expressive language skills, and this complicates obtaining subjective reports of mental health symptoms and physical discomfort. Communicative ability is affected by the severity of ID, ranging from mild to profound, and the clinician should assume that the individual's receptive language skills are better developed than are their expressive language skills. Each individual should be afforded the opportunity to communicate their thoughts in their own way and within their own developmental framework.

The relationship between a mental health provider and their patient is vital to accurate diagnosis, treatment planning, and ultimately, patient compliance (Finlay and Lyons 2002). The therapeutic dyad, which is the focus of most educational programs, typically becomes a triad due to collateral data source(s) being present during interface with the individual; the clinician must "manage the triangle" to utilize the time effectively. The clinician should address

the patient with ID during the appointment, regardless of the patient's communication ability. If patients are non-verbal or have significantly limited communication abilities, the clinician should observe them for relatedness to others; impulse control; activity level, including both voluntary and involuntary motor movements; expression of affect; attention span; and any unusual, ritualistic, or repetitive behavior; among other observations related to their psychological and/or medical status. If individuals with ID use assistive or communicative devices, the devices should be treated as part of the patient's personal space. According to the American Psychiatric Association's Guidelines for the Treatment of Psychiatric Disorders (2006), providers should:

use professionally trained interpreters with mental health experience ... for those who are deaf, who have severely limited hearing and who know a sign language. Evaluation of persons with [*intellectual disability*] may emphasize behavioral observations and functional measures, depending on the patient's ability to understand questions and report on his or her own mental experiences. Co-occurring general medical conditions are often undetected in adults with [*intellectual disability*].

More detail on the mental status examination is beyond the scope of this chapter; however, Levitas et al. (2001) discuss the interview for individuals with ID in detail and the nuances specific to the ID population. As with every patient, the clinician should be aware of and respect the cultural, socio-economic, educational, and environmental background of the individual.

Historically, clinicians working in the mental health field have found that the applicability of the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision* (2000) and the *International Classification of Diseases, Tenth Revision, Criteria for Mental Retardation* (1996) are relatively limited in their utility for patients with ID. Many of the diagnostic criteria in these manuals are based on subjective reports from the individual on their inner mood and perceptual experiences. Patients with ID often have limited expressive language skills, and hence the *Diagnostic Criteria—Learning Disability* (DC-LD 2001; see Table 28.1) and the *Diagnostic Manual—Intellectual Disability* (DM-ID 2007; see Table 28.2) were introduced to better accommodate the increased use of observational and collateral data sources often necessary for an accurate diagnosis. These specialized classification systems are founded in evidence-based practices and expert-consensus principles; descriptions of mental disorders that differentiate patients with cognitive deficits from individuals in the general population are included, in addition to proposed alterations of criteria that take into account the developmental framework of the individual. Table 28.3 shows the proposed diagnostic criteria for the upcoming *Diagnostic and Statistical Manual (Fifth Edition)* to be published in 2013 (subject to change).

Patients with ID experience the full range of mental disorders at higher prevalence rates, and in addition, common habit-forming disorders indicative of poor self-regulatory control, including behaviors such as biting, trichotillomania, bruxism, motor and vocal tics, and Tourette's disorder (Long and Miltenberger 1998). A thorough and recent physical examination is essential. Coordination of care with the person's primary care physician is a major task of assessment and management, as both medical *and* mental health conditions may present with behavioral changes or problem behaviors. (See Table 28.4 for Sovner's [1986] four concepts to assist clinicians in the psychiatric assessment of individuals with ID.)

Table 28.1: Diagnostic Criteria for Learning Disabilities (DC-LD) for Use with Adults

- Diagnostic criteria: Criteria are used synonymously with the ICD-10 term *mental retardation*. The diagnosis of mental retardation is dependent upon the person's having an intelligence quotient below 70, together with continued impairment in adaptive behavior/social functioning, and with onset during the developmental phase (i.e., before the age of 18 years). The term *borderline learning disabilities* is not included in the ICD-10, nor is it included in DC-LD. Within most European and North American cultures, ICD-10 recommends the use of the Vineland Adaptive Behavior Scales as an assessment tool.
- Severity of learning disabilities:
 - Mild learning disabilities: IQ Range = 50–69; mental age 9 to under 12 years
 - Moderate learning disabilities: IQ Range = 35–49; mental age 6 to under 9 years
 - Severe learning disabilities: IQ Range = 20–34; mental age 3 to under 6 years
 - Profound learning disabilities: IQ Range = 20; mental age less than 3 years
 - Other learning disabilities
 - Unspecified learning disabilities
- Clinical summary sheet (this relates the DC-LD descriptive classification to its etiology, using the four dimensions of *biological, psychological, social, and development*, and provides an example of other summary information relevant to clinical practice)
- Diagrammatic presentation of the hierarchical approach to diagnosis that is adopted throughout DC-LD (identify severity and cause of learning disability; identify developmental disorders, psychiatric illnesses, personality disorders, problem behaviors, and other ICD-10 disorders)

The text of DC-LD provides additional information on psychiatric assessment of adults with learning [intellectual] disabilities.

Adapted from The Royal College of Psychiatrists, *DC-LD (Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation)*. London: Gaskell, 2001; p. 18 and Figure 5.

CASE VIGNETTE, CONTINUED

Anne remained stable following her discharge from the hospital, for a period of three weeks, at which time her work supervisor was transferred to another location without warning. The following morning, staff noticed that Anne was talking to herself and required extra time to get ready for work. Anne stated that she would not get on the bus because “I won't be safe,” and she responded to staff only after long pauses, appearing confused by some of their statements. Staff noticed that she spent 45 minutes in the bathroom (much longer than was typical for her) and insisted on carrying her family photo album with her all day long. “Someone will steal my pictures if I leave them here.” Following breakfast, she wrapped up extra food in a napkin and placed it in her purse. She closed all of the curtains in the kitchen, stating she did not want the police to “come pick me up again.”

This vignette illustrates some of the nuances that Sovner (1986) outlined (see Table 28.4), including subtle changes in behavior that may initially be overlooked by direct care staff (baseline exaggeration), and how the structure of a supported residential setting combined with the individual's limited socialization in the community may complicate detection of symptoms (psychological masking). Furthermore, Anne had difficulty identifying and articulating her emotions, thus adding further layers of complication (intellectual distortion).

Table 28.2: Diagnostic Manual – Intellectual Disability Criteria for Intellectual Disabilities

American Association of Intellectual and Developmental Disabilities, from Diagnostic Manual – Intellectual Disability (DM-ID, 2007)

AAIDD definition: “a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The disability originates before age 18” (American Association of Mental Retardation, 2005). To this they add “Five Assumptions Essential to the Application of the Definition:”

1. Limitations in present functioning must be considered within the context of community environments typical of the individual’s age peers and culture.
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.
3. Within an individual, limitations often coexist with strengths.
4. An important purpose of describing limitations is to develop a profile of needed supports.
5. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve.

(American Association on Mental Retardation, 2005)

Degrees of Severity

Mild 50–55 to 70

Moderate 35–40 to 50–55

Severe 20–25 to 34–40

Profound below 20–25

AAIDD categories

Intermittent Support

Limited Support

Extensive Support

Pervasive Support

Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.). (2007). *Diagnostic Manual – Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability*. Kingston, NY: NADD Press. Pages 64–66.

Table 28.3: DSMV Proposed Criteria for Intellectual Disability

Proposed Criteria for Intellectual Developmental Disorder in DSM 5 (to be published in May, 2013)

Intellectual Developmental Disorder (IDD) is a disorder that includes both a current intellectual deficit and a deficit in adaptive functioning with onset during the developmental period. The following 3 criteria must be met:

- A. Intellectual Developmental Disorder is characterized by deficits in general mental abilities such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning and learning from experience.
- B. Impairment in adaptive functioning for the individual’s age and sociocultural background. Adaptive functioning refers to how well a person meets the standards of personal independence and social responsibility in one or more aspects of daily life activities, such as communication, social participation, functioning at school or at work, or personal independence at home or in community settings. The limitations result in the need for ongoing support at school, work, or independent life.
- C. All symptoms must have an onset during the developmental period.

Table 28.4: Challenges in the Diagnostic Assessment of Psychiatric Disorders in People with Intellectual Disability

<i>Cognitive disintegration:</i> vulnerability to decompensation under stress and subsequent overload of cognitive functioning may lead to bizarre, atypical, and even psychotic-like presentations
<i>Psychosocial masking:</i> limited life experiences and intellectual capacity can influence the content of psychiatric symptoms
<i>Intellectual distortion:</i> diminished abstract thinking and communication skills limit the ability of the person to accurately and fully describe their emotional and behavioral symptoms
<i>Baseline exaggeration:</i> pre-existing maladaptive behavior not attributed to a mental illness may increase in frequency or intensity with the onset of a psychiatric disorder

Sovner R. Limiting factors in the use of DSM-III criteria with mentally ill/mentally retarded persons. *Psychopharmacol Bull* 1986; 22(4): 1055–1059.

BIOPSYCHOSOCIAL MODEL

The utility of the biopsychosocial model is vital when determining the etiology of behavior and/or mental health symptoms in patients with communication difficulties. Many patients will present with undiagnosed or under-treated medical conditions, and the knowledgeable clinician is often faced with the difficult task of screening for these critical aspects of care and subsequently arranging the appropriate interdisciplinary referral.

In addition to the shift in disposition management of individuals with ID from institutionalization to deinstitutionalization, there has also come a shift in the paradigm of treatment approach with the ID population. Much like the treatment of patients with typical cognitive ability, new literature highlights the importance of a holistic approach for individuals in need of care. During the history-gathering and assessment phases performed by the clinician, better outcomes and more specific diagnoses are delineated when the patient is approached in a multidimensional format. Similar to the management of delirium in determining the underlying cause of an encephalopathic presentation, approaching the patient with ID warrants a systems-based approach, in which multiple facets of the patient are explored and analyzed. This was originally described and outlined as the biopsychosocial model, first developed by the physician George Engel in 1977 (Engel 1977, Engel 1980).

Essentially, recognizing that an entity in one system may be influencing or affecting an entity in another system is core to the model. For example, one’s primary attachment figures throughout one’s formative years most definitely impact one’s characterological makeup and personality throughout one’s life. This is illustrated in the vignette, where Anne’s mother, an unpredictable and chaotic presence during Anne’s childhood, significantly influences Anne’s current fears of abandonment and lack of security. This subsequently leads to Anne’s acting-out behaviors and poor coping mechanisms. All spheres, to include biological, psychological, and sociological components, must be acknowledged and addressed by the primary mental health provider and all collaborating treatment team members. (See Table 28.5 for Comprehensive Assessment of Persons with Intellectual Disabilities.)

Table 28.5: Comprehensive Assessment of People with Intellectual Disabilities and Aggressive Behavior (Charlot and Shedlack)

Identify genetic syndromes with known behavioral or psychiatric phenotypes
Establish any psychiatric diagnoses, based on most recent standardized evidence based diagnostic manual for individuals with intellectual disability
Determine if there are undetected or untreated medical problems
Determine if there is a correlation between drug changes and changes in behavior
Consider possible role of drug effects, including toxicity/delirium, side effects (akathisia, disinhibition), withdrawal effects, interaction effects
Identify objective measures of symptoms or behaviors: use screening tools as appropriate, measurement of behaviors, assessment of vegetative functions, mood, memory, and other mental status information
Look for any correlation with stressful life events and changes
Assess all environments, including structure/supports to meet cognitive developmental needs
Collect detailed data on baseline functioning of the individual
Consider likely developmental effects on the problems described
Assess the individual's abilities to describe internal states and other communicative abilities
Determine behavioral repertoire, including areas of strength and weaknesses
Assess probable functions of the aggressive behavior, including escape, attention, communication, expression of pain or frustration, modulation of stimulation levels, secure tangibles. Triggers? Factors that maintain behavior? Quantify frequency and severity. Identify variables contributing to a lowering of the threshold for aggression
Identify changes in behavioral or other psychosocial treatments correlated with increased problems
Clarify past treatment trials: What helped? What did not help? Was trial adequate? Were there possible confounding variables? Were successful interventions prematurely terminated?

Charlot L, Shedlack K. Masquerade: Uncovering and treating the many causes of aggression in individuals with developmental disabilities. *NADD Bulletin*. 2002; 5: 59–64.

VIGNETTE, CONTINUED

Several months later, Anne's caregivers report episodic physical aggression to the psychiatrist at a follow-up appointment. They request an increase in her psychotropic medication, specifically her antipsychotic medicine. The psychiatrist inquires about the circumstances of the aggression: "What is the nature of the aggression (physical? verbal? property destruction?) What are the precipitating factors or antecedents? Is there a pattern such as time of day and environment (home or work)? What interventions have been tried to de-escalate the patient? What tends to increase or decrease the frequency and severity of the aggression? Has the patient had a recent physical exam and laboratory workup? What are the acute or chronic psychosocial stressors (e.g., losses, changes in staff or routine, family conflicts, among others)?"

After collecting data on the biological, psychological, and social factors of the presentation, the psychiatrist concludes that Anne's physical aggression is almost exclusively directed toward staff that encourages her to eat her meals. The aggression is worse in the evening, and her sleep has become disrupted in the

previous four weeks. The psychiatrist recommends that Anne be evaluated by her primary care physician to rule out gastrointestinal conditions. Anne was found to have exacerbation of her gastro-esophageal reflux disease, a very painful condition that is common in individuals with ID, and if untreated for long periods of time puts the individual at increased risk for esophageal cancer.

Table 28.6: Clinical Pearls Based on Expert Consensus for Treating the Patient with ID Who Has Aggression or SIB

Treatment should be based upon the most specific psychiatric diagnosis possible. When only a tentative non-specific diagnosis can be made, such as in individuals with more severe ID, clinicians should focus on one or more behavioral symptoms as targets of treatment.
<ul style="list-style-type: none">• Utilize neuroreceptor correlates of aggression to guide pharmacological interventions• Utilize the biopsychosocial formulation to determine etiology• Identify “predisposing,” “perpetuating,” and “protective” factors• Rule out undiagnosed and/or under-treated medical conditions• Depression and anxiety tend to be under-diagnosed• Rule out physical pain (acute and chronic)• Rule out medication side effects• Shore up supports during transitions• Ensure thorough physical examination and laboratory workup are conducted• Identify grief and loss issues and address appropriately• Manage the triangle during the data collection process• Perform a functional analysis• Enlist a behavioral psychologist or behavior support specialist• Be familiar with the individual’s baseline functioning
Medication Practices to Avoid:
Long-term use of benzodiazepine anti-anxiety agents (e.g., diazepam) or shorter-acting sedative hypnotics (e.g., zolpidem)
Use of long-acting sedative hypnotics (e.g., chloral hydrate)
Use of anticholinergics without extrapyramidal symptoms
Higher than usual doses of psychotropic medications
Use of phenytoin, phenobarbital, primidone as psychotropics
Long-term use of “PRN” or “as needed” medication orders
Failure to integrate medication with psychosocial interventions

Aman MG, Gharabawi GM., for the Special Topic Advisory Panel on Transitioning to Risperidone Therapy in Patients with Mental Retardation and Developmental Disabilities. *Treatment of behavior disorders in mental retardation: Report on transitioning to atypical antipsychotics, with an emphasis on risperidone.* J Clin Psychiatry 2004; 65: 1197–1210.

(See Table 28.6 for Clinical Pearls from Expert Consensus Guidelines for Treatment of Patients with Intellectual Disabilities.)

According to the American Diabetic Association (2010), life expectancy for individuals with ID has increased to the extent that young adults with ID should experience the same “expected life” as their age-matched peers without ID (American Diabetic Association [ADA] Guidelines 2010). Prevalence rates are higher for seizure disorders, heart disease, obesity, hearing and vision

problems, and low bone-mineral density. They are at higher risk for medical conditions involving every organ system, further complicated by genetic conditions and the prevalence of polypharmacy. (For a review of the alterations to medical prevention and monitoring protocol for adults with ID, see Wilkinson et al. 2007.) Patients with ID are significantly less likely to participate in or be exposed to traditional preventative treatment methods for most if not all medical conditions (Havercamp et al. 2004). The obstacles to treatment must be eliminated at all costs.

NON-PHARMACOLOGICAL THERAPEUTIC INTERVENTIONS

The clinician must view behavior as a form of communication, as this will inevitably serve the patient well (Bongiorno 1996). Ultimately, understanding and identifying the underlying problem will reveal whether or not an underlying diagnosis of a comorbid psychiatric disorder or habit disorder exists. Because polypharmacy practices are so prevalent in the ID population, it is vital that the prescriber consider non-pharmacological intervention prior to any initiation of psychotropic medications. Often psychotherapy and socio-environmental interventions can be effective in and of themselves without the use of psychotropic medications. Investigation must continue to delineate the etiology of the presenting behavior (i.e., collection of behavior support data, collateral data across environments, performing a physical examination, obtaining laboratory values, and ensuring examination by a primary care physician).

Long and Miltenberger (1998) reviewed available literature on behavioral treatment modalities for individuals with ID. Those with efficacy included self-monitoring, covert sensitization, relaxation techniques, cognitive-behavioral therapy, over-correction, and positive and negative practice. In *Clinical Pearl: From the Use of Medication for the Management of Behavior Problems Among Adults With Intellectual Disabilities: A Clinician's Consensus Survey*, Unwin and Deb (2008) reported that one important finding is the very strong preference to use non-medication-based management options as one primary intervention for aggression and self-injurious behavior.

VIGNETTE, CONTINUED

Anne graduated from high school, having successfully completed an individualized educational plan. Many of Anne's peers who had been together throughout all of their school years lived with their families, and most transitioned to sheltered workshops at the same time as they were moving from family homes to supported residential group homes. Anne began compulsively checking and counting as her anxiety increased in anticipation of the two major transitions. She moved in to the group home with Jess, one of her female girlfriends with whom she had graduated. Shortly after they had moved into the group home, Anne became upset that Jess's family picked her up every weekend and visited the group home frequently. Jess's family regularly included Anne in their outings, but despite their best efforts, Anne experienced emotional upheaval every Friday evening as the young women discussed their weekend plans and Anne's mother would not return her phone calls.

The mental health team recommended consultation from a behavior support specialist who created a plan that identified the antecedents, behaviors, and consequences of the weekly emotional upheaval. Anne was given extra activities on weekends and incentives to spend more one-on-one time with her favorite direct-care staff if she was able to utilize coping strategies she learned in her individual psychotherapy. The staff was also asked to attend the last few minutes of each appointment (with Anne's consent) so that they were aware of the coping skills to be reinforced between appointments.

This part of the vignette illustrates the inherent difficulties during the transition years (from roughly 17–24 years of age) as many individuals with ID transition from family homes to supported residential systems in the community as well as from the educational to the occupational systems. Utilization of the entire multidisciplinary team is essential so that all of Anne's psychosocial needs are met and to increase her quality of life.

PSYCHOTHERAPY IN INDIVIDUALS WITH ID

Historically many mental health clinicians thought that individuals with ID could not suffer from mental illness; others believed that they did not possess the cognitive ability to benefit from psychotherapy. Over the past decade, mental health professionals have come to understand that individuals with ID can and do benefit from psychotherapy. However, the literature also suggests that several modifications to traditional treatment methods must be made in order to improve the efficacy of the treatment provided. Clinicians must adjust the mode of psychotherapy provided to fit the cognitive abilities of the patient, as insistence upon the use of traditional models of treatment will result in poor treatment outcomes and will prevent patients with ID from receiving appropriate care (Whitehouse et al. 2006). (See Table 28.7 for adaptations that should be considered regardless of the type of therapeutic intervention provided.)

There are also adjustments that can be made to specific treatment models that can help strengthen the impact of the therapeutic intervention being utilized. What follows is a brief review of several modalities that show promise with this population, along with suggestions regarding modifications that clinicians can consider when treating patients with ID.

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) was developed by Miller and Rollnick (2002) in order to address the conflicting feelings that individuals frequently experience when thinking about making changes in problematic behaviors (Miller and Rollnick 2002). The psychotherapist targets this ambivalence and works with the patient to resolve it. MI was initially intended as a tool in the treatment of substance-use disorders; however, it has now been shown to be an effective intervention to increase motivation for treatment when dealing with a variety of mental health disorders. When using this method, psychotherapists take a nonjudgmental approach and do not confront the patient about their continued engagement in problematic behaviors. Instead, they focus on

Table 28.7: Psychotherapy Adaptations for Patients with Intellectual Disability

Flexible sessions	Length of therapy sessions should match the individual's attention span. For some patients, this may be no longer than 30 minutes.
Simplification of interventions	Break down intervention into smaller chunks and reduce the complexity of the techniques being utilized.
Adjust language	Reduce level of vocabulary, sentence structure and length of thought to match the cognitive abilities of the patient.
Augment interventions with activities	Use of activities can help deepen change and learning and may include the use of drawing, therapeutic games, role play, and homework assignments.
Involve caregivers	Important source of collateral information necessary to ascertain progress between sessions.
Increased length of care	Most research indicates that a longer length of treatment (1–2 years) is a best practice with this population. This allows the psychotherapy to move at a slower pace so that the clinician can spend additional time on each intervention utilized, ensuring that the skills being taught are internalized. It also allows for the inclusion of additional treatment stages that may be necessary.

helping the patient develop insight regarding the nature of their problems, the potential consequences of their maladaptive behaviors, and the potential benefits of making positive changes.

MI may be a helpful treatment method when working with individuals with ID, as they are often not self-referred for care. Instead, they are typically referred by involved care providers who are concerned about some type of maladaptive behavior—which may or may not be a source of concern for the patient. This can result in patient ambivalence about participation in psychotherapy, as the referral may be seen as a punishment rather than as an opportunity for self-exploration and growth. Addressing issues related to motivation may help increase the patient's readiness and acceptance of treatment, which is necessary before problematic behaviors are addressed. When working with this population, clinicians may need to take a more directive stance than is typically utilized with this approach, as the patient may benefit from feedback regarding appropriate or socially acceptable behavior and may require assistance with identifying and expressing their feelings regarding the possibility of change.

COGNITIVE BEHAVIORAL THERAPY

Cognitive behavioral therapy (CBT) is a treatment modality that focuses on helping individuals understand how their thoughts, feelings, and behaviors are interconnected. Patients learn how their conscious thoughts, automatic thoughts, and cognitive schemas impact their sense of self-worth as well as their views of the world around them. They are taught to identify and change thinking patterns that negatively impact their feelings and behaviors, as well as learning to replace maladaptive behaviors with more appropriate responses (Romana 2003). This approach

has been shown to be highly effective; however, it is also understood that the ID population may find it difficult to understand the abstract concepts that are the central focus of treatment. Therefore, the psychotherapist will need to include a preparatory phase in the treatment process, in which the patient receives the education and training needed to ensure comprehension of all components. It is helpful to involve care providers, with the patient's consent, as they can be a valuable resource. In addition to providing much-needed collateral information, they can function as a part of the multidisciplinary team and help support the patient's engagement in psychotherapy. For example, they can facilitate the learning process by helping the patient practice the skills learned between sessions, such as the identification of thought distortions. Care providers can also assist with the completion of homework, reinforcing the work between appointments assigned to the patient to solidify concepts.

DIALECTICAL BEHAVIORAL THERAPY

Dialectical behavioral therapy (DBT) was developed as a treatment for chronically suicidal patients who were not benefiting from traditional treatment methods. It is proven to be an effective technique for patients diagnosed with borderline personality disorder. The psychotherapist focuses on teaching the patient to cope with life stressors, regulate their emotions, and improve their interpersonal relationships (Lew 2011). The provision of DBT includes both weekly individual therapy sessions and weekly group skills training. There are four main skills that are taught in the skills training: mindfulness, interpersonal effectiveness, distress tolerance, and emotional-regulation skills (Linehan 1993). This approach is a good fit for individuals with ID, who can benefit from the structure and the focus on skill building that it provides. Slight modifications can be made to the traditional treatment model to ensure that the cognitive needs of the patient are adequately addressed (Charlton and Dykstra 2011). Individuals with ID may have limited concentration ability, making it difficult for them to sustain attention for the two-and-a-half-hour group sessions, further decreasing their opportunity to benefit from the material presented. Recent literature suggests that this can be addressed by decreasing the length of group sessions to 30 minutes, and either adding a second session during the week or increasing the overall length of care to ensure that there is sufficient time to cover all pertinent material. Patients with ID may also benefit from increasing the amount of time that is spent on each of the four skills, as repetition of information and additional opportunities to practice the principles taught will help to make certain that the material is internalized. DBT typically utilizes handouts, homework, and diary cards as supplements to the information presented. For patients with ID, it is important to ensure these are simplified so that they are easily understood by the patient. The use of concrete language and the addition of pictures to illustrate the concepts and will increase the patient's ability to implement the skill modules between treatment sessions.

SUPPORTIVE PSYCHOTHERAPY

Supportive psychotherapy (SP) is an eclectic approach that combines several different treatment modalities, including CBT, psychodynamic therapy, and interpersonal psychotherapy. It is based on the theory that the positive and affirming relationship between the patient and

psychotherapist can serve to repair maladaptive core schemas that developed as a result of inadequate parenting (Douglas 2008). The goal of SP is to change self-destructive behavior and to improve the patient's ability to cope with stress as well as to improve their interpersonal skills and relationships. A more directive stance is taken with this modality, in which clinicians frequently provide suggestions, opinions, and feedback. The clinician also involves family members or care providers and may do some case management, such as assisting the patient in accessing community resources or engaging with an employer when necessary. SP is a sound treatment option for this population, as many individuals with ID can benefit from the validation, direction, and advocacy that is inherent in this approach. As with the other modalities, it is important for the clinician to simplify the interventions being utilized and to plan for a longer duration of care to allow for necessary practice and review of learned skills.

Overall, psychotherapy is a best practice when working with the ID population. However, it is also inherently more challenging due to their varying levels of cognitive ability. Clinicians will need to recognize and address language barriers, memory deficits, and learning variations in order to provide an intervention that will be meaningful and effective for the patient. Small modifications, such as increasing length of treatment and repetition of therapeutic interventions, significantly increase efficacy.

PSYCHOTROPIC MEDICATIONS

Primum non nocere ("first, do no harm"). Review of the literature and history indicates that the ID patient population has often been subject to polypharmacy and is known to be more vulnerable to medication side effects. The use of older or first-generation antipsychotics can cause extrapyramidal side effects, and the use of newer or second-generation neuroleptics increases the risk of cardiac and metabolic problems, including diabetes, obesity, and hyperlipidemia. In an effort to incorporate a universal and standardized level of care, The Clinical Bulletin of the Developmental Disabilities Division published a guide for prescribing psychotropic medication for the management of psychiatric disorders and problem behaviors in adults with ID (2010). The Bulletin reported that more than 30 percent of individuals with ID have a comorbid psychiatric disorder, which often has its onset in childhood and persists throughout the lifespan (Cooper et al. 2007, Einfeld et al. 2006). Of this 30 percent with ID and a co-occurring psychiatric diagnosis, 20 to 45 percent receive some form of psychotropic medication to target the identified problem, such as aggression, self-injurious behavior, or the diagnosed psychiatric disorder. More specifically, of those receiving psychotropic medication, 14 to 30 percent are receiving medication to manage their problem behavior (PB) (Clark et al. 1990, Deb and Fraser 1994).

"Problem behaviors" (PB) in the world of ID have been defined as a "socially unacceptable behavior that causes distress, harm or disadvantage to the persons, themselves or to other people, and usually requires some intervention" (Deb et al. 2006). PB is the most common justification for use of pharmacotherapy. The most effective way to navigate an investigation of the etiology of the PB is use of the biopsychosocial model; i.e., psychiatric and medical disorders, grief and loss issues, environmental factors, characterological pathology, among other etiologies. If a cause cannot be identified, the treatment goal should be to minimize the disruption to the patient's quality of life (Fletcher et al. 2007, Royal College of Psychiatrists Diagnostic Criteria for Learning Disorders (DC-LD), 2001).

Abbreviated care is unacceptable in patients with ID; therefore, serial in-person appointments, laboratory analyses with physical examinations, and diagnostic studies when deemed appropriate should be pursued according to universally accepted standards (Unwin and Deb 2008). Also, it is crucial to increase the use of standardized, measurable instruments when monitoring for extrapyramidal side effects, in particular in patients with muscular disorders such as cerebral palsy (Unwin and Deb 2008). It is recommended to begin with the lowest starting dose, to titrate slowly, and to remain within the dose range outlined by the *Physician's Desk Reference*, the Food and Drug Administration, and/or alternate prescribing authorities. Nonetheless, the following general recommendations are to be emphasized:

1. Try to stabilize the person's PB on a minimum number of medications prescribed at the lowest possible dose;
2. Withdraw one medication at a time;
3. Withdraw medication slowly;
4. If necessary, allow time after withdrawing one medication and before starting to withdraw another (Unwin and Deb, 2008).

It is a fact that patients with ID are more vulnerable to side effects of psychotropic medications, and there is often a lack of subjective complaints due to their deficits in expressive language skills. An empirical and standardized measure of target symptoms and behaviors must be instituted, including a format to quantify the benefits and adverse effects of psychotropic medication (Clinical Bulletin of the Developmental Disabilities Division, 2010).

PB remains a primary cause for clinicians' anxiety and can segue into unnecessary over-prescribing of medications and ancillary treatment strategies such as hospitalization. Nonetheless, PBs are the reason more than 90 percent of patients with ID present for mental health evaluation (even when they have undiagnosed and under-treated medical conditions). PBs are the most frequent reason for psychiatric hospitalization, the biggest cause for morbidity and mortality, and the reason many prescribers feel the only intervention available is to prescribe antipsychotic medications (Emerson et al. 2001, Lowe et al. 2007). Polypharmacy is especially common in mental health delivery systems where there is a lack of behavioral interventions, highly restrictive managed-care guidelines, and/or a lack of intersystem collaboration. Other types of disruptive behaviors have been found and included in the differential when addressing changes in patterns of behavior in the patient with ID. Aggressive, antisocial, and self-injurious behavior have been described by Aman and Gharabawi (2004) as analogous to disruptive behavior disorders as defined by the *DSM-IV TR* (2000).

Patients with ID are more susceptible to mood and anxiety disorders than others in the general population, and these tend to be under-diagnosed. They are more vulnerable to developing these disorders, in part due to their limited internal resources for dealing with stress and their circumscribed problem-solving skills. Treatment of anxiety is complicated by the paradoxical stimulation that some patients with ID experience with benzodiazepines. Other considerations with this medication class relevant to this specialized population include its potential to cause retrograde and anterograde amnesia (when memory problems already exist with cognitive deficits), impaired sensorium, sedation, and potential for respiratory depression (in patients already vulnerable to pulmonary pathology). When paradoxical stimulation occurs, it is thought to be due to disinhibition or disorientation, and this state can increase impulse control problems, agitation, or PBs. With regard to prescription of all psychotropics, it is important to be aware of

medications which alter seizure thresholds (e.g., bupropion) due to the high seizure prevalence in the ID population. Psychotic disorders tend to be over-diagnosed in the ID population, and antipsychotic medications are over-prescribed.

EXPERT CONSENSUS GUIDELINES

While no evidence-based practices exist in the field of ID, consensus-based practices will suffice; every acknowledged expert in the field of ID agrees that there is a need for evidence-based research. The following is a list of citations of documents written by acknowledged prescribing authorities in the field of intellectual disabilities.

- Kalachnik JE, Leventhal BL, James DH, Sovner R, Kastner TA, Walsh K, Weisblatt SA, Klitzke MG. (1998). Guidelines for the use of psychotropic medication. In S. Reiss and M. G. Aman (Eds.), *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook* (pp. 45–72). Columbus: Ohio State University, Nisonger Center.
- *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook* (Reiss, S. and Aman, M. G., eds.); American Association of Mental Retardation, 2000.
- Aman MG, Crismon ML, Frances A, King BH & Rojahn J (eds.) (2004) *Treatment of Psychiatric and Behavioral Problems in Individuals with Mental Retardation. An Update of the Expert Consensus Guidelines for mental retardation and developmental disability populations*. Postgraduate Institute for Medicine, Englewood, CO.
- Deb S, Clarke D, and Unwin G (2006). *Using Medication to Manage Behavior Problems Among Adults with a Learning Disability: Quick Reference Guide* (QRG). University of Birmingham, MENCAP, The Royal College of Psychiatrists, London. (See www.Id-medication.bham.ac.uk.)
- Fletcher R, Loschen E, Stavrakaki C, and First M. (Eds.). (2007). *Diagnostic Manual—Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability*. Kingston, NY: NADD Press.
- *Problem Behavior in Adults with Intellectual Disabilities: International Guide for Using Medication. Section on Psychiatry of Intellectual Disability (SPID)*. The World Psychiatric Association (WPA): Working group. September 2008.
- Unwin G and Deb S. (2008) Use of medication for the management of behavior problems among adults with intellectual disabilities: A clinicians' consensus survey. *American Journal on Mental Retardation*, 113(1), 19–31.
- *Clinical Bulletin of the Developmental Disabilities Division. International Guide to Prescribing Psychotropic Medication for the Management of Problem Behaviors in Adults with Intellectual Disabilities*. World Psychiatry Association, 2010.

Expert consensus recommends utilizing the same medications for patients with ID that are used to treat disorders in the general population. No evidence exists to support inter-class or intra-class polypharmacy or to prescribe regimens that are qualitatively different from those used in the general population. Use of general evidence-based practices is appropriate and logical until more specific empirical research is available.

FINAL THOUGHTS

The parameters outlined in this chapter provide a framework for mental health clinicians to use in adhering to the guidelines of evidence-based practices in the care of the patient with ID and mental illness. There are currently no best practices or evidence-based medicine principles specific to this specialized population, but consensus-based guidelines from acknowledged experts, combined with application of evidence-based medicine principles for the general population, will suffice. Individuals with ID are vulnerable to the side effects of psychotropic medications, and in particular the extrapyramidal and metabolic side effects of antipsychotics. Depressive and anxiety disorders tend to be under-diagnosed, and psychotic disorders tend to be over-diagnosed. It must be a priority to eliminate polypharmacy and offer the full range of mental health treatments to all individuals with ID. Behavior must be viewed as a form of communication; physical and mental health must be addressed in a collaborative effort to eliminate undiagnosed and under-treated medical conditions in this medically fragile population. Utilization of the biopsychosocial formulation and the institution of multidisciplinary treatment plans are core to effective mental health treatment. Collaboration of systems works well and is a necessity.

As is the case in all medical and mental health treatment modalities for any type of pathology, long-established assumptions about treating the patient require ongoing modification and review. Treating the patient with ID is no exception. The well-known physician Hunter Campbell Adams once said, "We can never get a re-creation of community and heal our society without giving our citizens a sense of belonging." Previously marginalized individuals with ID and mental illness are important members of our society and deserve the highest-quality mental health services. Psychotropic medications should improve cognitive function, not worsen it; psychotropic medications should fully treat mental health issues. We expect no less when treating an individual in the general population. Treating the patient with ID the same as any other, with virtue and professionalism, is sure to lead to their stability and increased quality of life.

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ADDRESSING SUICIDE RISK IN COMMUNITY MENTAL HEALTH

DARCY HAAG GRANELLO

In 2001, the Department of Health and Human Services (DHHS) issued the National Strategy for Suicide Prevention. Numerous public and private partners, including the Office of the Surgeon General, Substance Abuse Mental Health Services Administration (SAMHSA), the Centers for Disease Control (CDC), Department of Defense (DoD), and the National Institute of Mental Health (NIMH), developed the first-ever comprehensive and integrated public health approach to reducing suicide deaths and suicide attempts in the United States (DHHS, 2001). In 2003, the President's New Freedom Commission on Mental Health reiterated the importance of this strategy and called for the full implementation of the recommendations contained therein. More than a decade later, the original eleven goals outlined in the national strategy continue to provide an important structure for anyone working in community mental health. Divided into the three major categories of *awareness*, *intervention*, and *methodology*, the goals in the national strategy help focus suicide prevention efforts that involve millions of consumers of mental health as well as the professionals who work with them. This chapter uses the eleven goals in the national strategy to help organize the current research and best practices in suicide prevention and intervention in community mental health.

MAGNITUDE OF THE PROBLEM

Each year in the United States, more than 36,000 people take their own lives (Crosby, Han, Ortega, Parks, & Gfroerer, 2011). That equates to nearly 99 people a day, or a person lost to suicide every 14 minutes. In the United States, suicide is more than twice as common as homicide, and is now the tenth leading cause of death. Over the past decade, the suicide rate in America has been increasing. In 2008 (the latest year for which numbers are available), suicide rates increased 2.6% over the previous year, for a rate of 11.8 per 100,000 in the population, the highest rate in 15 years.

As alarming as these numbers are, focusing only on completed suicides belies the true magnitude of the problem. Each year, an estimated 1.1 million adults make a suicide attempt, translating to an attempt every 38 seconds. Greater still is the number of Americans who seriously consider suicide. In 2008, a national study of suicide risk found that 8.3 million American adults aged 18 or older (3.7% of the population) seriously considered suicide in the past year, and 2.3 million (1% of the population) made a suicide plan (Crosby et al., 2011). Among youth, 17% of high school students reported that they had seriously considered suicide in the past year, and more than 8% reported that they had actually attempted suicide during the same period, with 2.6% making an attempt that required medical attention (Eaton et al., 2006). A 2006 study of college students found that one in 10 said that they had “seriously considered suicide” during the past year (American College Health Association, 2007).

The effects of suicidal thoughts, attempts, and completions ripple outward beyond the individuals involved into the larger community. In addition to those who die by suicide each year, as many as 200,000 additional individuals are impacted by the loss of a loved one to suicide (Corso, Mercy, Simon, Finkelstein, & Miller, 2007). As many as 7% of the U.S. population (approximately 22 million people) state that they have been exposed to a suicide death within the last year, with 1.1% of the sample in a large national study stating that they have lost an immediate family member to suicide within the previous year (Crosby & Sacks, 2002).

There are also significant economic costs associated with suicide. The total lifetime costs of all self-inflicted injuries (attempts and deaths) occurring in just one year in the United States is approximately \$33 billion, which includes \$1 billion for medical treatment and \$32 billion in lost productivity. Translated into cost per person, the average cost per case of suicide death is \$1 million in lost productivity and \$2,596 in medical costs. The average cost for each suicide attempt is \$9,726 in lost productivity and \$7,234 in medical costs (Corso et al., 2007).

Although all races, ages, and both genders are affected by suicide, some groups are at higher risk. Males are four times more likely than females to die by suicide, representing 78.8% of all suicide deaths. However, women are three times more likely than men to attempt suicide, with approximately 59 attempts for every completion (compared with eight attempts for every completion in men). Whites/Caucasians have suicide rates that are higher than those of any other racial or ethnic group. The Caucasian rate of 15.1 per 100,000 is higher than the rates for Hispanics (5.2 per 100,000), Blacks/African Americans (5.2 per 100,000), American Indians/Alaskan Natives (11.9 per 100,000), or Asian/Pacific Islanders (5.8 per 100,000) (Crosby et al., 2011).

Suicide risk differs by age. Among those aged 25 to 34, suicide is the second leading cause of death (behind accidents). Suicides represent the third leading cause of death among 15- to 24-years-olds (nearly 13% of all deaths annually). In addition, young people are significantly more likely to engage in suicide attempts. For every completed suicide in the 15 to 24 age group, it is estimated that there are up to 200 suicide attempts (Arias, Anderson, Kung, Murphy, & Kochanek 2003), compared with between two to four attempts for every completion in adults older than 65 (Miller, Segal, & Coolidge, 2000).

There are significant gender differences in suicide risk based on age. For example, suicide rates for women peak between the ages of 45 and 54. For men, suicide rates rise with age, with the highest rates occurring after age 65. Suicide rates for males over age 65 are approximately 40 per 100,000, compared with 6 per 100,000 for females. The highest suicide rate for any age group, however, is for Caucasian males over age 85. Their rate of nearly 70 per 100,000 makes this group, by far, the most likely of any demographic group to complete suicide (Granello & Granello, 2007).

NATIONAL STRATEGY GOAL AREA: AWARENESS

If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, many lives can be saved.

—National Strategy for Suicide Prevention

GOAL #1: PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT IS PREVENTABLE

In 1999, the Surgeon General issued a “Call to Action to Prevent Suicide,” in which he acknowledged suicide as a major public health concern (U.S. Public Health Service, 1999). The World Health Organization declared suicide a “huge, but largely preventable public health problem” (World Health Organization, 2004). National and international campaigns have been launched to promote increased understanding and awareness of suicide. Underpinning these efforts is the widely held belief that promoting a better understanding of suicide risk and the importance of prevention and intervention among the general public can lead to a reduction in suicide deaths.

There have been significant efforts made over the past decade in moving toward a public-health approach to suicide. Increasingly, suicide is recognized as a product of the complex interaction of many different factors, both biological and environmental, spanning the socio-cultural, interpersonal, psychological, genetic, and neurological realms. As a result, there is increased understanding that suicide prevention is something that must be addressed using a population-based systems approach *in addition to* individually based intervention efforts (Center for Substance Abuse Treatment, 2008).

Strategies for Implementation of Goal #1

In community mental health, the goal of raising awareness is primarily done through education campaigns at the individual, group, and societal levels. There is evidence that Americans are often unaware of the options they have for effective mental health interventions, and in general, they do not have an adequate understanding of mental health or the preventable nature of suicide (U.S. Public Health Service, 1999).

Individual efforts. Education and information about a client’s particular mental illness or disorder is recognized as one of the curative factors that helps clients improve in treatment (Yalom, 2000). By the same token, education and information about suicide can help “normalize” the topic of suicide and give clients permission to discuss this difficult topic, as well as the strong emotions that often accompany thoughts of suicide (Juhnke, Granello, & Granello, 2011).

Group efforts. Mental health offices, agencies, and hospitals can provide educational information to their clients and families. For example, posters and brochures that raise awareness about suicide crises as well as depression are available for free from many different sources, including the Suicide Prevention Resource Center (SPRC.org).

Community/societal efforts. Research demonstrates that giving members of the general public a list of information about suicide risk factors significantly improves people’s ability to recognize if someone is suicidal, while simultaneously lowering the stigma associated with suicide

(Van Orden et al., 2006). Other strategies, such as posting the suicide hotline number, can be particularly effective. When seriously suicidal individuals call the suicide hotline, significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks (Gould, Kalafat, Munfakh, & Kleinman, 2007).

GOAL #2: DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION

During the last decade, suicide prevention has been recognized as a key element of a comprehensive mental health system (Center for Substance Abuse Treatment, 2008). There is increased understanding of the importance of a multidisciplinary approach. All human services professionals, not just mental health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence (U.S. Public Health Service, 1999).

Unfortunately, research demonstrates that there is widespread variability in the education and training of mental health professionals in the area of suicide risk assessment and intervention, and even less training for professionals in the general healthcare field. The average amount of training in suicide in most graduate programs in behavioral healthcare is less than one hour (Granello & Granello, 2007), and fewer than 50% of pre-doctoral psychology interns say that their programs offer *any* formal education in suicide risk assessment or intervention (Dexter-Mazza & Freeman, 2003). In fact, most of the helping professions have no standardized requirements for working with suicidal clients during graduate training, and there are no standardized requirements for continuing education for professionals (Daniels & Walter, 2002).

Training for behavioral healthcare professionals alone, however, is clearly not sufficient. Physicians and others in the general medical field must be trained as well. More than 20% of *all individuals* who die by suicide have had contact with their primary physician in the *week* prior to their death. Among older adults, more than 75% visited their physician in the month prior to their suicide (National Research Council, 2002). Unfortunately, research has found that only about one-third of primary care physicians inquire about suicidal thoughts with patients demonstrating clear signs of depression and/or seeking antidepressant medication (Feldman et al., 2007). In another study, 47% of primary care physicians stated that at least one of their adolescent patients had a suicide attempt during the previous year, but only 23% of these physicians stated that they routinely screened their patients for suicide (Frankenfield, Keyl, & Gielen, 2000).

Strategies for Implementation of Goal #2

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups—from schools, to faith-based organizations, to health care associations—is a way to ensure that prevention efforts are comprehensive.

Individual Efforts

Collaboration and consultation are the cornerstone of successful management of suicidal clients (Granello & Granello, 2007). Strong professional relationships between hospital and agency staff

are critical to the successful outcome of suicidal emergencies, and these relationships are best managed when they are formed and nurtured outside of the context of the crisis. Taking time now to reach out and establish connections at the individual level can help ensure smoother transitions and better outcomes for suicidal individuals during crises. In addition, individuals can advocate for discussion and education about suicide in their respective practice environments, seeking out training at the individual or agency level.

Group Efforts

Education of all staff in agencies, hospitals, schools, and offices can help reinforce the message that suicide prevention is a shared responsibility. Relying on front-line behavioral health providers to recognize suicide risk means that many suicidal individuals will never be properly assessed for suicide. Relatively simple and cost-effective measures, such as hanging posters about suicide prevention in emergency room departments, can be highly effective. In fact, one study found that simply hanging a poster titled “Is your patient suicidal?” with a list of key risk factors and questions to ask (available from SPRC.org) significantly improved assessment of suicide risk by all types of providers, including physicians, residents, and nurses (Otto, 2011).

Community/Societal Efforts

To make suicide prevention efforts more effective and to make efficient use of resources, suicide prevention should be integrated into programs and activities that already exist and included in the agendas of pre-existing community-level groups. It is often possible to target several health or social problems with one intervention, particularly since some risk factors put population groups at risk for more than one problem at the same time. Therefore, an intervention that targets one or more risk or protective factors has the potential to effect change in more than one identified problem. For example, the suicide rate has risen steeply over the last two decades for African-American youth, a group with a high risk for other health and social problems. Programs focused on enhancing educational and occupational opportunities for African-American youth may contribute to feelings of hope and self-assurance, and as a byproduct reduce suicide. However, by consciously integrating program elements that address suicide prevention more directly (for example, encouraging help-seeking for emotional distress), a program may be even more effective overall (DHHS, 2001).

GOAL #3: DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE, AND SUICIDE PREVENTION

Suicide is closely linked to mental illness and substance abuse, and effective interventions exist for both. More than 90% of individuals who die by suicide have a diagnosable mental illness and/or substance-use disorder (Granello & Granello, 2007), but the stigma associated with these disorders can prevent people from seeking the assistance they need. According to SAMHSA's 2006 National Survey on Drug Use and Health (NSDUH), of the 23.6 million people aged 12 or older in need of treatment for an illicit-drug-use or alcohol-use problem, only 2.5 million

(fewer than 10%) received treatment at a specialty facility. In the same year, among the 24.9 million adults aged 18 or older reporting serious psychological distress (having a level of symptoms known to be indicative of a mental disorder), fewer than half, or 10.9 million (44.0%), received treatment for a mental health problem (Office of Applied Studies, 2007). Stigma for mental health and suicide is especially pronounced in rural areas and among certain cultural groups (Center for Substance Abuse Treatment, 2008).

Strategies for Implementation of Goal #3

Due to the historic bias and prejudice against those with mental illnesses, health care, mental health care, and substance-abuse treatment have traditionally been viewed as separate types of treatment, with behavioral healthcare and substance-abuse treatment receiving less funding and viewed as due, at least in part, to the “moral failings” of the individual (DHHS, 2001). Reducing stigma related to mental illness and substance abuse has great potential to increase the number of persons from all groups who receive appropriate treatment for mental disorders associated with suicide. Dispelling myths about mental illness, providing accurate knowledge to ensure more-informed consumers, and encouraging help-seeking by individuals experiencing mental health problems can all contribute toward positive outcomes of this goal.

Individual Efforts

Suicidal individuals suffer from internalized stigma, which can inhibit not only their willingness to seek treatment, but their level of involvement and participation in their treatment as well. Efforts to reduce stigma at the individual level, therefore, often are focused on empowerment and participation in treatment. Increased participation in the formulation of care plans and crisis plans, education and information about mental illness and suicide, peer-support and family involvement in treatment, and regular assessment of consumer satisfaction with services are all methods to help empower clients and reverse negative self-stigma (DHHS, 2001). Paying more attention to what clients and family members say about their experiences of discrimination, for example, in relation to work or housing, can allow mental health workers to deal more directly with the effects of stigma for their clients (Graham, Brohan, Kassam, & Lewis-Holmes, 2008).

Group Efforts

There is evidence that individuals who possess more information about mental illness are less stigmatizing than individuals who are misinformed about mental illness. Education campaigns and gatekeeper trainings of school staff, police departments, and other groups have been demonstrated to lessen stigma and improve help-seeking behaviors.

Community/Societal Efforts

Developing or supporting educational campaigns designed to help the public understand mental illness and suicide and to reduce stigma can have extremely positive effects. For example, as of April 2010, the Veteran's Administration (VA) reported nearly 7,000 rescues of actively suicidal veterans, which were directly attributed to seeing print ads, public service announcements

(PSAs), or promotional products. Additionally, referrals to VA mental health services increased. In Phoenix, Arizona, the VA reported a 234% increase in calls to the suicide hotline within 30 days of the launch of its public-awareness campaign (House Committee on Veteran's Affairs, 2010).

NATIONAL STRATEGY GOAL AREA: INTERVENTION

The close association between mental disorders, especially depression, and suicidal behaviors warrants ensuring that professionals are competent in applying the tools and techniques of diagnosis, treatment, management, and prevention to those mental disorders associated with suicidal behaviors.

—National Strategy for Suicide Prevention

GOAL #4: DEVELOP AND IMPLEMENT SUICIDE PREVENTION PROGRAMS

Because many suicide attempts and completions are the result of unrecognized and/or sub-clinically treated mental health and substance-abuse disorders, an important key to preventing many suicides is the ability to detect and intervene with people who are exhibiting signs of mental and emotional distress at the earliest possible occasion. Unfortunately, in the United States, most medical and social service systems are designed to respond only after a problem arises. Although the United States spends more on health care per individual than any other country in the world, only 1% of total health care expenditures are spent in prevention efforts (Granello & Granello, 2007). Many communities simply do not have adequate mental health care programs or resources available to provide effective primary prevention programs. However, it has become increasingly clear that in order to make significant progress in preventing suicides, we must challenge the current approach of responding only to crises or providing a minimal social safety net to the public.

A public-health approach to suicide prevention takes a long view. From a population perspective, prevention means providing people with the tools, skills, and knowledge they need to be healthy. According to the NIMH definition (1998), *prevention* includes not only interventions that occur before the initial onset of a disorder, “but also . . . interventions that prevent comorbidity, relapse, disability, and the consequences of severe illness. . . .” Thus prevention is seen as spanning the full gamut of the health–illness continuum, with interventions ranging from primary prevention through recovery support (Center for Substance Abuse Treatment, 2008).

Although no specific tests can identify a person who is suicidal, specific risk and protective factors for suicide are known and can be identified. Protective factors include:

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes

- Cultural and religious beliefs that discourage suicide and support self-preservation (Suicide Prevention Resource Center, 2008).

According to SAMHSA, the two most significant issues related to the development and implementation of suicide prevention programs are (1) the adoption of an “upstream” approach that brings prevention to the people, with integrated services for prevention, assessment, diagnosis, and treatment; and (2) the identification and advancement of specific evidence-based programs to the specific cultural, community, and developmental norms of program participants (Center for Substance Abuse Treatment, 2008). Put simply, an upstream approach differs from the traditional model of mental health, by focusing not only on the people who are drowning, but moving upstream to keep people from falling into the river in the first place. By moving upstream and integrating care across disciplines, the toll taken by excess disability that arises when diagnosis and treatment come later along the health–illness continuum can be lowered.

Strategies for Implementation of Goal #4

The public-health approach provides a framework for developing prevention programs: clearly define the problem, identify risk and protective factors, develop and test interventions, implement programs that are based on local needs, and evaluate their effectiveness. Programs may be specific to one particular organization, such as a university or a community health center, or they may encompass an entire state. The integration of suicide prevention into existing service-based organizations provides opportunities to expand the numbers of individuals who may be reached by preventive interventions (DHHS, 2001).

Individual Efforts

Prevention efforts at the individual level are often targeted to individuals or small groups who may, without appropriate intervention, lack the necessary skills to manage crises. For example, teaching conflict-resolution or strategies for building positive relationships can help at-risk clients learn to cope with their problems before they escalate.

Group Efforts

Outreach prevention programs for families, schools, and other groups in the community can have positive and lasting effects. Most suicide prevention efforts are curriculum-based, with a focus on increasing awareness of the problem of suicide, identifying individuals at risk, and teaching referral techniques and resources. SPRC’s registry of best practices highlights several education and gatekeeper training programs that have been demonstrated to be effective in suicide prevention, such as the Lifelines curriculum and Signs of Suicide (SOS) (SPRC, 2011).

Community/Societal Efforts

Universal prevention programs, such as depression screenings at local community events, fairs, or sports programs, can spread the message of prevention. Other examples include general suicide education, screening programs, crisis centers and hotlines, and gatekeeper training offered in the community.

GOAL #5. PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS

Evidence from many countries and cultures demonstrates that limiting access to lethal means and methods of self-harm can be an effective strategy to prevent at least some suicides (Center for Substance Abuse Treatment, 2008). Referred to as “means restriction,” this preventative approach is based on the belief that at least some suicidal acts are, in fact, impulsive, and a suicide may be prevented by limiting the individual’s access to means. Suicide methods that have been successfully limited with means restriction include poisons and toxic fumes, prescription and over-the-counter medications, firearms, and bridges and tall buildings. Although a certain number of individuals who have their suicide thwarted through means restrictions will find alternative methods, it is clear that many will not. For example, a study of 515 people who were prevented from jumping from the Golden Gate Bridge found that 26 years later, 94% of the would-be suicides were either still alive or had died of natural causes. The study “confirmed previous observations that suicidal behavior is crisis-oriented and acute in nature. It concluded that if a suicidal person can be helped through his/her crises, one at a time, chances are extremely good that he/she won’t die by suicide later” (Friend, 2003).

Several studies have shown that the mere presence of a firearm in a home significantly increases the risk of completed suicide. This holds true for the population as a whole and for every age group (Miller, Hemenway & Azrael, 2004). A national study found that the adjusted odds ratio for adult suicide by gun increased by a factor of 16 in homes with guns (Wiebe, 2003). In addition to efforts related to firearms, activities have been devoted to educating physicians and other prescribing and dispensing professionals about limiting prescriptions of potentially lethal medications to amounts that are non-lethal (Center for Substance Abuse Treatment, 2008).

Strategies for Implementation of Goal #5

Community mental health providers can advocate with local governments and institutions to help control and make safe the community environment (Granello & Granello, 2007). Many examples of means restriction must be handled at the community or state level, such as putting up barriers on overpasses or fencing along rail lines. Other strategies can be handled within particular environments, such as locking away dangerous chemicals in university labs. Still other examples of means restriction, such as limiting an individual’s access to specific means, are handled with each client and his or her family.

Individual Efforts

Providing means restriction education to parents and families of potentially suicidal individuals is one of the most effective methods for suicide prevention. An SPRC evidence-based practice model for emergency room means-restriction education found that parents who received means restriction education following an emergency room visit for a child’s suicide attempt were 27% more likely to restrict access to potentially lethal medications, 36% more likely to restrict access to or dispose of alcohol, and 63% more likely to restrict access to or dispose of firearms (Kruesi, 2009). Individualized means restriction education is designed to be brief and consists of three components: (1) informing the family when the client is not present that the client is at increased risk for suicide and why; (2) telling family they can reduce this risk by

limiting the client's access to lethal means; and (3) educating the family and problem-solving with them about how to limit access to lethal means (SPRC, 2011). In spite of the relative simplicity of this approach, it is not universally employed in crisis situations. For example, one study of emergency department nurses found only 28% provided means restriction training to parents of children who had made a suicide attempt and only 18% worked in departments where such training was standard practice (Grossman, Dontes, Kruesi, Pennington, & Fendrich, 2003). Restricting access to guns is a critical component of suicide prevention. Locking guns away and keeping guns and ammunition in different locations can reduce the risk of death by up to 73% (Spielmann, 2011).

Group Efforts

Because it is impossible to limit all potential means for suicide from all environments, means restriction is often handled within subpopulations, based on potential risks that have been identified for that group. For example, after four suicide deaths by jumping from bridges by Cornell University students in 2010, the university engaged in a large-scale effort to install protective netting on all bridges around campus (Cornell University, 2011). Local surveillance of risk factors within specific groups can highlight the strategies necessary for means restriction.

Community/Societal Efforts

Educating the public is an important strategy for shaping behavior. Education and training programs that highlight the importance of gun safety or proper disposal of potentially dangerous medications can be important strategies in means restriction.

GOAL #6: IMPLEMENT TRAINING FOR RECOGNITION OF AT-RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT

Training members of the community to recognize risk factors and warning signs that place individuals at elevated risk for suicide and to learn effective strategies to intervene is typically done through gatekeeper training. "Gatekeepers" are any individuals who regularly come into contact with individuals or families in distress. Gatekeeper training has several inherent strengths, including the ability to adapt the training to the specific needs of a population, the ability to capitalize on existing relationships and systems by training multiple members of the same group, and the capacity to strengthen trainees' sense of control in situations in which they may have previously felt helpless. A comprehensive review of the existing research on the effects of gatekeeper training found positive impacts on the knowledge, skills, and attitudes of participants (Feister & Granello, 2011). Gatekeepers interact with people in the environments in which they live, work, and play, and they include (but are not limited to):

- Teachers and school staff
- School health personnel

- Clergy
- Police officers
- Correctional personnel
- Supervisors in occupational settings
- Natural community helpers
- Hospice and nursing home volunteers
- Primary healthcare providers
- Mental health care and substance-abuse treatment providers
- Emergency health care personnel
- Source: DHHS, 2001

Strategies for Implementation of Goal #6

Most suicidal people (more than 80% in some studies) tell someone else of their intent to kill themselves (Granello & Granello, 2007). However, they often tell peers or family members who do not know what to do to help. Afraid of making things worse or of breaking a confidence, these confidantes often remain silent. In fact, only 25% of adolescents say they would tell an adult if they knew a friend was suicidal (Juhnke et al., 2011). Gatekeeper training gives people the skills they need to recognize risk and intervene appropriately.

Individual Efforts

The knowledge, skills, and awareness that are part of gatekeeper training do not have to occur only in group settings in the community. These skills can be an important component of individualized treatment as well. Research has demonstrated that educating family members about how to understand, monitor, and intervene with family members at risk for suicide results in better management and treatment of those identified individuals (DHHS, 2001). Because the exact timing of suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network are knowledgeable about potential risks for suicide and how to protect an individual from self-harm.

Group Efforts

Identifying groups who would benefit from gatekeeper training is an important component of community mental health interventions. For example, workers in respite houses or domestic violence shelters, attorneys working with families in divorce or conflict, and probation officers and workers in detention centers all could benefit from this type of training.

Community/Societal Efforts

Just like the first three goals in the national strategy focus on campaigns that educate the public and reduce stigma, this goal also can be appropriately addressed at the macro level. Having raised awareness that suicide is a problem that can be prevented, the next step is to teach people *how* to help prevent suicide by recognizing risk factors and warning signs and knowing what to do to intervene. Some of the most important aspects of implementing Goal #6 at the community

level involve communication and marketing of existing effective community-level educational and support programs through collaboration with faith communities, mental health clinics, public health announcement providers, mass transit advertisers, and community service organizations (DHHS, 2001).

GOAL #7: DEVELOP AND PROMOTE EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES

GOAL #8: INCREASE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Goals #7 and #8 of the National Suicide Prevention Strategy will be addressed together, as these are the two that essentially address the clinical implementation of intervention strategies for individuals at risk for suicide. Suicidal clients are some of the most difficult and challenging for mental health professionals, and developing and implementing strategies for working with these clients are critical to saving lives. There is a widely held belief among suicidologists that most suicidal individuals do not want to die, but simply cannot imagine continuing to live in their current state of psychological turmoil (Granello & Granello, 2007). In fact, suicidal crises are typically the result of a temporary, reversible, and ambivalent state, and interventions with suicidal clients are based on the premise that the suicidal crisis, if successfully navigated, need not be fatal (Granello, 2010a).

Individuals who receive appropriate treatment for mental disorders have the best likelihood of recovery (Bongar, 2002). Thus, it is critical that individuals with psychiatric disorders or who are at increased suicidal risk receive adequate assessment, treatment, and follow-up care. Assessing individuals to determine their level of suicide risk is one of the most difficult and challenging experiences a mental health professional can face. Accurate suicide risk assessment is essential to identify acute, modifiable, and treatable risk factors and to help clinicians recognize when clients need more specific interventions to help them manage their lives. Assessing a person for suicide risk always includes a comprehensive analysis of risk factors and warning signs. Risk factors can be biological, psychological, cognitive, and/or environmental/situational. There are over 75 identified suicide risk factors in the literature (Granello, 2010b). Among the most common are these:

Biopsychosocial

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance-use disorders
- Hopelessness
- Impulsiveness and/or aggressiveness
- History of trauma or abuse
- Major physical illness
- Previous suicide attempt
- Family history of suicide

Environmental

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide with a contagious influence

Sociocultural

- Lack of social support; sense of isolation
- Stigma of help-seeking behavior
- Barriers to accessing health care, especially mental health care and substance-abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to (including through the media) and influence of others who have died by suicide

(Source: Suicide Prevention Resource Center, 2008)

Although there are ongoing attempts to develop evidence-based best practice models for assessment and intervention, at present, validated assessment and intervention strategies are limited. Dialectical behavior therapy (DBT) has the most empirical support among the evidence-based models, and it has been adapted for use with several different populations of suicidal individuals (SPRC, 2011). In general, working with clients in suicidal crisis includes many levels of care, including inpatient, short- and long-term outpatient, day treatment, and emergency intervention. Models and algorithms are available to assist clinicians in determining appropriate levels of care. These models vary, but generally include (a) conducting meaningful assessments, (b) developing treatment plans, (c) determining levels of care, (d) engaging in psychiatric evaluations for medications, (e) increasing access to treatment, (f) developing risk management plans, (g) managing clinician liability, and (h) assessing outcomes. (For more information on determining levels of care, see Bongar, 2002).

Interventions with suicidal clients are based on a two-tier approach. The first tier is short-term stabilization. Mental health professionals working with clients in suicidal crises use very specific acute management and crisis intervention strategies to keep clients alive and invested in counseling long enough to move to the core problems underlying their suicidality. The goal of the first tier of intervention is to prevent death or injury and restore the client to a state of equilibrium. The second tier of intervention addresses the client's underlying psychological vulnerability, mental disorders, stressors, and risk factors. However, it is not until clients are stabilized using crisis intervention strategies that the ongoing work of counseling can begin (Granello, 2010b).

Strategies for Implementation of Goals #7 and #8

Individual Efforts

One of the most important decisions any mental health professional can make is to seek out advanced training and education in suicide assessment and intervention. Almost all practicing

mental health professionals will encounter a suicidal client during their careers, and most—as many as 71% in one study—will work with an individual who has made a suicide attempt (Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001). In general, mental health professionals who experience a client suicide describe it as “the most profoundly disturbing event of their professional careers” (Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000, p. 2022). There is evidence that even a single workshop can significantly alter a clinician’s confidence and ability to work with suicidal clients. Six months after the completion of a continuing education workshop on empirically based assessment and treatment approaches to working with suicidal clients, 44% of practitioners reported feeling increased confidence in assessing suicide risk, 54% reported increased confidence in managing suicidal patients, 83% reported changing suicide care practices, and 66% reported changing their clinic policy (Oordt, Jobes, Fonseca, & Schmidt, 2009).

Group Efforts

Enhancing the quality of direct care of suicidal individuals is dependent on the extent to which community organizations and service delivery systems communicate with each other to facilitate the provision of mental health services to those in need, and the extent to which individuals at risk use these services. Because of the strong link between suicide and substance abuse as well as several mental disorders, such as schizophrenia, clients who are seen in specialty mental health and substance abuse treatment centers must be appropriately evaluated for suicide risk and given appropriate interventions (DHHS, 2001).

Community/Societal Efforts

Individuals at high risk for suicide due to mental health and substance abuse must receive prevention and treatment, but barriers to access can negatively affect outcomes. The elimination of health disparities and the improvement of the quality of life for all Americans are central goals for Healthy People 2010 (DHHS, 2000). Some of these health disparities are associated with differences of gender, race, or ethnicity; education; income; disability; geographic location; or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors, because they limit access to mental health and substance abuse services (DHHS, 2001). Strategies to eliminate or reduce these barriers must be developed and implemented at community and state levels.

GOAL #9: IMPROVE REPORTING AND PORTRAYALS OF SUICIDAL BEHAVIOR, MENTAL ILLNESS, AND SUBSTANCE ABUSE IN THE ENTERTAINMENT AND NEWS MEDIA

The media has a powerful influence over the American psyche. With people connected to television, movies, Internet videos, and video games at an ever-increasing rate, there is greater concern about the role that the media plays in beliefs about mental illness and suicide. Approximately one-third of college students say that entertainment programming on television is their *primary*

source of information about mental illness, and those who used television as their primary source of information were far more likely to hold negative views of people with mental illnesses (Granello, Pauley, & Carmichael, 1999).

There is also evidence that media coverage of suicide deaths can significantly influence “suicide contagion.” The recognition of the role of the media began in the 1980s, after a suicide death by a man who jumped in front of a subway train in Vienna, Austria. Following his death, television reporters engaged in a series of dramatic and sensational stories of the suicide that culminated in a “reenactment” of the suicide on the evening news. Over the following weeks and months, there was a series of copycat suicides on the same subway tracks. It became clear that the news reporting itself was increasing the risk for suicide. An alternative media campaign was put into place, and within six months, subway suicides and non-fatal attempts dropped by more than 80%. Importantly, *all suicide deaths*, not just subway deaths, decreased significantly (Etzersdorfer, & Sonneck, 1998).

Because of the power of the media to impact suicide and suicide prevention, a protocol for media reporting has been developed by the American Foundation for Suicide Prevention (available at AFSP.org). Currently, no consensus recommendations have been formulated for entertainment media that specifically address the depiction of suicide and suicidal behaviors in the United States. In Australia, where such guidelines were developed and implemented, suicide rates declined 7% in the first year, nearly 20% in the four-year follow-up period, and subway suicides (a particular focus of the media guidelines) decreased by 75% (Pirkis et al., 2001).

Strategies for Implementation of Goal #9

Individual Efforts

Helping young people develop critical viewing skills can be an important protective factor for suicide. There is evidence that both educational programs and individualized discussions can help children and adolescents better decode the messages that they receive from the media. Direct interventions can help young people make sense of the way suicide and self-harm are depicted in the media and may be counteracted by accompanying messages of education and prevention (Bondora & Goodwin, 2005).

Group Efforts

Outreach efforts by community mental health professionals to media leaders could provide partnerships and strategies for appropriate and responsible depictions of suicide, mental illness, and substance use disorders within the local television markets.

Community/Societal Efforts

Given the substantial evidence for suicide contagion, a recommended suicide prevention strategy involves educating media professionals about contagion, in order to yield stories that minimize harm. Moreover, the media’s positive role in educating the public about risks for suicide and shaping attitudes about suicide should be encouraged (DHHS, 2001).

NATIONAL STRATEGY GOAL AREA: METHODOLOGY

By advancing a comprehensive research agenda, industry and government, working together, can contribute significantly to the development of a knowledge base on the causes of suicide and the development of interventions aimed at prevention.

—National Strategy for Suicide Prevention

GOAL #10: PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION

GOAL #11: IMPROVE AND EXPAND SURVEILLANCE SYSTEMS

Goals #10 and #11 of the National Suicide Prevention Strategy will be addressed together, as these two essentially address the management of data and research. The quantity and quality of research on suicide prevention, assessment, and intervention has increased dramatically over the last several decades, but there are still many questions remaining. The complexity of suicide risk, the confounding variables of culture and environment, and the comorbid role of mental illness and substance abuse, all make research into developing best-practice models particularly difficult.

At least part of the problem with the research is the lack of surveillance data. For example, there is no national registry of suicide attempts, making it difficult to determine even something as basic as how many Americans seek emergency room treatment following a suicide attempt each year. According to the national strategy report, “continued advancements in the prevention of suicidal behaviors can only come with solid support of a wide range of basic, clinical, and applied research endeavors designed to enhance understanding of the etiology, development, and expression of suicidal behaviors across the life span as well as those factors which enhance resiliency” (DHHS, 2001).

Strategies for Implementation of Goals #10 and #11

Mental health professionals have an important role to play in the collection of data and the implementation of research with suicidal clients. Effectiveness studies (or, what actually works in clinical practice) that occur within the community mental health system can offer practical and real-world complements to efficacy studies, which are often based on highly controlled laboratory situations that may have little applicability to practice (Granello & Granello, 2001).

Individual Efforts

Although research and data collection can seem daunting, keeping initial efforts manageable can help practitioners engage in research projects that are meaningful. Complex designs with multiple administrations and a large number of instruments may so overwhelm the clinician that they are never completed, or once completed, they are never statistically analyzed in a meaningful way (Granello & Granello, 2001).

Group Efforts

Agencies, hospitals, or programs who work with suicidal clients and their families already have a wealth of clinical data at their disposal, from client satisfaction surveys (demonstrated to be a critical for suicidal clients), to state-mandated reports and data, to clinician notes and reactions. An analysis of these data could be extremely useful to help identify gaps as well as areas of success.

Community/Societal Efforts

Without widespread data surveillance systems, it is difficult for any community or locale to accurately assess their population's risk and protective factors. Working together with state regulatory boards can be an important first step toward accurate data collection.

CONCLUSION

The magnitude of the impact of suicide makes suicide prevention a critical issue for anyone concerned with improving the mental health care of the nation. Crisis stabilization and hospitalizations, while critical to responding to imminent risk, are only part of the solution. A long-term vision for prevention and education at the individual, group, and societal levels, as well as a coordinated system of care for those at risk, may offer the best hope for reducing completed suicides. Everyone in the community mental health care system has a role to play, and the national strategy can offer a starting place for more active involvement in suicide prevention.

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JAIL DIVERSION

Using the Sequential Intercept Model

MARK R. MUNETZ, PATRICIA A. GRIFFIN, AND KATHLEEN KEMP

ABSTRACT

Capital City, USA, is a medium-sized city in any state in the United States. Its downtown is active during the day, but at night it is dominated by the homeless, about half of whom appear to have a mental illness, a substance abuse problem, or both. The local police who work the downtown district are frustrated that so much of their time is spent addressing the needs of people with untreated mental illness. Its local hospitals have closed most of their inpatient psychiatric units, and the state hospital is 30 miles away and always full. The police feel there is no place to take people with mental illness who create a disturbance, so they frequently end up taking them to jail.

The sheriff in town is angry. He thinks his jail has turned into a mental hospital and his deputies are ill prepared to manage the screaming, irrational people who stream in day after day. His budget is increasingly consumed by psychiatric medication—and people who need to move to the state hospital for competency evaluations sit for days and often weeks in jail, awaiting an open hospital bed. He can't find psychiatrists willing to work in the jail, and it seems the professionals providing primary medical care and the mental health staff don't know how to coordinate care effectively.

The judges in town are frustrated. Every day they see defendants with obvious mental illness appearing in their courtroom—the same people again and again. The judges look for guidance from the mental health system but find it lacking. They order treatment as a condition of probation, but the probation officers don't seem to know what to do to get their probationers the help they need. Mental health staff rarely return the probation officers' phone calls; when they do, they cite Health Insurance Portability Accountability Act (HIPAA) and confidentiality as a reason they cannot share information.

The mental health staff are overloaded with cases, and the last thing they want to do is serve criminals with mental illness. They get angry when a judge tries to order treatment for

someone whom the mental health professional has not assessed. They want to see motivated patients, not patients ordered into treatment by a judge who is untrained in mental health. People with mental illness who want help face long waiting lists and have little time with their doctor, nurse, counselor, or case manager. Many people with mental illness do not believe they are ill and don't want anything to do with the mental health system. Alcohol or street drugs provide more relief than psychiatric medication. The investigative reporter for the *Capital City Gazette* wants to know why the streets and the jail have become the new asylums for people with mental illness in her town.

THE CONTEXT

As deinstitutionalization has progressed and community mental health systems have developed, it has become increasingly clear that there is an over-representation of people with severe and persistent mental illness in our nation's jails and prisons (Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1983, Telpin, 1984; Torrey et al., 1993). While it is tempting to refer to this as "transinstitutionalization," this is probably an oversimplification. The people with serious mental illness (SMI) in criminal justice institutions are not directly the same people who used to occupy long-term state hospital units (Prins, 2011).

For many years the mental health community turned a blind eye to this problem. In fact, many did not consider it a problem. That people with mental illness were no longer confined for long periods in psychiatric hospitals was considered a successful outcome of deinstitutionalization. If this meant that some people ended up committing crimes and subsequently going to jail, this was the consequence of the choices these individuals made and was seen as a larger consequence of normalizing mental illness. This let the mental health system off the hook. The incarceration of people for behavior directly or indirectly related to symptomatic mental illness, according to this line of thinking, was not the fault of the mental health system. Clinicians sometimes saw the arrest of their patients (clients) as a needed respite for the clinician from a challenging case. Rarely would the clinician follow the patient while he or she was incarcerated in a local jail awaiting trial or serving a short sentence; even more rarely would clinicians have any contact with patients serving sentences in state prisons.

Jail and prison administrators could rightly claim that it was not their business to address the needs of people with mental illness. However, ironically, since the 1976 U.S. Supreme Court decision in *Estelle v. Gamble*, prisons (and probably jails) are the only places in the United States where people have a Constitutional right to medical treatment, including mental health treatment. Furthermore, it is increasingly clear that jails and prisons need to attend to the discharge-planning needs of their inmates. The New York City case of *Brad H. (Brad H. v. City of New York)*, 2000) established, at least in that jurisdiction, a responsibility on behalf of the correctional institution to conduct discharge planning with the local community mental health system (Barr, 2003).

Law enforcement was often caught in the middle of these situations. As first responders to people in a mental illness crisis, police officers were poorly prepared to deal with these situations, which at times led to tragic outcomes. More often, however, the police had few good options. They learned from experience that if they transported someone to a hospital, he often ended up back on the street very quickly, with no apparent improvement. If they took the person to jail, which at times seemed the only alternative, then they also found the justice system

ill-prepared to handle the situation. The revolving door in and out of jail was often as fast as the door through the treatment system.

This is how many communities in America felt in the 1990s. Perhaps many still do today. It is clear that people with serious mental illness are over-represented in the criminal justice system. The prevalence of people with mental illness who are incarcerated in local jails is at least three times higher for men and almost six times higher for women relative to people with mental illness in the general population (National GAINS Center, 2004; Steadman et al., 2009; Teplin, 1990; Teplin, Abram, McClelland, 1996). No one can find this acceptable.

By the start of the twenty-first century, a number of novel efforts were taking place around the country to address what is often referred to as the problem of “criminalization of people with mental illness.” These innovations included the Memphis Crisis Intervention Team model, specialized mental health dockets, specialized parole or probation officers, and reentry programs targeting individuals with serious mental illness. These programs all shared in common working across traditional boundaries, bringing people from the mental health system and people from the criminal justice systems together to work with their common clients. Often this work involved family members and other advocates, as well as people in recovery from a serious mental illness themselves.

As these specialized programs came to be known around the country, especially after the publication of the *Council of State Governments Consensus Project Report* in 2002 (Council of State Governments, 2002), many communities were interested in starting jail diversion programs. But where to start? There was no conceptual model to help a community to assess itself and determine where it might begin.

ORIGINS OF THE SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model (SIM) was developed through collaborations between the National GAINS Center (Hank Steadman and Patty Griffin), the Summit County (Ohio) Alcohol, Drug Addiction and Mental Health Services (ADM) Board, and the Northeast Ohio Medical University (NEOMED, formerly known as the Northeastern Ohio Universities College of Medicine) (Mark Munetz) and the Ohio Department of Mental Health (ODMH). It is likely that the GAINS Center would have eventually developed a model like the SIM if these relationships had never developed, but arguably the SIM was developed and promulgated because of the public–academic partnerships at the local, state, and national levels.

In the late 1990s, Akron, Ohio, like many communities, was exploring ways to address the over-representation of people with mental illness in its local jail (Munetz, Grande, & Chambers, 2001; APA Bronze Achievement Award, 2003; Summit County [Ohio] Alcohol, Drug Addiction and Mental Health Services Board, 2003). Its county mental health system partnered with the Akron Police Department to develop a crisis intervention team (CIT) program and, with the Akron Municipal Court, to start a mental health court. To assist in the development of these programs and to address some other local systems issues, the Summit County ADM Board requested technical assistance from the GAINS Center. Patty Griffin provided the technical assistance consultation. In 2000, the Ohio Department of Mental Health—under the leadership of Mike Hogan—was developing a concept of statewide coordinating centers of excellence (CCoE). These centers were primarily based in a medical school or university with particular

energy and expertise around a specific evidence-based practice. The CCoE would then be supported by the state to promote, disseminate, and support said practices statewide.

Essentially technical assistance centers, the concept was similar, at a state level, to what the GAINS Center had done nationally. Given the enthusiasm, in Summit County, for jail diversion alternatives like CIT and Mental Health Court, Summit County encouraged Dr. Hogan to designate it a center for jail diversion. Dr. Hogan consulted with Dr. Steadman and came to see the possibility of a “mini-GAINS Center” for the state. However, the Ohio Department of Mental Health was reluctant to support a center of excellence in jail diversion for three reasons (which on reflection are ironic): 1) they were unsure of the salience of the problem of criminalization of people with mental illness; 2) there were no clear evidence-based jail diversion practices; and 3) there was no conceptual model. The first concern, hard to fathom today, was real but overcome with the enthusiasm about jail diversion efforts like CIT that also helped address the second reservation. Ultimately, the Criminal Justice Coordinating Center of Excellence was established with a grant to the Summit County ADM Board, which contracted with Northeast Ohio Medical University (NEOMED) to operate the center. With funding of the center came a mandate from Dr. Hogan to develop a conceptual model.

THE SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model is conceptually simple (Munetz & Griffin, 2006). People move from the community through the criminal justice system in a reasonably predictable, linear fashion, from arrest; to an initial hearing; to jail awaiting trial or adjudication of competence to stand trial; to release or reentry; and finally, to community supervision or support. Each of these points through the justice system can be seen as an opportunity to intervene and “intercept” the person, moving them from the justice system to the treatment system; i.e., *diversion*.

Graphically, the model has been presented three ways: as a funnel, as a circle, and as a horizontal line. The funnel graphic makes the point that the earlier in the process an intervention occurs, the larger the number of individuals can be affected (see Figure 30.1). So Intercept 1 interventions (law enforcement/crisis services [e.g., a CIT program]) may divert more individuals than Intercept 3 interventions (e.g., a specialty mental health docket). The circular graphic makes the point that people can get caught in a revolving door and that intervention at any of the intercepts can stop or at least slow the door (see Figure 30.2). From this perspective, an intervention at any of the intercepts is likely to be helpful to some people. Finally, the horizontal graphic makes the point that movement through the system is in fact linear and predictable (see Figure 30.3).

The Sequential Intercept Model is based on the premise that, in an ideal world, the presence of people with mental disorders in the criminal justice system would be no greater than that of people from the same community without mental disorders. Fundamental to that premise is that people with mental illness who end up in the criminal justice system because of behavior resulting from untreated, symptomatic mental illness reflect a system failure. While the problem of the over-representation of people with mental illness in the justice system cannot be blamed entirely on a failed mental health system, at least part of the blame does belong there. Since the turn of this century, there has been a fraying of the mental health service systems in most parts of the United States. The Sequential Intercept Model encourages the system as a whole to examine its efforts.

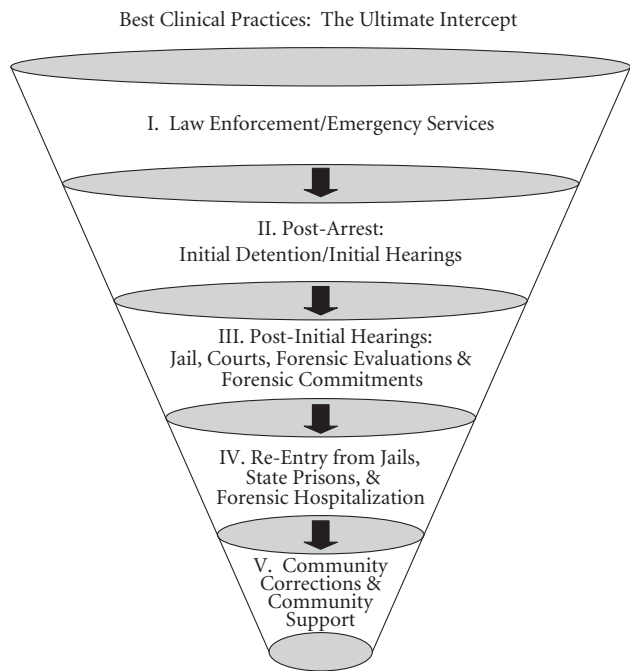


FIGURE 30.1 Sequential Intercepts

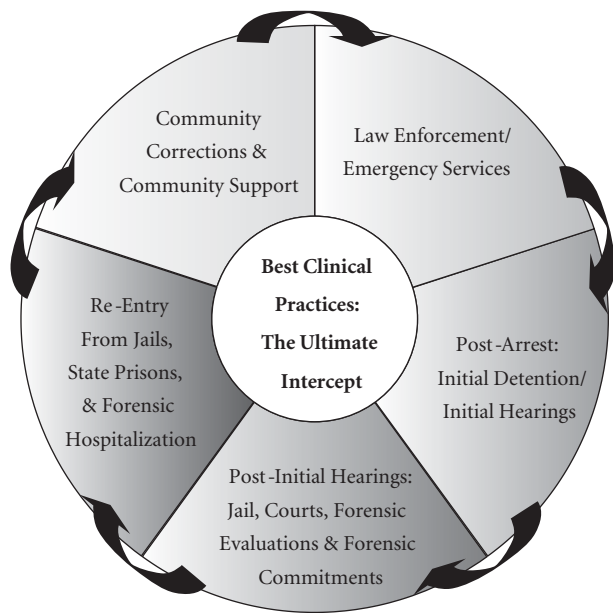


FIGURE 30.2 Sequential Intercept Model: A Circular View

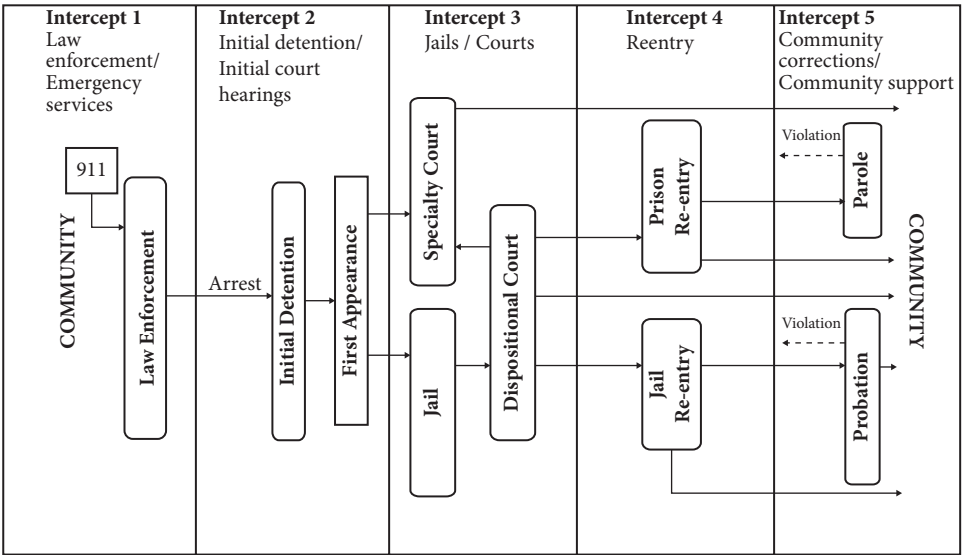


FIGURE 30.3 The Linear Model

There are many questions to be asked about how behavioral health efforts have contributed to the current crisis. How do individuals gain access to treatment? What barriers does the system put in place to remain in treatment? How does a system keep professionals adequately trained on evidence-based practices? While it would be easy to see this situation as a failure of the mental health system alone, it is more appropriate to view it as a community or total system failure. Efforts to address the needs of people with mental illness are complex and go beyond just the mental health system. The criminal justice system shares fault with the mental health system. Individuals with serious mental illness who enter the criminal justice system penetrate deeper into the system and often remain involved longer than people without mental illness (Ditton, 1999). The California Supreme Court rulings (*Coleman v. Schwarzenegger* [E.D. Cal. August 4, 2009]; *Plata v. Schwarzenegger* [N.D. Cal. August 4, 2009]) on the failings of the criminal justice system to provide adequate medical and mental health treatment, upheld by the U.S. Supreme Court (*Brown v. Plata*, 2011), demonstrate the limited tolerance of the mistreatment of a vulnerable population.

The problem of the over-representation of people with mental illness in the criminal justice system is a complex one with no single cause. In the same way, there is no single solution to this problem. A single new program or change in policy is not sufficient. The problem has to be approached systematically, at many levels, and as early as possible in the process. Steadman (2011) articulated the broader context of issues faced by the criminal justice and behavioral health systems that have led to the overrepresentation of individuals with serious mental illness in the criminal justice system. His argument stressed the importance of developing, modifying, or eliminating policies in order to prevent the unnecessary incarceration of individuals with serious mental illness by looking at the complicated system as a whole as well as its small moving parts. He further suggested that the four solutions proposed by the California Supreme Court to address the high numbers of people with mental illness in the state prison system (early release; diversion of technical parole violators to community-based sanctions or local jails; alternate

sanctions for low-risk offenders; and increased community- and prison-based rehabilitation programming) focus on preventive or front-end efforts.

Ownership of the problem must be shared by the mental health, addiction, and criminal justice systems. Collaboration across these systems, rather than finger-pointing and blaming or simply ignoring each other, is key to creating effective solutions. This collaboration is necessarily interdisciplinary. Mental health and addiction professionals who work in the public sector, especially those who work with individuals with SMI, understand that to be effective they need to work in interdisciplinary teams. Mental health systems have been expanding the number of disciplines needed to work effectively beyond the traditional mental health disciplines (e.g., psychiatry, psychology, nursing, and social work) to include others viewed as critical in a recovery-oriented treatment system. These include, for example, supported employment and supported education specialists, housing specialists, and peer-support workers. Integrated dual disorders treatment (IDDT), an evidence-based treatment (Drake et al., 2001), is a team-based approach to integrating treatment of both serious mental illness and comorbid substance use disorders. While roughly half of the people with SMI in the community have a comorbid substance use disorder, 72% to 80% of justice-involved individuals with SMI have a co-occurring diagnosis (Abram & Teplin, 1991; Abram, Teplin, & McClelland, 2003). IDDT teams require representatives from the full array of mental health and chemical dependency disciplines as well as supported employment specialists, housing specialists, and peer support. In addition to behavioral health providers (mental health and addiction) working together, effective efforts at jail diversion require collaboration between behavioral health and criminal justice professionals. It has long been recognized that successful jail diversion requires “boundary spanners” (Steadman, 1992), individuals who are familiar with both mental health and criminal justice systems and cultures.

EVOLUTION OF THE MODEL—THE ULTIMATE INTERCEPT

At its inception, the Sequential Intercept Model assumed that the over-representation of people with mental illness in the criminal justice system was largely the result of symptomatic mental illness that directly resulted in behavior leading to criminal justice involvement. Thus, if more people with mental illness received effective treatment in the community, the problem would be diminished. Accordingly, Munetz and Griffin called an accessible mental health system the “*ultimate intercept*”: “An accessible, comprehensive, effective mental health system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness” (Munetz & Griffin, 2006).

We have argued that the most effective way to keep people with mental illness out of the justice system is by providing accessible, effective treatment services using treatment interventions for which there is evidence of efficacy and effectiveness. Recent research has examined the use of evidence-based practices as they specifically focus on justice-involved populations, including research on assertive community treatment (Morrissey & Meyer, 2008), integrated substance abuse and mental health treatment (Osher, 2006), and illness management and recovery (Mueser & MacKain, 2008). Furthermore, evidence-based intervention efforts are not limited to the mental health system. Skeem and colleagues (2006; 2011) identified community supervision approaches and probation officer characteristics that contribute to improved outcomes for

individuals with SMI. Their research suggests that specialty mental health caseloads, probation officers with a “firm but fair” approach, and close working relationships between probation and behavioral health systems reduced recidivism rates for individuals with SMI.

It is also becoming increasingly evident that people with SMI who end up in the criminal justice system differ in important respects from people with SMI who do not. One example is the current debate as to what proportion of crimes committed by people with SMI involved in the criminal justice system are attributable to symptomatic illness (Peterson, Skeem, Hart, Vidal, & Keith, 2010; Skeem, Manchak, & Peterson, 2011). Recent studies suggest that we have overestimated the proportion of people with SMI who end up in the justice system because of untreated psychosis and underestimated the proportion who end up in the justice system because of additional risk factors including criminogenic influences (e.g., substance abuse, unemployment, criminal thinking, family dysfunction, antisocial peers), trauma, situational stress, and environmental factors. Peterson and colleagues (2010) found that only 7% of offenders with a mental illness committed crimes that were a direct result of psychosis (5%) or minor “survival” crimes related to poverty. Recent research advances reveal that treating mental illness alone may not be sufficient (Epperson et al, 2011; Fisher, Silver, & Wolff, 2006; Peterson et al., 2010; Skeem et al., 2011). An adequate mental health system is clearly necessary, though not sufficient, to effectively keeping people with SMI out of the criminal justice system. New evidence suggests that the mental health system as a whole needs to reconsider the goals of treatment—to go beyond mental illness and substance use needs and incorporate criminogenic needs that also contribute to recidivism. The mental health system has not traditionally addressed these risk and need factors in its population, not seeing that as its mission (Morgan, Fisher, Duan, Mandracchia, & Murray, 2010).

As the problem of over-representation of people with mental illness in the criminal justice system is better understood, it becomes increasingly clear that these criminogenic risk factors, in addition to the results of untreated, symptomatic mental illness, probably increase the risk that people with SMI will end up in the justice system. So, an accessible, effective mental health system, the “ultimate intercept,” is still not the complete answer to the criminalization problem, unless that system includes expertise on the treatment of criminality. It has taken several decades to recognize that it is not effective to first treat mental illness and then substance dependence (or *visa versa*). They are more effectively treated simultaneously. It now appears that, to keep people with SMI out of the criminal justice system, treatment needs to be integrated in multiple areas. These include mental illness, substance dependence, trauma, situational stress, social disadvantages, and criminogenic risks (Epperson et al, 2011; Morgan et al., 2010).

Appelbaum (Daly, 2011) has suggested, as have Skeem and colleagues (2011), that we need to consider a paradigm shift. Commenting on the study by Peterson and associates (2010), Appelbaum (Daly, 2011) noted, “The new paradigm suggests that merely treating mental disorders may be insufficient to reduce criminality, including violence, unless specific criminogenic factors are addressed as well—for example, anger management and cognitive therapy for criminal cognitions.” Epperson and colleagues (2011) suggest that mental health and criminal justice interventions must address a variety of factors that influence criminal behavior in an integrated and centralized format. The six modules of integrated treatment are medication adherence, criminogenic risk, addiction risk, trauma risk, stress risk, and social disadvantage risk. These modules parallel the research advances in risk assessment and risk management (for a complete review, see Epperson et al, 2011).

So perhaps the real “ultimate intercept” is a comprehensive, accessible, effective mental health and addiction system that is criminologically informed and working closely with criminal justice partners who understand the behavioral health needs of offenders.

BLUEPRINT OF USING THE SEQUENTIAL INTERCEPT MODEL FOR JUSTICE-INVOLVED CLIENTS IN THE COMMUNITY

The Sequential Intercept Model provides a working framework to help communities assess themselves and know where to begin to move forward with building a stronger, more effective system of behavioral health/criminal justice collaboration. The following intercept-by-intercept inventory of service-level action steps is based on the National GAINS Center’s widely distributed brochure titled “Developing a Comprehensive Plan for Mental Health and Justice Collaboration: The Sequential Intercept Model” (available at http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf). Additional action steps have been added, based on work with counties and states across the country as they address the issue of over-representation of people with severe mental illness in their criminal justice systems. The first community inventory using the Sequential Intercept Model was developed by five southeastern counties in Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia) as they used the model as a tool to organize their work in a forensic task force charged with planning coordinated regional initiatives (Pennsylvania’s Southeast Region Interagency Forensic Task Force, 2002).

INTERCEPT 1: LAW ENFORCEMENT AND EMERGENCY SERVICES

The first intercept reflects the pre-arrest period. Initial contacts may involve various agencies, including 911, mental health crisis response teams, homeless outreach services, Veterans’ Affairs, and law enforcement. Experts estimate that 7% to 10% of patrol officer contacts involve individuals with mental health issues (Deane et al., 1999; Janik, 1992), and law enforcement plays an important role in the initial diversion of individuals with serious mental illness. Traditionally, law enforcement and mental health agencies have not coordinated responses to individuals in mental health crisis, such as developing cross-training program or committing to additional physical and personnel resources. However, recent attention to this intercept has resulted in the development of several models to address the needs of local systems. Mobile crisis teams responding with police, mental health workers hired by police to provide on-site or telephone consultation to officers, and specially trained police officers to respond to mental health crisis calls, are a few examples (Lamb, Weinberger, Decuir, 2002). One example of a police pre-arrest diversion program is the Crisis Intervention Team (CIT) model developed in Memphis, Tennessee (Memphis Police Crisis Intervention Team, 1999), and widely disseminated nationally and internationally (see <http://www.cit.memphis.edu>).

Service-Level Change Action Steps at Intercept 1

- 911: Train dispatchers to identify calls involving persons with mental illness, respond in ways that de-escalate crisis situations, and refer calls with appropriate information to designated, trained respondents.
- Police: Train officers to respond to calls where mental illness may be a factor; training should focus on strategies to de-escalate crisis situations and provide community alternatives to incarceration.
- Documentation: Document police contacts with persons with mental illness and outcomes of those contacts.
- Emergency/Crisis Response: Provide police-friendly drop-off at local hospital, crisis, or triage centers; integrate mental illness and substance abuse crisis services.
- Victims: Provide support services to assist in dealing with the stress of the situation and understand options for response.
- Follow Up: Provide service linkages and follow-up services to individuals who are not hospitalized and those leaving the hospital.
- Evaluation: Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

INTERCEPT 2: INITIAL HEARINGS AND INITIAL DETENTION

Once an individual is formally arrested, post-arrest diversion may occur during initial hearings (e.g., bail hearings or arraignment) or initial detention (e.g., detention in local jail prior to adjudication). Individuals with SMI not diverted at pre-arrest may have a variety of summary, misdemeanor, or felony charges that will impact their ability to be considered for alternatives to prosecution or incarceration regardless of the presence of mental illness. Legal procedures vary significantly based on local and state systems, which makes efforts to address diversion at this phase complicated. Some communities have focused on screening for mental illness as an integral part of a standard medical intake procedure, while other jurisdictions have sought to coordinate treatment services in lieu of bail. Connecticut has a long-established statewide post-booking diversion program (Frisman, Sturges, Baranoski & Levinson, 2001). Dallas County, Texas (CMHS National GAINS Center, 2007), has an Intercept 2 diversion program that integrates fast electronic information-sharing and continuity of care of psychotropic medication and case management with diversion after arrest.

Service-Level Change Action Steps at Intercept 2

- Screening:
 - Screen for mental illness and substance use disorders at earliest opportunity
 - Initiate process that identifies those eligible for diversion or needing treatment in jail
 - Use validated, simple instrument or matching management information systems
 - Screen at initial detention, jail, or court by booking officers; pretrial services, prosecution, defense, judge/court staff; or service providers

- Screen for military service history or status; if present, link to Veterans Justice Outreach Specialist at nearest Veterans Affairs Medical Center
- Pretrial Diversion: Maximize opportunities for pretrial release and assist defendants with mental illness in complying with conditions of pretrial diversion
- Service Linkage: Link to comprehensive services, including care coordination, access to medication, integrated dual disorder treatment (IDDT—an evidence-based practice; Drake et al., 2001); as appropriate, prompt access to benefits, health care, and housing

INTERCEPT 3: JAILS AND COURTS

Once incarcerated, individuals with SMI often spend significantly longer time in jail compared with individuals charged with the same crimes but having no SMI (Axelson, 1987; McNiel, Binder, & Robinson, 2005). Diversion programs at Intercept 3 focus on alternatives to prosecution, alternatives to incarceration, and early-release programs. Problem-solving courts such as mental health courts and, more recently, veterans' courts have received widespread attention and press. Courts vary on whether participation in diversion programs at this intercept requires a pre- or post-adjudication plea, and eligibility criteria typically vary by jurisdiction. For example, having committed serious or violent felonies may exclude some individuals from eligibility. Additional efforts go beyond diversion to include the timely and accurate assessment and treatment of serious mental illness in the jail to reduce symptoms and increase treatment engagement prior to release. Efforts to coordinate between the local jail and behavioral health systems also serve to improve reentry at Intercept 4.

Service-Level Change Action Steps at Intercept 3

- Screening: Include diversion opportunities and need for treatment in jail with screening information from Intercept 2
- Court Coordination: Maximize potential for diversion in a mental health court or non-specialty court
- Service Linkage: Link to comprehensive services, including previous community care coordination and services, prompt access to psychotropic medication, IDDT as appropriate, and prompt access to benefits, health care, and housing
- Court Coordination: Monitor progress with scheduled appearances (typically directed by court); promote communication and information sharing between non-specialty courts and service providers by establishing clear policies and procedures
- Jail-based Services:
 - Provide services consistent with community and public health standards, including appropriate psychiatric medications
 - Coordinate care with community providers upon admission to jail and in preparation for release

INTERCEPT 4: REENTRY FROM JAILS, PRISONS, AND HOSPITALS

Continuity of care from jails and prisons into the community has received increased attention; partially due to class action litigations such as the successful *Brad H.* case (*Brad H. v.*

City of New York, 2000) against the New York City jail system for failing to provide adequate aftercare linkages for inmates with severe mental illness. Coordination of services between correctional institutions and community partners focus on identifying appropriate providers, establishing rapport through in-reach into jails, medication continuity, and housing as just a few of the important issues. The APIC model developed by Osher and colleagues (2003) offers a best practices approach to assess, plan, identify, and coordinate transition into the community.

Service-Level Change Action Steps at Intercept 4

- Assess clinical and social needs and public safety risks
- Develop Boundary Spanner position (e.g., discharge coordinator, transition planner) to systematically coordinate institutional care with community mental health and community service agencies
- Plan for treatment and services that address needs
 - GAINS Reentry Checklist outlines treatment plan and communicates it to community providers and supervision agencies—domains include prompt access to medication, mental health and health services, benefits, and housing
 - Identify required community and correctional programs responsible for post-release services; best practices include reach-in engagement and specialized case management teams
 - Coordinate transition plans to avoid gaps in care with community-based services with an emphasis on ensuring continuity in needed psychotropic medication from jail to community
 - Develop strategies to link and relink to public benefits, especially to health insurance such as Medical Assistance in order to facilitate continued access to treatment services
 - Work with client to ensure he/she is aware of aftercare appointments and required criminal justice obligations; Discuss transportation alternatives
- Incorporate Forensic Peer Specialists in reentry process in order to support the client's successful reintegration into the community

INTERCEPT 5: COMMUNITY CORRECTIONS AND COMMUNITY SUPPORT SERVICES

Individuals supervised in the community on federal, state, and local probation and parole represented over 5 million individuals in 2009 (Glaze & Bonczar, 2010). Conditions of probation and parole often mandate compliance with treatment; therefore, noncompliance poses a risk of revocation and reincarceration. As discussed previously, successful strategies require adaptation by both criminal justice and treatment providers to address all of the factors affecting recidivism. Research by Skeem and Loudon has identified characteristics of successful probation approaches (2006) as well as individual criminogenic risk factors (2011) that impact outcomes of individuals with SMI.

Service-Level Change Action Steps at Intercept 5

- Screening: Screen all individuals under community supervision for mental illness and co-occurring substance use disorders; link to necessary services
- Maintain a Community of Care:
 - Connect individuals to employment, including supportive employment
 - Link to housing
 - Facilitate collaboration between community corrections and service providers to facilitate adherence to treatment conditions, address criminogenic needs and risk, and support individual's adjustment to the community
 - Establish policies and procedures that promote communication and information sharing
- Implement a Supervision Strategy:
 - Concentrate supervision immediately after release
 - Adjust strategies as needs change
 - Implement specialized caseloads
 - Implement cross-systems training
- Develop Graduated Responses and Modification of Conditions of Supervision:
 - Ensure a range of options for community corrections officers to reinforce positive behavioral and effectively address violations on noncompliance with conditions of release

CROSS INTERCEPTS

The GAINS Center identified several system-level approaches relevant across intercepts designed to facilitate successful outcomes for people with SMI who are involved in the criminal justice system:

- Encourage and support collaboration among stakeholders through:
 - Task forces
 - Joint projects
 - Blended and braided funding
 - Information sharing
 - Cross-training
- Make housing for persons with mental illness and criminal justice involvement a priority; remove constraints that exclude persons formerly incarcerated from housing or services
- Expand access to treatment; provide comprehensive and evidence-based services; integrate treatment of mental illness and substance use disorders
- Expand supportive services to sustain recovery efforts, such as supported housing, education and training, supportive employment, and forensic peer advocacy
- Ensure all systems and services are culturally competent, gender specific, and trauma informed—with specific interventions for women, men, and veterans

PRACTICAL APPLICATIONS OF THE SEQUENTIAL INTERCEPT MODEL

STATE, LOCAL, AND FEDERAL PLANNING

The Sequential Intercept Model is used for a variety of planning purposes at local, state, and federal levels. Pennsylvania has widely disseminated the model, especially to frame county annual plans for justice-related services. For instance, Allegheny County has used the model in their strategic planning (Cherna & Valentine, 2007), and a national conference on community alternatives to justice involvement for people with SMI. Another local example is the thoughtful way Beaver County has used the model to develop a broader range of criminal justice/behavioral health services and facilitate collaboration over time between their Criminal Justice Advisory Board and their county behavioral health system (see http://www.pacenterofexcellence.pitt.edu/documents/BeaverCoSIM_ForensicConf_12012011_Final.pdf).

A state planning guide addressing housing needs for justice-involved individuals with mental illness recently used the model to structure “how-to” information addressing the challenging issue of appropriate and accessible housing for this population (Diana T. Myers and Associates, Inc., 2010). Finally, the Pennsylvania Mental Health and Justice Center of Excellence organizes their technical assistance and website around the model (see <http://www.pacenterofexcellence.pitt.edu/>).

At the federal level, the U.S. Department of Veterans Affairs incorporates the Sequential Intercept Model in their policies outlining outreach, diversion, and services provided by the Veterans Health Administration facilities to veterans in the criminal justice system (see http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2019).

CROSS-SYSTEMS MAPPING AND “TAKING ACTION FOR CHANGE” WORKSHOPS

Another real-world application of the Sequential Intercept Model is the Cross-Systems Mapping (CSM) workshop initially developed through the work of the National GAINS Center providing technical assistance during the SAMHSA jail diversion Knowledge and Development Application initiative (Steadman, et al, 1999). Seeing the practical utility, the Policy Research Associates, Inc., obtained a small-business-initiative grant to further develop the CSM workshops and create a facilitator training manual, workshop planning guide, and workshop curriculum (Vogel et al, 2007). The CSM consists of two separate workshops: the “Cross-Systems Mapping” workshop (Recently renamed “Sequential Intercept Mapping” by Policy Research Associates; see <http://www.prainc.com/pdfs/training/fliersequentialinterceptmapping.pdf>) and the “Taking Action for Change” workshop (see <http://www.prainc.com/pdfs/training/fliertakingactionforchange.pdf>). Each can be completed separately, but they are designed to benefit and build on each other. These workshops provide intensive technical assistance by facilitating cross-system collaboration, recording available services at each intercept, identifying gaps and opportunities, and developing action steps for each priority the local community wants to address (Policy Research Associates, 2007).

New Jersey, Florida, Virginia, and Pennsylvania are among the states with statewide initiatives providing the cross-systems mapping workshops to their counties in conjunction with state efforts to decrease the justice involvement of people with SMI. Virginia has mapped the most counties to date, as part of the work of the Commonwealth Consortium for Mental Health and Criminal Justice Transformation (see www.dbhds.virginia.gov/documents/Adm/091022Reinhard.pp). Pennsylvania has mapped over twenty-five counties through the work of the Mental Health and Justice Center of Excellence. Ohio is actively working to implement a similar statewide cross-systems mapping initiative.

CSM Facilitators—Successful CSM workshops require facilitators who provide an open forum to encourage local stakeholders to discuss challenging issues. A facilitator remains objective and encourages dialogue from all participants. They allow the priorities of the local community to remain at the forefront. The facilitators are also well versed in promising and best practices and national trends, and are familiar with various diversion programs throughout the country, which may provide a local community with some guidance. In addition, the facilitators, having gathered information about the local systems, recognize challenging issues that may arise during the workshop and affect the momentum of the group. Local leaders do not facilitate CSM workshops, so a more neutral and objective atmosphere is fostered. In order to become a CSM facilitator, each person must attend a train-the-trainer workshop conducted by Policy Research Associates. Two or more facilitators are assigned to each workshop.

Cross-System Mapping Participants—Cross-system interdisciplinary collaboration is a key feature of the CSM workshop. Participants should represent key players in behavioral health and criminal justice systems. The pre-planning period, discussed below, is used to confirm attendance from key stakeholders. The number of individuals attending the workshop varies significantly by location, but a recommended range based on previous experience is 30 to 45. It is important to engage both leaders and line staff in the CSM workshops from each of the intercepts. Behavioral health representatives may include directors of mental health/substance abuse (MH/SA) systems, MH/SA diversion program staff, local community treatment and case management programs, hospital emergency services, housing specialists, vocational training programs, and consumers. Criminal justice stakeholders include local law enforcement (sheriffs, local and state police, etc.), judges, court administration, probation/parole departments, jail diversion programs, pre-trial services, district attorney's office, and the public defender's office.

CSM Pre-Planning—The pre-planning phase utilizes a local representative(s) to identify potential participants, gather descriptive and specific data, coordinate workshop dates and location, send invitations, and maintain contact with stakeholders leading up to the workshop. The identified local representative(s) must have the time, motivation, and resources to coordinate the workshop and be the liaison between workshop facilitators and the local community for any planning issues. The facilitators provide a helpful pre-planning resource kit with detailed CSM information and examples (i.e., invitation, room set-up, etc.).

CSM Workshop—The CSM workshop is a full day, using both presentation and interactive formats. The typical agenda for a workshop includes:

- **Opening:** Local leaders from both the behavioral health and criminal justice systems introduce and welcome participants and the workshop facilitators. The facilitators provide an overview of the workshop agenda, including the focus, goals, and tasks for the

day. At each intercept, facilitators present promising practices using local and national examples to illustrate cross-system collaboration and diversion program efforts. Based on experience and research, facilitators also help lay out keys to success in developing, implementing, and maintaining diversion programs.

- **Cross-Systems Mapping:** The facilitators begin the mapping with an overview of the Sequential Intercept Model, and then turn to an intercept-by-intercept inventory of the local community, focused on individuals with mental health coming in contact with the criminal justice system. Visible to all participants, facilitators record information to provide a visual representation about the services available at each intercept. Facilitators pay close attention to how the services connect to each other, how they are accessed, and any relevant data. The process continues until all five intercepts have been mapped, the participants are satisfied that all of the relevant services/programs have been noted, and the facilitators have enough information to create a local systems map. Throughout the mapping process, gaps (e.g., obstacles such as Medicaid applications, lack of housing, etc.) and opportunities (e.g., new funding opportunities, previously unknown service availability, etc.) are recorded. The gaps are then used to help develop a list of priorities for change.
- **Establishing Priorities:** Following the successful completion of the local systems map, the conversation focuses on the future direction of the community and their priorities for change. The group collaborates to integrate priorities for change that has been identified at each intercept as the mapping progressed throughout the day. The priorities may focus on larger system-wide issues or more specific problems that the local community identifies as important. Participants are encouraged to lobby for priorities they feel are important to address. Each person then votes for his or her top two priorities. Facilitators add up the votes and finalize a list of the top five priorities identified by the group.
- **Wrap-Up:** Facilitators review the day's accomplishments, get feedback from participants about the process, and review the priorities the group process has generated. If the Taking Action for Change workshop is scheduled for the next day, facilitators will discuss how the newly established priorities will be used to develop action steps.

TAKING ACTION FOR CHANGE WORKSHOP

The Taking Action for Change (TAC) workshop is a half-day workshop designed to follow the CSM workshop. The TAC workshop builds on the momentum and creates concrete action steps for each of the top five priorities identified during the CSM. Ideally, the same individuals who participated in the CSM will return for the TAC workshop.

There are a few possible approaches to the TAC. Facilitators may break the larger group into small work groups to develop clearly defined and achievable action steps for each priority separately. The entire group then comes together for discussion and agreement on the action steps for each priority. If small groups are established, it is important to keep the cross-system collaboration spirit by having as much diversity in each small group as possible. The facilitators may also keep the larger group together to work together on a step-by-step action for each priority. With every action step, a community or facilitator point person is assigned to take responsibility for the task, and timelines are established.

CSM/TAC FINAL REPORT AND MAP

The final and most important product of the CSM workshop is the written report and Sequential Intercept map that incorporates all data obtained during the pre-planning phase and the workshop. The map is a visual representation of all the work currently being done in the local community and the relationships between those activities, represented by arrows connecting them. The final report includes:

- Introduction, background, and objectives to the Sequential Intercept Model and Cross-Systems Mapping
- Local community map and narrative of activities and programs at each intercept with as much specific data as possible (e.g., number of arrests, number of prison and hospital admissions, etc.)
- Top five priorities and Action Planning Matrix
- Summary of recommendations generated by CSM participants and facilitators
- Participant list with name, description, and contact information
- Appendices, which vary based on the local community and may include lists of local resources (e.g., housing, treatment programs, etc.), resources for cultural competence, and evidence-based practices

Several examples of reports and maps developed as the result of Cross-Systems Mapping workshops can be found at http://www.pacenterofexcellence.pitt.edu/mapping_Reports.html.

CSM workshops have occurred nationwide to facilitate understanding between behavioral health and criminal justice systems as well as generate diversion strategies that meet local need and fill gaps in services. These workshops can be conducted on either local or statewide levels in a variety of ways and can have significant impact on the creation, coordination, and provision of services in local communities for individuals with mental illness who contact the justice system.

FUTURE DIRECTIONS

Although many communities are interested in addressing the over-representation of people with mental illness in their local criminal justice system, the task can seem daunting, the various options confusing, and the challenges to collaboration across systems overwhelming. The Sequential Intercept Model provides a proven framework to facilitate jail diversion and collaboration between criminal justice and treatment systems that is easily adaptable to localities of varying sizes.

The field of jail diversion has grown significantly in the past twenty years. We expect to see continued growth in this area, although the current strained economic environment poses a real test to our efforts. Some localities and states have taken advantage, though, of this environment by implementing a variety of innovative cost-savings strategies that reduce the number of people with mental illness in the criminal justice system. To continue to move forward, it will be necessary in the future to pay close attention to the cross-intercept issues at the same time that each intercept is

considered and addressed. In addition, recent work on the importance of addressing criminogenic risk in preventing recidivism underscores the need for behavioral health and criminal justice professions to work together, always including individuals in recovery in the process.

In closing, we leave you with the following quote, which guides our efforts in this area and provides encouragement in tackling the complexities and challenges of this work:

I also saw how bringing disparate groups together—even those with conflicting missions—could often be effective.... The power of proximity—spending time side-by-side—had pulled us all to compromise in our efforts to help.... People, not programs, change people. The cooperation, respect, and collaboration we experienced gave us hope that we could make a difference.... (Perry & Szalavitz, 2006).

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S E C T I O N I V

LEADERSHIP,
ADMINISTRATION,
MANAGEMENT

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NEW PROMISES

*Specialized Dockets as Partnerships Between Treatment and
the Criminal Justice System*

ROBERT W. AHERN AND CHARLOTTE COLEMAN-EUFINGER

BACKGROUND

The mentally ill and substance abuse populations are frequently involved in the criminal justice system. The Los Angeles County jail, in a wing known as the Twin Towers, is the largest mental institution in the United States, housing 1,400 mentally ill patients (www.npr.org, retrieved October 3, 2011, p. 1). The Bureau of Justice Statistics noted that 56% of state prisoners and 45% of federal prisoners have current symptoms or a recent history of severe mental health problems (James & Glaze 2006). These trends in the United States are demonstrated in other regions of the world as well (Metzer, Gill, & Pettigrew 1994). Likewise, 53% of state prisoners and 45% of federal prisoners meet the criteria for drug abuse or dependency (Mumula & Karberg 2006). The 1997 *Office of Justice Drug Court Report* notes, "For several decades, drug use has shaped our criminal justice system" (p. 5). Husak (2004) points out that alcohol is the substance most frequently connected to criminality, and it has been reported that 60% to 80% of people who break the law abuse recreational drugs (Hartwell (2004). Among those prisoners diagnosed with mental illness, 72% had a co-occurring substance abuse or dependency diagnosis. (Abram & Tepin, 1991). But our criminal justice system and prisons were not established to address, nor are they currently capable of addressing, the wide-ranging issues of mental illness and addiction. These vulnerable populations with the brain disorders of mental illness or addiction are also at risk in prison settings for abuse and maltreatment (*NIDA News*, May 2011, p. 1). The complex psychosocial treatment needs with concomitant legal issues calls for new methods to be established to attend to this set of realities.

SPECIALIZED DOCKETS

As a result of these concerns, mental health and drug courts, or *specialized dockets*, were begun in 1989 when a drug court was established in Miami-Dade County, Florida. Mental health courts began in the early 1980s in Indianapolis, Indiana. The assumption of such specialized dockets is that community partnerships would collaborate for continuity of care and bring about more efficacious treatment, symptom management, and a reduction of recidivism. Rather than just punishing the behavior of this population, treatment is provided under court monitoring. This includes intensive counseling, comprehensive wrap-around services, specialized treatment modalities, multi-agency treatment planning, and intensive monitoring by applying immediate sanctions. These new dockets (there are also prostitution dockets, domestic violence dockets, etc.) are not like the typical adversarial court in that a strength-oriented perspective is used as treatment is integrated with court compliance. Social services and enforcement work together to treat the mental illness or substance dependency that is at the root of this population's antisocial behavior. The Miami-Dade County report found that there was a lower rate of recidivism as well as a higher completion of probation requirements (Oetjen, Cohen, Tribble, & Suthahar 2003).

Hamilton County had the first specialized docket in Ohio, and the trend has spread throughout the state, to the point that the Ohio Supreme Court now has a Specialized Docket Section, which provides technical support in the planning and implementing of these programs. There are over 1,600 drugs courts currently operating in the United States (Wormer & Davis, 2008).

Also of note is that there are specialized dockets for both adults and adolescents. Adult drug courts can exist in Common Pleas, Municipal, and Juvenile Courts (Juvenile Courts have Family Dependency Courts that work with adults whose children have been removed due to their drug and/or alcohol dependency). There also are adolescent drug courts in many locations in the United States. As adult mental health courts are newer than adult drug courts, even more recent on the scene are adolescent mental health courts, which serve the needs of mentally ill who are in the juvenile justice system. Of note here is that probate courts, which function to provide safety to the mentally ill due to competency issues, are different from these specialized dockets because the probate system is not designed for those people who have broken the law. Specialized dockets provide judicially supervised treatment and are partnerships between substance abuse treatment services, mental health treatment services, the courts, prosecution, law enforcement, the defense bar, probation, child welfare and the recovery community. Thus, the courts mandate treatment for substance abuse or mental illness, and Marlowe, Festinger, Dugosh, Lee, and Benasutti (2007) report that there is no difference in the clinical outcomes between voluntary clients and those who are pressured by the court system to participate in treatment.

CASE STUDY: DRUG COURTS

John Doe is a 24-year-old European American male who was referred to the drug court coordinator for an assessment to determine his appropriateness for the program. He had four prior failed attempts at treatment, and reported that he had first smoked cocaine at the age of twelve, with his mother's then-boyfriend. This man also physically abused John Doe for the two years he was romantically

involved with his mother. Raised in poverty by his mother, who was in and out of the criminal justice system due to her drug addiction, Mr. Doe has never met his father. He always had a close emotional bond with his mother (who began getting clean from her addiction issues when he was in his early twenties). Mr. Doe's drug use escalated so that by the time he was fifteen he met the criteria for polysubstance dependency. While he abused many drugs and alcohol, upon admission to the drug court program he reported that his drugs of choice were opiates and cocaine. He dropped out of high school at the age of 17, had various short-term jobs, but made most of his money by being a drug runner (delivering drugs for a dealer).

He contracted hepatitis C due to using dirty intravenous needles, and he had numerous girlfriends throughout his teen years and his twenties, which led to the girls' having both a miscarriage and an abortion. He currently is the father of a four-year-old son. His son's mother is incarcerated due to drug possession (she used opiates to self-medicate her untreated bipolar disorder). He and his son live together in a small apartment above a barbershop in a downtown urban location.

John Doe is an engaging young man who is intelligent and resourceful, with a desire to change the direction of his life. He is caring and musically gifted, but said that being "drug sick" (as a result of withdrawal) was so terrible that he has not been clean and sober for more than a few days since his mid-teens. He also complained of having depression and anxiety for the past ten years, which were self-medicated with street drugs but professionally untreated.

He was referred to drug court because the county Children's Services Agency had received a report that John Doe's son was seen walking alone at 10:30 p.m. in the streets near his apartment. An investigation was completed, and his son was taken into custody by the agency, alleging parental neglect. John Doe was then referred for a drug court assessment and was accepted into the program. He reported that he would do anything to get his son back, that he wanted to be a father that he never had, but that he could not tolerate the feelings of being "drug sick."

This program, a family dependency drug court, works to reunite families that have been affected due to parental drug or alcohol dependency. It is approximately a twelve-month program, with four approximate three-month distinct phases of treatment. The first phase includes weekly hearings with the judge; completion of detoxification; then beginning Intensive Outpatient Therapy (IOP) at the local treatment provider; three weekly drug screens; a weekly individual counseling session; seven Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings; and weekly work with his case manager to address psychosocial needs like health care (treatment of his hepatitis), employment, housing, etc. The Children's Services Agency arranged twice-a-week supervised visits with his son as well. The treatment court coordinator also met with Mr. Doe weekly, to oversee his multi-agency treatment with wrap-around services. He was also referred to a local psychiatrist for a medication assessment.

Because the drug court program was "strength based," the hearings were intended to be reward based. Applause, small rewards (movie rental certificates, gas vouchers, AA tokens, etc.) were given for compliance with court orders. The judge was trained in motivational interviewing and used these skills from the bench. Prior to each of the weekly hearings (there were thirty-five participants in drug court, in various phases of the program) an interdisciplinary case conference

took place that included the judge, drug court coordinator, therapists from the local substance abuse treatment agency, representatives from the prosecutor's office, ongoing case worker from Children's Services, and the case manager.

John Doe had both success and clinical setbacks in Phase One of the program. While he did receive much praise for his involvement in therapy, he was not compliant with the required AA/NA meetings. He was given community service as a sanction, and as the compliance issues continued, he was given more graduated sanctions, an essay, and additional community service. The expected three months of Phase One took five and a half months, with multiple failed drug screens. This resulted in three weekend stays at the local county jail, with recovery homework assigned to be completed while incarcerated (reading a chapter a day of recovery-based books with a three-page essay on each chapter). While the psychiatrist and drug court team did not want to employ antidepressant medications until he had some time of being clean to assess his emotional stability, Mr. Doe did experience suicidal ideation (he had two prior attempts at suicide), and by the seventh week in the program it was decided to prescribe Mr. Doe medication for his affect disorder. Mr. Doe also asked a member of his 12-Step recovery group to be his sponsor, and this relationship became key to his future success.

At the end of five months the team discussed his compliance with court orders and treatment progress. Mr. Doe was asked to write a three-page essay on what he had learned in Phase One, which was read in court and which received applause, and he moved to Phase Two of the program. This phase continued with many of the Phase One requirements, but the hearings with the judge were moved to every other week and the intensive outpatient program was complete, so he began an aftercare program of a weekly three-hour group. During this phase his depression became more manageable and suicidal ideation abated, but symptoms of post-traumatic stress disorder (PTSD) emerged, related to the physical abuse he had experienced as a child. As a result, the treatment court coordinator made use of an evidence-informed treatment modality for trauma, Eye Movement Desensitization Reprocessing (EMDR). This work took ten sessions and was very helpful to Mr. Doe in that his PTSD was now managed quite well. Key to his recovery was this trauma-sensitive focus of the interagency treatment team and the court's focus on trauma issues that were very common in this specialized docket.

Of note is that, while each of the thirty-five participants in the drug court program had similar requirements in the four phases, the multi-agency treatment plan was tailored to meet the needs of each client. Also of note is that as the drug court program was planned, which was done in partnership with community agencies, it was decided that the treatment provided for the participants would only include evidence-informed services. An example here is that the Intensive Outpatient Program that the substance abuse agency provided used the Matrix model, an evidence-informed best practice developed by the University of California at Los Angeles (Rawson et al. 1995). A strength of this family drug court was the collaboration that took place within the community between key stakeholders. A quarterly meeting of key stakeholders took place; this was facilitated by the judge and included the executive director of the Mental Health and Recovery Board, the executive director of the Department of Child and Family Services, the sheriff, the prosecutor, and the lead attorney in the Defense Bar. Also of note is that a not-for-profit corporation was formed to support the family drug court. This organization, with trustees independent of the court staff, did fund-raising for the drug court, provided community awareness about the program, and worked with

the media to communicate to the community the purposes and outcomes of this program. When Mr. Doe would receive an award for success in a hearing due to compliance with treatment and court orders, this was funded by the not-for-profit corporation.

Mr. Doe continued to do well in his supervised visits with his children. But six months into the program he had a relapse on heroin and almost died due to an overdose. He also lost his part-time job in food service at this time, was evicted from his apartment, and was involved in a misdemeanor assault (he was put on probation for this charge). As he was hospitalized for the overdose, the team worked in collaboration with him and decided that he would attend an inpatient residential program. His sanction was thus a clinical sanction (rather than a punitive judicial response like time in jail) in that he was ordered to attend inpatient care. The team sought treatment options, but due to fiscal restrictions and the assault charges there were many limitations on the alternatives available. After further searching, a facility was found and he was court-ordered and agreed to a thirty-day stay in a treatment center that would accept his Medicaid as partial funding (other funding came from the county Mental Health and Recovery Board). While in this treatment setting he was visited by the treatment court coordinator, who provided support to Mr. Doe, utilization review, and assisted in discharge planning.

Upon discharge from the inpatient program, he was integrated back into Phase Two of the program, but with higher accountability (more drug screens and increased supervision by the drug court coordinator) and increased treatment requirements. Because he came out of the program homeless, he was housed in a facility operated by the county Mental Health and Recovery Board that was designed for homeless clients who are in early recovery. This stable housing assisted him in socializing with pro-social peers, assisted him in searching for a job, and treatment staff closely monitored the facility. He also returned to his involvement with his sponsor and AA or NA groups.

What became integral for him during this time was being reunited with his mother. They had lost connection due to each of their addiction issues, but as she was now clean and sober for ten months and very active in twelve-step recovery. Their new healthy relationship galvanized his growth and his nascent recovery began to take a deeper meaning in Mr. Doe's life. They gathered around each other in their recovery journeys, and they each also grew closer to John's son, who continued in the care of the Children's Services Agency. More frequent visits with his son took place as he began to gain credibility with the treatment team.

The partnership of treatment and the courts was very important to John Doe. While prior treatment attempts had been unsuccessful, the intensive coordinated treatment, the accountability of the Court, along with his relationship with the judge from the bench, proved immeasurable in its importance. The comprehensive treatment provided to him assisted him in all aspects of his recovery. This holistic care, based on the community partnerships in the drug court, contributed to his success. While incarceration was used as a sanction while he was in the early phases, he began to be motivated by the praise and rewards that were also possible. He was treated with respect; he was supported; he was confronted. Throughout the program he kept his goals in mind: to get clean, to be in recovery, and to be reunited with his son.

In the final two phases of the drug court program, he continued to do his twelve-step work with his sponsor. His treatment plan for this time also included

completing his General Education Development (GED) diploma and a twelve-week parenting class. Court staff and the counseling center where he received services collaboratively offered the parenting class. Again, an evidence-informed best practice was used, the Strengthening Families curriculum (Kumpfer, 2011). Visits with his son continued and now were unsupervised by the Children's Service Agency. Throughout the process John Doe received much positive reinforcement, which moved him in that the judge "caught me doing the right behavior." He was very active in Narcotics Anonymous meetings, chairing some meetings and developing deeply supportive sober relationships.

Mr. Doe continued to experience triggers to use drugs to alter his mood. But he used new coping methods that did not involve substances. He also struggled with obtaining viable employment. Due to his legal history he had difficulty obtaining work outside of food service, but the interagency team assisted him with obtaining volunteer work in addition to working in food service. He was aware that he would have to have both viable housing and income to be reunited with his son, who remained in foster care as he completed his treatment goals. At this point he attended individual counseling once a week, spoke with his sponsor daily, and went to five NA meetings weekly. He was only court-ordered to attend two NA meetings, but said that he was going to meetings now because he wanted to attend, not because he had to attend.

Of note is that the judge's interventions with him from the bench made use of the assumptions and language of twelve-step recovery. She reinforced living a day at a time. She discussed the first step of NA/AA with him from the bench, how his life was both unmanageable and that he was powerless to restore his life on his own. The interagency team also assisted him with twelve-step recovery, and during the latter half of his sixteen months in drug court he began incorporating recovery into his personality and everyday philosophy of life.

Near the end of his time in the drug court program, he was able to obtain a job as a forklift driver in a factory, a position with good pay and health insurance. As a result the judge approved that he find housing outside of the homeless facility in which he was living. He found a two-bedroom apartment, which met the requirements to be reunited with his son.

The first weekend in his new apartment, a knock came to his front door. When he answered the door, he discovered one of his old drug-using friends, high on crack cocaine and asking Mr. Doe to get high with him. For a moment Mr. Doe's cravings returned, the hunger for both the pleasure of getting high and the excitement of a drug dealer's life. But he thought about what he had learned from the judge, from his counselors, from his sponsor, and he refused to invite the person into his home. As soon as he asked this person to leave, he called his sponsor and they talked through what had taken place.

When he reported this at his next hearing, being in Phase Four he now only had a hearing every four weeks, he received applause and embraces from the judge and interagency team. He also began preparing his graduation essay, which he read in court to the interagency team at his next hearing. He reported that he had learned so much about himself and about recovery that gratitude was his primary feeling. After graduation, John Doe celebrated with the judge and team with cake and punch, and he received a graduation gift from the not-for-profit corporation that supports the drug court.

Within a few weeks his son left foster care and moved into his father's new apartment. Mr. Doe continued to attend three NA/AA meetings a week, and looked forward to sponsoring new people in recovery. He also attended individual counseling twice a month and worked through his deep shame and regret for all that he had done during his years of using drugs and alcohol. He had "a day at a time" of sober living ahead of him, and while it certainly would not always be easy, he could deal with life as a recovering person rather than as an active addict. Most of all, he prided himself on being the father to his son that he had never had.

OUTCOMES AND EFFICACY

While this case study illustrates a drug court case of an individual addicted to street drugs who also was diagnosed with dysthymia, the model has many similarities with other specialized dockets. Mental health courts, prostitution courts, domestic violence courts, all are multi-phased programs that are community partnerships. Of note is that there are specialized dockets for both adults and juveniles, with drug courts and mental health courts most common for the juvenile population. All include a coordination of court enforcement and psychotherapeutic programs.

Related to the above case study, empirical studies demonstrate considerable effectiveness. A meta-analysis of the literature (Belenko, Patapis, & French, 2005) compared the rates of recidivism of drug court graduates and those completing jail time and general probation. Over four years, the data demonstrated significant cost-benefit ratios. With reduced recidivism in the criminal justice system, the graduates not only saved the community the criminal justice costs, but also there was a decrease in future criminal activities, and a decrease in the use of Medicaid, mental health and recovery services, drug exposure of infants, and health problems.

Marlowe et al. (2007) write, "The effectiveness of drug courts is not a matter of conjecture. It is the product of decades of exhaustive scientific research . . . by 2006 the scientific community had concluded beyond a reasonable doubt from advanced statistical procedures that drug courts reduce criminal recidivism" (p. 1).

Positive clinical outcomes with drug courts have been demonstrated by Giacomazzi and Bell (2007, p. 309): "Our findings present ample evidence that the county drug court is experiencing considerable success. With only a few exceptions, the county drug court program, as implemented, is in compliance with benchmarks identified as a 'best practice for drug court operations.'" It has also been noted (Lutze & von Wormer 2007): "The overall success of drug courts to date is fully recognized and it is our hope that this trend will continue into further implementation" (p. 242). McNeil and Binder (2007) have reported that drug courts have much success in reducing both criminal behavior and violence of participants.

While mental health courts are newer and the research on outcomes is currently not as in-depth as drug courts, Herinckx et al. (2005) discovered the following trends. Overall crime by mental health court participants was reduced four times one year post-graduation from the program. Fifty-four percent of the participants, again one year after completion of the program, had no further arrests. Probation violations were reduced by 34%, and program graduates were 3.7 times less likely to re-offend.

CRITICISMS

In some communities, the public behavioral health system has capacity issues and struggles to meet the needs of their clients. And in some communities, the only way to access a higher level of care or more intense services is through specialized dockets, which tend to deal with the more challenging cases in a community. It is problematic, therefore, that one would have to enter the criminal justice system to access services. The solution here is to increase access for those needing more intense treatment *outside* of the criminal justice system,

Another criticism is that specialized dockets deepen rather than lessen a person's involvement with the criminal justice system. A "criminalization" of persons with mental illness or addictive behaviors could socialize individuals to antisocial norms of behavior. A judge and interagency team who take care to balance treatment with the social norms of the community and understanding of deviance can minimize this concern, especially if a strength-oriented perspective is frequently raised as a key assumption of how specialized dockets function.

Another criticism of specialized dockets is that treatment can be co-opted by the assumptions of criminal justice. With the leadership of the judge and treatment court coordinator, treatment can be seen as a function of the criminal justice system while steadfastly holding to the values of psychotherapy and counseling. There are some potential conflicts between the axiological world view of courts and treatment, but a cross-fertilization of ideas can take place, and the separate but connected realities of criminal justice and treatment can have a positive dynamic and further develop the program while better addressing the clinical needs of the participants.

A final critique is that legally, the considerable requirements of these intense and rather long programs are not necessarily the shortest routes through the criminal justice system. Some may prefer to go to jail rather than go to counseling and other types of treatment. Some may choose court sanctions over treatment as the path of least resistance. But the rewards of a life with managed mental health symptoms or a life of recovery from the devastating consequences of addiction offer much hope and promise.

CONCLUSION AND FUTURE DIRECTIONS

Substance dependency and mental illness are brain disorders. Our society has criminalized these brain disorders rather than treating them as a public health concern. Until we radically rethink the meaning of addiction and mental illness, and since they do frequently end up in the criminal justice system, drug and mental health courts are viable ways to provide treatment that is integrated with the court system. More humane treatment of these brain disorders is possible in the rapidly growing field of specialized dockets. To incarcerate a nonviolent person in many prisons is to put them at risk of being institutionalized to criminogenic ways of thinking and behaving. Many prisons have a paucity of treatment resources, and vulnerable populations can experience maltreatment.

Judges who initiate these specialized dockets have, therefore, developed problem-solving courts. As some clients are mentally ill and/or addicts who engage in criminal acts, and are not so much criminals who are mentally ill and/or addicts, a combination of treatment and enforcement is required. The marriage of the courts and treatment was long coming in that treatment providers have for years recommended group therapy or attendance at self-help meetings, only

to discover that their recommendations were not heeded. With specialized dockets, treatment adherence is made more likely, and as people in society wrestle with being mentally ill, being an addict, or both, there is much promise for this new way of providing care.

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THE USE OF TECHNOLOGY IN A COMMUNITY MENTAL HEALTH SETTING

JESSICA LEVY AUSLANDER

As technology advances, we will be continually faced with the issue of deciding what types of technology to incorporate into our personal and professional lives. We use technology to access information, facilitate communication, and improve efficiency on a daily basis. For those who work in the service of others, the use of technology raises unique professional, legal, and ethical questions. As various professional governing bodies struggle to establish best practices and guidelines, we must recognize that technology is constantly evolving, requiring us to periodically analyze and take responsibility for our own technology use. This chapter will address a few basic issues surrounding technology faced by new professionals in community mental health work, such as technology use by consumers, managing your digital reputation, technology-enhanced communication, and distance therapy.

Communication using phone, cell phone, email, or other Internet methods will be referred to as *distance communication*, and is not to be confused with *distance therapy*. Eysenbach (2001) defined a similar term, *e-health*, as “an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies. In a broader sense, the term characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve health care locally, regionally, and worldwide by using information and communication technology.” With the sophistication of information technology, the medical field has developed the electronic medical record (EMR) and other tools to facilitate communication between physicians and their patients, improve accuracy and efficiency of tasks such as documentation and ordering prescriptions or procedures, and enhance the flow of information both within and between medical networks and providers. This advancement in the medical field has the potential to enhance the interaction among physicians,

psychiatrists, and community mental health providers to facilitate more effective communication and care for consumers.

TECHNOLOGY USE BY CONSUMERS

Studies of the use of the Internet by consumers of both medical and mental health services are becoming more common. There is an increasing body of literature that addresses the intersection of technology and healthcare. Trends include using the Internet to access information about diagnoses and treatment, using Internet-based methods to communicate with providers, and using the Internet to research the credentials and backgrounds of potential providers. Wald, Dube, and Anthony (2007) described a “triangulation” of the consumer, the provider and the Internet. This concept of triangulation emphasizes the extent to which technology can affect the dynamic between the consumer and provider. While there is a very real concern that the consumer is accessing incorrect information, this dynamic also provides an opportunity for the provider to work with the person to discuss the quality of information and help them be better informed about their treatment options. A person’s ability to access information prior to their appointment and discuss it with their provider may help them feel more empowered and more like a partner in their care, presenting a shift in the perceived power of provider over the consumer. It is important to note that while the Internet is being used more and more by consumers, Sillence et al. found that the provider was still seen as the primary source of information (2007).

In 2006, Powell and Clarke found that 18 percent of all Internet users had accessed information related to mental health. This was higher among populations with a history of mental illness or who were currently experiencing symptoms. It is advisable for providers in the community mental health setting to be aware of the websites that are being accessed by consumers and their families. This can be accomplished by performing a variety of searches on diagnoses or symptoms using different search engines. In doing so, one can find thousands of websites that provide a wealth of information that may or may not be accurate. It is also easy to find online support groups, networks, and websites that even promote unhealthy lifestyles in connection to specific diagnoses. A strong example is the collection of websites, blogs, and online support groups that are referred to as “Pro-Ana” (pro-anorexia) and “Pro-Mia” (pro-bulimia). While some claim to be support networks for those suffering from an eating disorder, many state that it is a lifestyle choice that should be respected, not a diagnosis, and advise others on how to lose extreme amounts of weight and maintain drastically low body-weights. Other examples include “self help” websites that instruct readers how to sober up quickly or how to hide signs of alcohol and chemical dependence and abuse. One approach to assisting people in accessing correct information is to develop a list of websites that you or your agency leadership have evaluated and approved for distribution to consumers and their families. However, keep in mind that the Internet is fluid and pages are added, deleted, and changed every second, all over the world, so any list you provide should be rechecked on a regular basis to insure that the websites are still appropriate and the links are still functional.

Beckjord, et al. (2007) reported that in 2003, seven percent of Internet users had communicated with a health provider online; this number increased to 10 percent in 2005. They also found that those who had “more years of education, who lived in a metro area, who reported poorer health status, or who had a personal history of cancer” were more likely to have engaged

in online communication with a healthcare provider this does not include telemedicine, which is addressed later in this chapter). This increase shows the need for providers to become aware of the progressing expectations of consumers and their families in regard to technologically enhanced communication, and to address issues of access and policy within their organizations.

Potential and current consumers and their families may also use the Internet to search for care providers. If your agency has a website, not only do you want to ensure that the information presented about you and your services is accurate, but you will want to advocate that it is accessible and appropriate for your audience. For example, many mental health-related websites are written by professionals with advanced degrees. While the information may be excellent, it may be above the reading level of the general public. Microsoft Word has the ability to analyze text and calculate the Flesch-Kincaid reading level. This metric applies a formula created by Rudolph Flesch and John P. Kincaid that incorporates the average number of words per sentence and syllables per word used in a text. The resulting score corresponds to the American academic grade levels 1–16 (first grade through collegiate postgraduate level). By enabling the “readability statistics” option, you can determine the reading-grade level of your text. To do this in Microsoft Word, open the spelling and grammar check function, click “Options,” then click “Show readability statistics.” Most newspapers are at the high-school level (9–12), but, depending on the population served, it may be better to have text at a lower reading level. Keep in mind that specific words can advance the reading level, so it may be helpful to analyze the text with and without technical terms, such as the names of diagnoses or medications. Another aspect of website accessibility involves user options that allow consumers to increase or decrease font sizes or disable graphics (a “text-only” option). It can be helpful to have a section of your website designed for consumers and their families, and another area designed for other stakeholders.

YOUR DIGITAL FOOTPRINT

Those who work in the service of others in either public or private settings and who are licensed or credentialed must hold themselves to a higher standard of ethical scrutiny. It is the responsibility of the individual to be vigilant in protecting his or her reputation both online and offline. Greysen, Kind, and Chretien (2010) discussed the impact of an individual’s “digital footprint” on their own professional reputation, as well as how it could impact their professional community as a whole. Regulatory bodies throughout the world and a myriad of professions struggle with defining appropriate Internet use for their professionals. Consequences of questionable technology use or inappropriate material posted on social media sites can range from loss of a job, to loss or suspension of one’s license, even to legal action. These actions can also have a ripple effect and tarnish the reputation of the organization or profession with which the individual in question was affiliated. Therefore, it is vital that professionals be vigilant in creating and maintaining a positive online presence.

There are no universally adopted standards for the non-clinical use of technology in the professional setting. Always refer to your profession’s code of ethics and any policies put in place by your agency. While there are companies who specialize in online “reputation management,” there are several additional things professionals can do to protect themselves in terms of their web presence, communication methods, and the use of personal electronic devices. It is important to keep in mind that everything posted or published on the Internet is considered

permanent; even though it may not be actively online, it can still be retrieved electronically. The best way to maintain a positive online presence is to be very conservative about what you post and to constantly monitor what is posted about you. For those who are very active online, an initial audit of online activity can be daunting. A quick way to begin is to enter your name into a search engine and go through as many results as you can. Repeat this with variations of your name (and maiden name if applicable), and with different search engines. This should be done on a regular basis to catch any obvious errors or misrepresentations. It is also helpful to pay attention to search results that do not directly apply to you. If someone has the same or similar name as you and they have a less-than-appealing web presence, educate yourself so that you can be prepared to explain the coincidence to others.

Another benefit to conducting regular web searches on your own name is to determine what information has been made public about you. Many websites now exist that allow consumers to rate their providers or choose potential providers from a public directory. The information provided in these unsolicited directories is often incorrect and can cause frustration for potential consumers and their families. Other sites, such as www.whitepages.com, specialize in publishing personal information that can include full name, address, phone numbers, email addresses, and even family members' information. If you do find information published about you that is incorrect, contact the site administrator immediately to have it corrected or removed.

Many licensing boards and professional organizations provide online directories of their members to promote the profession or provide transparency to the public regarding the status of providers' licenses. Check with any applicable boards' websites to determine how your information is presented online and to ensure that it is accurate. If you have any former employers who list staff on their websites, also ensure that your information has been removed from their site if you no longer have a professional relationship.

One of the most controversial aspects of professional web presence is the use of social networking. While many companies have policies that prohibit employees from accessing social networking sites during work hours, others, such as some public school districts, have prohibited their employees from holding accounts on sites like Facebook to prevent inappropriate social interaction or the portrayal of a negative image of the organization. If you choose to engage in social media, review the privacy policies and your personal account settings on a regular basis. If your personal page includes photos, make sure they are tasteful and ones that you would want other professionals or clients to see. Even if you have strict privacy settings, it is always possible for someone who has approved access to your page to show it to another individual who is not on your personal network.

While universities and organizations provide their students and employees with a standardized email address, most people have a personal email address. The personal email address should not be used as a primary method of communication with consumers, as it is probably not protected or encrypted. Many organizations have developed policies restricting employees from accessing personal email accounts at the workplace due to security concerns. While it is wise to have a secondary email account as a backup, if it will be used for professional purposes at any point, choose an email address and carrier that sounds professional and legitimate. This is particularly crucial when initially applying for positions if your university email address will expire shortly after graduation. A typical acceptable format is `firstname.lastname@domain.com` or `firstinitial.lastname@domain.com`. Avoid nicknames, references to hobbies, etc., in your email address. When choosing your domain provider, research security features, document-download capability, and the use of advertising.

As mobile phone technology advances, more and more users are upgrading to “smartphone” devices that have voice, text, and web capabilities. It is important to keep in mind that communication using cell phones is not considered secure, as they can be easily overheard by others and the signals picked up by other phones and devices. These devices are also designed to be replaced every one to three years, so it is not advisable to store important data directly on the phones; rather, consider them access points to more reliable sources. Be sure that your phone is locked with at least one password in case it is picked up by another person, and always be mindful of your ringer and notification settings while in the workplace. Many smartphones allow users to set up a “work” profile where you can set a generic ringtone and not have personal application icons displayed on the screen.

As smartphone technology advances, so does its potential as a therapy-enhancing tool. Consumers who use smartphones could use them to track appointments, save key contacts in the event of crisis or emergency, and send and receive email and other forms of electronic messaging. Providers can use this opportunity to reinforce the work being done together in the office by sending handouts or reminders, or checking in with the consumer between sessions. Users of smartphones and similar electronic devices also have access to thousands of applications (commonly referred to as “apps”) to expand their device’s capabilities. A quick search for mental health applications will lead the user to thousands of possible choices (free or for a small fee) that serve as references, self-tests, and apps designed specifically to support certain diagnoses. Consumers can download entire workbooks written by experts, or track daily behaviors or moods. The quality of these varies, so it may be helpful to discuss this with a consumer or family member if they use this technology.

TECHNOLOGY-ENHANCED COMMUNICATION

One of the most common uses of technology is to facilitate communication. Phones, cell phones, and email have become part of our daily lives, both personally and professionally. As Kane and Sands (1998) emphasized in a paper written for the American Medical Informatics Association, technology-enhanced communication should improve a caregiver’s relationship to a client, not make things confusing or complicated. AMIA also recognized that it would not be realistic to set universal recommendations, as every care organization is unique. As a new professional entering a community mental health agency, you should familiarize yourself with your agency’s policies regarding the use of phone, email, and other distance communication technologies with clients and professionals from other agencies. If your organization does not have any such policies, advocate that this area be explored and written policies created to protect yourself and your clients. Policies regarding communication methods should also be communicated in your professional-disclosure statement.

Factors to consider in creating your communication policy can include:

- If contacted by a professional from another agency by phone or email, how will these requests be handled, and how will confidentiality be maintained?
- Does my organization’s technology infrastructure have the necessary security features in place?
- Does my email have a disclaimer on the bottom addressing confidentiality and an emergency plan?

- Does my voicemail clearly state the hours I am available by phone, and what to do in my absence or in case of emergency?
- How will I handle phone calls from clients between office visits if they are calling for reasons other than scheduling an appointment?
- How will I handle emails from clients?
- Will I allow my cell phone number to be given out, or is there an agency cell phone for after-hours use?
- Does my agency have legal counsel available if I have questions?

DISTANCE THERAPY

The terms *distance therapy*, *distance counseling*, and *telemedicine* all refer to providing treatment or interventions using technology when not face-to-face with the consumer. For the purposes of including all disciplines in this chapter, these will be generally referred to as *distance care*. This should not be confused with computer-assisted therapies, which use computer technology to either complement traditional therapy to enhance efficacy or are used with little interaction with a therapist to reduce therapist time (Wright et al., 2002, 2005).

While it is easy to think of anything involving technology as modern and advanced, the concept of distance care is not a new one. Wootton (2001) noted an early example of doctor-patient communication using ship-to-shore radio to give medical advice to captains at sea. In 1958, the first American suicide prevention telephone hotline was created at the Los Angeles Suicide Prevention Center (Spencer-Thomas & Jahn, 2012). As communication technology has advanced, so has the number of ways it can be used to facilitate medical and mental health care.

There are both benefits and disadvantages to engaging in distance care that have been documented across professions. One of the primary advantages is that it can provide access to care for traditionally underserved populations (Riemer-Reiss, 2000). The United States Department of Health and Human Services (HHS), through their Health Resources and Services Administration, provides an online directory of Health Professional Shortage Areas (HPSA) (<http://hpsafind.hrsa.gov/HPSASearch.aspx>). This directory is updated daily and provides information about shortages in primary medical care, dental care, or mental health care by state and county, including island territories. For example, as of December 14, 2011, they estimated 88.9 million people living in Mental Health HPSAs. Using a ratio of one mental health practitioner per 10,000 people, it is estimated that 5,818 additional practitioners would be needed to meet the current need.

Providing access to underserved populations is not just about spanning a geographical distance. Other barriers to accessing care that could be addressed by distance care include persons suffering from severe physical or mental illness who are not comfortable or able to leave their homes to attend regular appointments in an office setting. Others may not be comfortable with face-to-face social interaction, or would benefit more from using the written word via email, chat, or other Web-based communication methods than speaking. Stigma is another barrier to accessing care that could be greatly reduced by distance methods. If an individual is concerned about the stigma associated with attending appointments at a mental health agency, that person may be more comfortable accessing the care they need in the privacy of their home.

Another benefit of distance care is that it can be cost-effective for both the consumer and the provider. Medicaid covers telemedicine and telehealth services, and over the past few years, several states have passed legislation to require that these services be covered by private insurers as well. This allows providers to be reimbursed just as they would be for providing traditional office care, but with less administrative cost. Also, the consumer does not have the expense of transportation or extra time spent commuting and waiting at an office.

While distance care can provide many benefits for consumers and their caregivers, there are also some risks. Distance care is not appropriate for every consumer, and a professional trained in distance methods should appropriately screen and provide a distance-specific disclosure statement educating consumers of the benefits and potential risks. Risks can vary by distance method used. For example, if conducting a counseling session on the phone, both the counselor and the consumer need to be aware of the absence of nonverbal cues. Other risks include security (and therefore confidentiality) issues, and reliability of the technological infrastructure used.

The primary barrier to accessing distance care is a lack of resources. While distance care can be very beneficial to serving a rural population, there must first be the technological infrastructure to support the methods used. While a provider may prefer to use video conferencing, it may not be possible if the consumer is in a remote area that does not have high-speed Internet access, or if they do not have access to a computer that can support such a technology.

Another major resource that is lacking is the provider. Providing distance care is not as simple as just using a phone or computer instead of being in the same room with a person. Individual professions have developed or are in the process of developing policies and credentials for providing distance care. These address the legal issues (for example: if you are licensed in one state, can you provide services to someone in a different state?), the ethical concerns, and the best practices in adapting service provision to distance methods. Vitacca et al. (2009) developed the following core competencies (Table 32.1) in implementing telemedicine or other e-health services.

Anyone providing distance care must first hold a clinical license in their field, but some professions have developed additional training and credentials for those looking to expand their scope of practice. For physicians, this varies by state, as more are starting to recognize the need for services. This has already been recognized at the national level; in 2011, the Centers for Medicare and Medicaid Services made providing telemedicine services to rural area hospitals easier by removing the rule that required that physicians providing telemedicine services must be credentialed by the receiving hospital (Lowes, 2011). This makes it easier for experts from larger hospital systems to provide consultation to smaller hospitals that may not have access to highly specialized providers. The American Medical Association (AMA) Code of Medical Ethics also addressed the practice of physicians' contributing to health-related websites in Code 5.027–Use of Health-Related Online Sites (AMA, 2003).

Regarding the use of email to communicate with patients, the AMA incorporated Opinion 5.026–The Use of Electronic Mail into the AMA Code of Medical Ethics (2002). The AMA supports the use of email to enhance the physician–patient relationship, but outlined a series of precautions that should be taken when engaging in email communication (Table 32.2).

They also established specific guidelines for physicians using email for patient and practice related communications, as well as a separate list to address administrative concerns (see Tables 32.3 and 32.4).

Table 32.1 Core Competencies to Implement E-Health and Telemedicine

Patient-centred care	Interviewing and communicating effectively
	Assisting behavior change
	Supporting self-management
	Using a proactive approach
Partnering	Partnering with patients
	Partnering with other providers
	Partnering with communities
Quality improvement	Measuring care delivery and outcomes
	Learning and adapting to change
	Translating evidence into practice
Information and communication Technology	Designing and using patient registries
	Using computers
	Communicating with partners
Public health perspective	Providing population-based care
	Systems thinking
	Working across the disease continuum
	Working in primary care-led systems

Vitacca, M., Mazzu, M., and Scalvini, S. (2009). Socio-technical and organizational challenges to wider e-Health implementation. *Chronic Respiratory Disease* 6:91–97. doi:10.1177/1479972309102805

Table 32.2 AMA Code of Medical Ethics, Opinion 5.026

- (1) E-mail correspondence should not be used to establish a patient–physician relationship. Rather, e-mail should supplement other, more personal, encounters.
- (2) When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies can provide specific guidance as to the appropriateness of offering specialty care or advice through e-mail communication.
- (3) Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.
- (4) Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's authorization. (I, IV, VI, VIII) (Opinion 5.026, AMA Code of Ethics, 2002).

The American Counseling Association Code of Ethics addresses similar aspects of technology use, but covers a wider base of technological applications and their uses (Table 32.5).

Professional counselors, social workers, couple and family therapists, psychologists, psychiatrists, and other independently licensed mental health care providers can attend specialized training and obtain the Distance Credentialed Counselor (DCC) credential, which is recognized by the National Board for Certified Counselors (NBCC). This is a five-year credential that must be maintained through continuing education. As this is a rapidly evolving field, it is predicted that other professions will develop distance-specific guidelines and credentials. Professional organizations and journals are developing to specifically address the intersection of health, mental health, and technology, such as the International Society for Mental Health Online (ISMHO), an interdisciplinary, international organization for mental health professionals.

As the fields of health and mental health expand, it is expected that technology will continue to enhance and facilitate professional growth and consumer access to services. At the least, in order to meet or anticipate the needs of current and future consumers, providers will need to incorporate technology-related topics into their professional development and continuing-education

Table 32.3 AMA Communication Guidelines When Using Email

<ol style="list-style-type: none">1. Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.2. Inform patient about privacy issues.3. Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.4. Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mails communications with patients.5. Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.6. Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.7. Request that patients put their name and patient identification number in the body of the message.8. Configure automatic reply to acknowledge receipt of messages.9. Send a new message to inform patient of completion of request.10. Request that patients use autoreply feature to acknowledge reading clinicians message.11. Develop archival and retrieval mechanisms.12. Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.13. Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.14. Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.15. Explain to patients that their messages should be concise.16. When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.17. Remind patients when they do not adhere to the guidelines.18. For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.
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Table 32.4 AMA Guidelines for Using Email for Administrative Concerns

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1. Develop a patient–clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
 2. Terms in communication guidelines (stated above).
 3. Provide instructions for when and how to convert to phone calls and office visits.
 4. Describe security mechanisms in place.
 5. Hold harmless the health care institution for information loss due to technical failures.
 6. Waive encryption requirement, if any, at patient's insistence.
 7. Describe security mechanisms in place including:
 8. Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 9. Never forwarding patient-identifiable information to a third party without the patient's express permission.
 10. Never using patient's e-mail address in a marketing scheme.
 11. Not sharing professional e-mail accounts with family members.
 12. Not using unencrypted wireless communications with patient-identifiable information.
 13. Double-checking all "To" fields prior to sending messages.
 14. Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
 15. Commit policy decisions to writing and electronic form.
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Table 32.5 From the American Counseling Association (ACA) Code of Ethics, Relating to Technology

A.12. Technology Applications**A.12.a. Benefits and Limitations**

Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/ billing procedures. Such technologies include but are not limited to computer hardware and software, telephones, the World Wide Web, the Internet, online assessment instruments, and other communication devices.

A.12.b. Technology-Assisted Services

When providing technology-assisted distance counseling services, counselors determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.

A.12.c. Inappropriate Services

When technology-assisted distance counseling services are deemed inappropriate by the counselor or client, counselors consider delivering services face to face.

A.12.d. Access

Counselors provide reasonable access to computer applications when providing technology-assisted distance counseling services.

A.12.e. Laws and Statutes

Counselors ensure that the use of technology does not violate the laws of any local, state, national, or international entity, and observe all relevant statutes.

A.12.f. Assistance

Counselors seek business, legal, and technical assistance when using technology applications, particularly when the use of such applications crosses state or national boundaries.

(continued)

Table 32.5 Continued

A.12.g. Technology and Informed Consent

As part of the process of establishing informed consent, counselors do the following:

1. Address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.
2. Inform clients of all colleagues, supervisors, and employees, such as informational technology (IT) administrators, who might have authorized or unauthorized access to electronic transmissions.
3. Urge clients to be aware of all authorized or unauthorized users, including family members and fellow employees who might have access to any technology clients may use in the counseling process.
4. Inform clients of pertinent legal rights and limitations governing the practice of a profession over state lines or international boundaries.
5. Use encrypted Web sites and e-mail communications to help ensure confidentiality when possible.
6. When the use of encryption is not possible, counselors notify clients of this fact and limit electronic transmissions to general communications that are not client-specific.
7. Inform clients if and for how long archival storage of transaction records is maintained.
8. Discuss the possibility of technology failure and alternate methods of service delivery.
9. Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available.
10. Discuss time zone differences, local customs, and cultural or language differences that might impact service delivery.
11. Inform clients when technology assisted distance counseling services are not covered by insurance. (See A.2.)

A.12.h. Sites on the World Wide Web

Counselors maintaining sites on the World Wide Web (the Internet) do the following:

1. Regularly check that electronic links are working and professionally appropriate.
2. Establish ways clients can contact the counselor in case of technology failure.
3. Provide electronic links to relevant state licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
4. Establish a method for verifying client identity.
5. Obtain the written consent of the legal guardian or other authorized legal representative prior to rendering services in the event the client is a minor child, an adult who is legally incompetent, or an adult incapable of giving informed consent.
6. Strive to provide a site that is accessible to persons with disabilities.
7. Strive to provide translation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations.
8. Assist clients in determining the validity and reliability of information found on the World Wide Web and other technology applications.

regimens. The challenge will be to go beyond simply learning what others have already done with technology; providers must explore new ways to use technology in the practice of mental health. Technology, used in line with a profession's code of ethics or adopted professional standards, can be a powerful tool for facilitating interdisciplinary collaboration among other professionals, community members, and consumers. Mental health providers can also serve as advocates for consumers on issues of public policy related to access, standards, and regulation, as society will also continue to struggle with the questions raised by technology's rapid progress.

CONCLUSION

This chapter provided a brief overview of different aspects of technology and its impact on mental health care providers and consumers. It is important to make the distinction between the use of technology to enhance current practices (distance communication) and the use of technology to provide services (distance therapy or distance care). As technology progresses, it is vital for the mental health professional to remain vigilant about their own digital footprint as well as how advancements impact the lives of consumers and their families. It is also imperative that professionals remain current with the changes in their field's codes of ethics or professional standards as well as with any local laws in regard to the use of technology with consumers and the general public. By staying current with emerging technologies, mental health professionals can also find opportunities to revolutionize how we collaborate with each other and deliver services to those in need, and likely underserved.

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ESTABLISHING A COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE FOR PERSONS WITH CO-OCCURRING CONDITIONS

KENNETH R. YEAGER AND KENNETH MINKOFF

INTRODUCTION

The term *co-occurring conditions* in this chapter is used to refer to people of any age with any combination of any mental health and any substance use or addictive problem, including gambling, Internet porn, sex, shopping, or nicotine dependence. Kohn, Saxena, Levav, and Laraceno (2004) reported a high prevalence of co-occurring conditions worldwide, with as many as seven to ten million persons in the United States suffering from combined mental illness and substance use disorder (DHHS, 2003). While definitions vary, the term *severe and persistent mental illness* generally includes the conditions of: schizophrenia, bipolar disorder, severe and recurrent depression, post-traumatic stress disorder, and other associated anxiety conditions, including severe obsessive-compulsive disorder. Substance use conditions include alcohol, cannabis, cocaine, opiate, amphetamine, and sedative hypnotic use and dependence, as abuse of these mood-altering substances may adversely affect the functioning, stability, and behaviors of those with severe and persistent mental illness.

Two decades of research in a wide variety of settings, and with a variety of populations ranging from adolescents and families involved within the court system (e.g., criminal justice or child protection) to adult populations with severe and persistent mental illness, has demonstrated a need to develop approaches to care that integrate both mental health and substance-use conditions. Increasingly, researchers and care providers are recognizing individuals with co-occurring conditions as a population with higher costs and poorer outcomes within multiple domains of care. In a 2002 report to Congress, the Substance Abuse and Mental Health Services

Administration (SAMHSA) acknowledged that “dual diagnosis is an expectation, rather than an exception” in all settings (Kohn et al., 2004).

In recent years, it has been increasingly clear that the issues and experiences of persons with co-occurring mental health and substance-use disorder conditions are relevant to multiple other types of issues and conditions, and that the strategies that have been learned for mental health and substance-use disorders apply to all types of complex needs among persons seeking care. Thus, we need to consider the problems faced by individuals with combinations of health and behavioral health conditions, behavioral health and developmental disability/brain injury/cognitive disabilities, trauma with all types of conditions, as well as co-occurring “social conditions” such as homelessness, criminal-justice involvement, child welfare issues, unemployment/disability, and so on. In this chapter, we propose a general systems approach. While we mostly focus on co-occurring mental health/substance abuse, this approach can be, and is being applied, to systems, programs, families, and individuals addressing all types of overlapping and complex needs.

ESTIMATES OF THE PROBLEM

Numerous studies have demonstrated a strong link between mental illness and substance-use conditions. The question of the current prevalence of the problem is also well understood. According to National Health Survey Data in 2009, there were an estimated 45.1 million adults aged 18 or older in the United States with “any mental illness” in the past year. This represents 19.9% of all adults in this country. Among adults aged 18 or older in 2009, the percentage having serious mental illness (SMI) in the past year was 4.8% (11.0 million adults) (SAMHSA, 2010, p. 9).

Within the 45.1 million adults aged 18 or older with any mental illness in the past year, 19.7% (8.9 million adults) met criteria for substance dependence or abuse in that period, compared with 6.5% (11.9 million adults) among those who did not have mental illness in the past year. Of the 11.0 million adults aged 18 or older with SMI in the past year, 25.7% also had past-year substance dependence or abuse compared with 6.5% of adults who did not have mental illness (SAMSHA 2010, p. 33).

Compounding this already prominent public health issue is the fact that many with severe mental illness and substance-use conditions remain untreated. Estimations of this lack of treatment have been documented in as many as 37 studies examining service utilization. The most frequently referenced percentage associated with schizophrenia was 32.2%. Depression demonstrated a 53.6% treatment gap. Dysthymia demonstrated a 56.0% treatment gap; bipolar disorder demonstrated a 50.2% treatment gap; and generalized anxiety disorder demonstrated a 57.5% treatment gap, with the average gap between onset of symptoms and active treatment estimated to be as high as 30 years. Obsessive-compulsive disorder demonstrated a 57.3% treatment gap. Furthermore, alcohol abuse and dependence presented the most significant treatment gap, with an estimated 78.1% gap. While the estrangement between prevalence of conditions and the number of those receiving treatment varies greatly around the world, it can be assumed that the numbers may be even higher than suspected, as gathering data from community-based data programming, including data from developing countries, where services are few and far between, may even raise the level of this already enormous treatment gap (Kohn et al., 2004).

The landmark study “Comorbidity of mental conditions with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) Study” (Regier et al., 1990) highlighted

the prevalence of comorbid mental illness and substance-use conditions in the United States. This study indicated that 47% of persons with active schizophrenia have experienced an active substance-use disorder in their lifetime, with 34% reporting an alcohol use disorder and approximately 28% reporting use of other drugs; specifically cannabis and cocaine as frequently referenced as drugs of choice. Persons with active mood conditions demonstrated a 32% lifetime prevalence of comorbid substance-use disorder, with bipolar conditions occurring at nearly twice the rate of major depression: 57% versus 27%. Within this population, alcohol was reported to be the most frequently abused substance. Within the bipolar disorder population, abuse of drugs remained second to alcohol. Commonly abused drugs included cannabis, cocaine, and amphetamine. Within the population suffering with anxiety conditions, approximately 15% reported co-occurring substance-use disorder. Within this population, persons with generalized anxiety disorder reported the highest rates, at 21%, those with post-traumatic stress disorder (PTSD) reporting 18%, and those with social phobia reporting 17% prevalence of co-occurring substance-use conditions (Regier, et al., 1990; Strakowski and DelBello, 2000; Cassidy et al., 2001; Winokur et al., 1995). Additionally, Kessler and Wang (2008) reported that among the 17.1 million adults aged 18 or older with “past-year any mental illness” who reported receiving mental health services in the previous year, 55.2% received one type of care (inpatient, outpatient, or prescription medication), 39.9% received two types of care, while only 4.9% received all three types of care.

CHALLENGES WITHIN THE TREATMENT PROCESS

Questions related to addressing both mental illness and substance abuse are complex. Compared with substance-use conditions alone, persons with severe and persistent mental illness have impairments that obstruct thinking, leading to cognitive deficits, low motivation to change, and poor social skills. As those with comorbid illness are more difficult to engage in treatment, they are likely to make slower progress and have higher dropout rates; additionally, they are likely to experience greater social challenges such as prominent lack of support systems, economic challenges, and housing difficulties. This population challenges the clinician’s therapeutic skills in both the establishment of working relationships and the development and implementation of a clearly outlined plan of care that is not only effective but is agreed upon by both the clinician and the client (Mueser, 2005; Linszen et al., 1994; Pages et al., 1998).

To optimize effectiveness, the plan should address the individual’s personality, environment, physical and mental factors, and financial, legal, emotional, and spiritual strengths and challenges. When optimally effective, the treatment plan should engage the person, clinician, and others within the person’s day-to-day environment who can support implementation of the treatment plan. In doing so, the plan should be based on a mutually agreed-upon goal or outcome that works toward solutions that capitalize on the individual strengths of the person in a manner that preserves or restores his or her natural dignity (Dejong & Berg, 2002; Saleebey, 2002; Yeager, 2002).

Current evidence suggests reorganizing care around the individual with teams that are accountable to each other and to consumers, and that are supported by information systems that guide and drive improvement, have the potential to eliminate waste, reduce medical errors, and improve outcomes—at lower total cost. Such accountability was notably absent when the managed care movement was growing in the 1990s, giving rise to concerns that financial incentives were undermining rather than enhancing quality of care (Robinow, 2010).

Accomplishing this requires changing the incentives upon which the health care system is built. The fee-for-service payment that currently typifies the U.S. health system emphasizes the provision of health services by individual providers rather than coordinated teams of providers who collaborate to address individuals' needs. Within an accountable care organization, payer sources will be monitoring a number of outcome indicators to determine the overall effectiveness of care provided, which will in the long term determine levels of reimbursement for the organization (Guterman, Schoenbaum, Davis, et al., 2011). Thus, care providers will be challenged directly to demonstrate positive outcomes in a manner that will drive future reimbursement. Within this challenging environment, mental health professionals providing direct care are finding the combination of crisis intervention with brief solution-focused approaches is effective in producing positive outcomes while meeting the rigorous demands of accountable care organizations.

The emergence of managed care drove market shifts from inpatient to outpatient therapy approaches in the past 25 years. Currently, the movement is to minimize inpatient hospitalization, establishing patient care within a medical home that will provide a holistic approach within an outpatient setting. This shift in care environment has led many to consider application of innovative approaches to mental health care. The focus has been placed on the individual and how the system of care can interact with the individual in ways that lead to effective outcomes within a cost contained framework (O'Hanlon & Weiner-Davis, 2003; Pinkerton, 1996).

Historically, individuals with co-occurring conditions have not been well served in either mental health, substance abuse, or rehabilitation settings or systems. Efforts to refer persons with co-occurring conditions to specialized programming or "parallel" substance abuse and mental health programming have been consistently challenged to meet the need of the populations. As a result of difficulties associated with coordination of parallel mental health rehabilitation and substance-abuse services, providing for this complex population has proven to be difficult. Yet there has been increasing research in the development of successful treatment approaches for individuals with co-occurring conditions, and this research has progressed from examining specialized programs to beginning to explore the specific intervention strategies within individual programs.

APPROACHES TO CO-OCCURRING CONDITIONS

Building on these findings, Minkoff (2000) and Minkoff and Cline (2004, 2005) have elaborated the comprehensive, continuous, integrated system of care approach for system design and transformation. Simply put, within this approach, all programs and clinicians become co-occurring-disorder-capable. This requires a systemic change to assure the system is designed to support a structure where each component of programming has an organized set of instructions that provide matched interventions to the co-occurring population served. This matching of care is supported by evidence-based approaches to care placed within the context of an integrated care model of service that provides not only common language but also a common treatment philosophy that makes sense from the perspectives of both mental health and addiction. Within this model of care, each principle is tied to specific intervention strategies to be applied by any clinician with any population, in any setting. When tied together, these principles

provide a set of practice guidelines for assessment, treatment rehabilitation, and psychopharmacology. (Full information can be found at www.ziapartners.com.)

This approach emphasizing the development of co-occurring capability within the field of psychiatric rehabilitation is philosophically consistent, mainly requiring the integration of existing rehabilitation approaches to include relevant attention to substance-related choices, decisions, skills, and disorder management. This integrated model of service delivery builds on best practice findings within a clinical conceptual framework of empathic, hopeful, integrated, strength-based community-based learning relationships in which persons with complex problems are assisted to identify attainable, measurable, clinician- and client-agreed-upon goals to work their way through the stages of change while learning how to make better choices that support the advancement of their treatment incrementally and to support implementation of treatment based skills into day-to-day activities.

At a minimum, staff working with individuals with co-occurring mental health and substance-use conditions should be able to implement the following activities:

1. Welcome the client into an empathic, hopeful, strength-based, and integrated bi-directional approach for recovery.
2. Screen for the presence of comorbidity, and arrange appropriate follow-up evaluation and/or intervention for individuals who screen positively.
3. Identify acute risk issues and know how to help the person remain or become safe.
4. Obtain a comprehensive bidirectional assessment of the co-occurring conditions and understand the content of the assessment to facilitate the development of recommendations for care.
5. Support adherence to these recommendations with the client.
6. Identify stage of change for each problem presented by the client.
7. Encourage the client in individual, group motivational, and/or educational intervention to facilitate better choices regarding co-occurring conditions using person centered goals to guide the recovery process.
8. Provide specific skills training to assist the client in managing co-occurring conditions and related difficulties (e.g., asking for help and assuming greater levels of responsibility for the recovery process).
9. Provide assistance with accessing resources to support treatment of co-occurring disorders.
10. Assist the client in their interface with community resources to support her/his co-occurring needs.
11. Collaborate with involved care providers to insure that the client receives an integrated message.
12. Modify skills training to accommodate the clients' cognitive, emotional, and social impairments.
13. Identify methods to reward incremental progress in decisions and skill acquisition.
14. Provide specific rehabilitation services (e.g., vocational rehabilitation, individualized placement, and support to individuals with co-occurring conditions) as a means of developing hope and capacity to achieve a stable functional outcome.
15. Educate the client regarding how to participate in recovery programming, including the appropriateness of taking prescribed medication while participating in 12-Step or other addiction recovery self-help meetings.

CONCEPTUAL FRAMEWORK OF BEHAVIORAL HEALTH INTEGRATION

Historically, and perhaps currently within some states and programs, the idea was that mental health systems funded mental health programs with mental health funds to provide mental health services to individuals with mental health needs. At the same time, the substance-abuse system funded substance-abuse programs with substance-abuse funds to provide substance-use disorder services to individuals with substance abuse or dependence issues. Within these systems, individuals with co-occurring conditions were experienced as “misfits,” and services for both problems could occur primarily only through parallel or sequential treatment involving multiple systems, programs, and funding streams, and the individual (or family) was responsible for figuring out how to integrate the multiple services needed on his or her own. In this context, research supporting the development of “integrated treatment or recovery services” was built on the creation of specialized program models for this population, and the evaluation of those program models was conducted through a steady accumulation of research efforts. The result is a variety of evidence-based (to varying degrees) specialized “integrated programs” for this population. Some of the better known examples of “integrated programs” are Integrated Dual Disorder Treatment (IDDT) teams as described in the SAMHSA IDDT Toolkit (Drake et al., 2001), the Modified Therapeutic Community, described by Sacks and others (Sacks et al., 1999), and Treatment Improvement Protocol (TIP-42) TIP a recognized set of evidence-based guidelines for substance-use clinicians to assist in working with co-occurring client populations (CSAT, 2005).

Because these specially developed programs existed in a context that was not an integrated system, there has been a growing and evolving assumption that the only “integrated program” could be a specialized program providing specialized interventions for persons with co-occurring conditions that were somehow to be maintained outside of mainstream treatment services. Yet, more and more programs are recognizing the need for some form of integrated services within the framework of integrated programming. These include interventions for individuals and families with co-occurring conditions, because of the prevalence of poor outcomes associated with this population.

To make heads or tails of the concept of *integrated care* it is important to begin by examining the term itself. When broadly defined, *integration* within the term *integrated care* always includes two components. First is an organizational function, and second is a client/family interface component.

Within the organizational function level, Cline (2005) indicated that “integration” refers to those activities at the level of any behavioral health organization to develop a structure within the organization that supports an interwoven approach to both mental health and substance-use conditions that is articulated in a coherent manner that supports the organization’s mission and supports the population of individuals and families with co-occurring conditions.

At the client family interface, integration refers to any mechanism by which appropriately matched interventions for both mental health and substance-use issues or conditions are combined in the context of a clinical relationship with an individual clinician or clinical team so that the client or family experiences the intervention as a person-centered or family-centered integrated experience rather than as a disjointed or disconnected process.

PRINCIPLES OF SUCCESSFUL TREATMENT

PRINCIPLE #1: CO-OCCURRING CONDITIONS AND ISSUES ARE AN EXPECTATION, NOT AN EXCEPTION

This expectation must be incorporated in a welcoming manner and is a key clinical component that begins the moment the client makes initial contact. These welcoming functions promote access to care and are the first step in providing accurate screening and identification of individuals and families with co-occurring conditions and issues. Structured interviews seek to explore the individual's experience from a "desire to know and understand" basis, and by doing so, this inquisitive nature demonstrated by the caregiver establishes a rapport with the client and serves as the foundation for information gathering that examines all aspects of the client's presenting problem.

PRINCIPLE #2: THE FOUNDATION OF A RECOVERY PARTNERSHIP IS AN EMPATHIC, HOPEFUL, INTEGRATED STRENGTH-BASED RELATIONSHIP

Within the working partnership between the client and caregivers, integrated longitudinal strengths-based assessment, intervention, support, and continuity of care promote a step-by-step community-based learning approach for each issue or condition. Within this approach, clients and caregivers explore the dimensions of the illness in an effort to understand what works and what doesn't work. It is a simplistic yet complex effort that involves an honest exploration that results in building upon what works and learning to discard what doesn't work. All too often, persons with co-occurring conditions who relapse have been asked to leave treatment because their use of mood-altering substances has "violated" program rules. In this new strengths based approach, however, empathy is the mantra. When individuals with mental illness and substance conditions are not following recommendations, they are doing their job. Yes that's right... *they are doing their job!* It is the job of the professional to understand their job, to join them in it, and to help them make it better. This is a very different approach. It is approach of seeking to understand, not to blame. The job of the professional is to assist the client in coming to terms with the painful reality of having both mental illness and a substance disorder. The client really would rather not have either, yet they are required to build an identity that involves making an active effort toward recovery for both illnesses. This is a difficult task that requires empathy and understanding from the professional.

A funny thing happens when the professional begins seeking to understand the work of the client. It is called hope, and this is really a five-step process that begins with: (1) establishing a goal of a happy life. That's a goal that nearly everyone can agree with. When the caregivers (2) genuinely empathize with the client's "current reality," the life they are living, and acknowledge the despair the clients are experiencing, it functions to (3) establish a legitimacy of the need to ask for help, at times extensive help. This is not an easy task. When clients understand the appropriateness of asking for help, a balanced working relationship is established that naturally leads to (4) identifying and establishing realistic, attainable, and measurable goals that function as steps of success and progress. Finally, as clients experience success, celebrations of success provide the opportunity to (5) foster a hopeful vision of pride and dignity to counter self-stigmatization.

**PRINCIPLE #3: ALL PEOPLE WITH CO-OCCURRING CONDITIONS
AND ISSUES ARE NOT THE SAME, SO DIFFERENT PARTS OF
THE SYSTEM HAVE A RESPONSIBILITY TO
PROVIDE CO-OCCURRING CAPABLE SERVICES
FOR DIFFERENT POPULATIONS**

The four-quadrant model is primarily used for systems mapping, but it has been applied to co-occurring behavioral health/developmental disabilities. In this system-mapping process, each “subsystem” is responsible for integrated care for its own cohort of clients, and other “subsystems” function as helpful partners to support integrated capability development. Thus, the mental health system is responsible for integrated care for severe mental illness and severely emotionally disturbed children. With support for other co-occurring conditions that are less severe from other “subsystem” care providers who assume responsibility for addiction services. In turn, the highly acute substance-use disorder care provider assumes primary responsibility for treatment of substance-related issues, while mental health partners address lower severity mental health issues. Hence each system helps the other build internal capacity through consultation, education, in-reach, and support so more people get what they need through a “single door” of access to services.

**PRINCIPLE #4: WHEN CO-OCCURRING CONDITIONS AND
ISSUES CO-EXIST, EACH CONDITION OR
ISSUE IS CONSIDERED PRIMARY**

The best-practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time. This requires a different approach to mental health and substance-use conditions within a model that seeks to match equally the need of the individual with interventions that function as a balanced approach to stabilization of mood and substance withdrawal. The reality is that health, substance-use disorder, and mental health symptoms overlap and manifest across the individual. There is no such thing as good physical health without good mental health; additionally there is no such thing as “recovery” from addiction when mental health issues remain unaddressed. And finally, there is no mental health recovery when the individual is attempting to self-medicate symptoms of mental illness with mood-altering substances. For true recovery to begin, all systems must be addressed concurrently; this leads us to Principle #5.

**PRINCIPLE #5: PARALLEL PRIMARY RECOVERY PROCESSES,
INVOLVES MOVING THROUGH STAGES OF CHANGE AND PHASES
OF RECOVERY FOR EACH CO-OCCURRING CONDITION OR ISSUE**

Recovery applies not just to mental health, physical health, and addiction. Recovery applies to all types of chronic incurable conditions, such as trauma, physical disability, incarceration, homelessness, etc. In this sense, “recovery” is not recovery from the condition, but recovery of the human being who has the condition, so a person with one or more chronic incurable conditions

recovers a sense of pride, self worth, hope, dignity, and meaning, even though the conditions may persist, the risk of relapse may persist, the need for services may persist, and the stigma, symptoms, and disability may persist. This requires approaching healing within stepwise phases of recovery in which change is considered in reference to issue-specific not person-specific frames of reference; thus, as new issues present, individuals are challenged to work through the stages of change with each new issue. When we are asked, “What stage of change is a person in?” the correct answer is, “For which issue?”

Phase 1: Acute Stabilization

This phase involves actions required to stabilize symptoms associated with active substance abuse or acute psychiatric symptoms or other immediate risks.

Phase 2: Engagement/Motivation Enhancement

This phase involves assisting the individual in moving through the stages of change (Bellack & DiClemente, 1999).

- Pre-contemplation: You may think this is an issue, but I don’t and even if I do I don’t want to deal with it so don’t bug me.
- Contemplation: I’m willing to think with you, and consider if I want to change, but have on interest in changing, at least for now.
- Preparation: I’m ready to start changing but haven’t yet started, and I need some help to know how to begin.
- Early Action: I’ve begun to make some changes, and need some help to continue, but I’m not committed to maintenance or to following all of your recommendations.
- Late Action: I’m working toward maintenance, but I haven’t gotten there, and need some help to get there.
- Maintenance: I’m stable and trying to stay that way, as life continues to throw challenges in my path.

It is important to note that stage of change is issue specific, not person specific.

Phase 3: prolonged stabilization

Prolonged stabilization entails working to achieve maintenance and to support ongoing recovery through active and aggressive actions to prevent relapse; this speaks to the level of sustainable recovery efforts developed during the treatment process.

Phase 4: rehabilitation

Rehabilitation requires active engagement in recovery activities on a daily basis leading to personal growth and learning over time; this is not a project or process that is ever completed. Rather, it is a repetitive process of growth, self-definition, and change.

One final note prior to leaving Principle #5: it is essential that, for each condition or issue, interventions and outcomes be matched to the stage of change and the phase of recovery for optimal outcome. Recovery is a process that is never really complete. As individuals continue their lives, they continue to experience life challenges and will be challenged to work through each phase and stage of change.

PRINCIPLE #6: PROGRESS OCCURS THROUGH ADEQUATELY SUPPORTED, ADEQUATELY REWARDED SKILL-BASED LEARNING FOR EACH CO-OCCURRING CONDITION AND ISSUE

Skill-based learning involves obtaining an accurate history for the individual seeking treatment. Based on the assessment, treatment providers work with persons with co-occurring conditions to develop an accurate set of recommendations that are patient-centered, and thus more likely to engage the patient in developing new skills to support the recovery process. For any issue individuals have, there is a need to help them develop the skill sets needed to succeed. The more challenged the individual, the more and smaller are the steps that will be required; each step should be accompanied by bigger rounds of applause. Such skills as self-management, self-responsibility and asking for help are key and necessary skills that can be acquired and practiced. There are increasing numbers of skill manuals available for co-occurring teaching, such as: *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits 2001), *Overcoming Addictions: Skills Training for People with Schizophrenia* (Roberts et al., 1999), *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals* (Bellack, Bennet, & Gearon, 2007) and *Social Skills Training for Schizophrenia: A Step-by-Step Guide*, 2nd edition (Bellack et al., 2004).

PRINCIPLE #7: RECOVERY PLANS, INTERVENTIONS AND OUTCOMES MUST BE INDIVIDUALIZED; THERE IS NO SINGLE "CORRECT" CO-OCCURRING PROGRAM OR INTERVENTION FOR EVERYONE

For each person, integrated treatment interventions and treatment outcomes must be tailored to the person's goals, specific diagnosis, conditions, and issues, phase of recovery, stages of changes, strengths, skills, and available support for each condition. The recovery plan is a blueprint for progress designed to meet the individual needs of the person with co-occurring conditions as he or she progresses. The recovery plan begins with the assessment process. Quantifiable processes and goals are established and agreed on with input from the individual, his or her family, and all members of the treatment team. The recovery plan is then implemented, assessed, revised, and implemented again, until the agreed-upon goals are completed. The goals in the recovery plan are broad statements that are reflective of the overall desired outcome; the objectives of the recovery plan are statements of targeted observable and measurable changes to support recovery efforts (see Fig. 33.1).

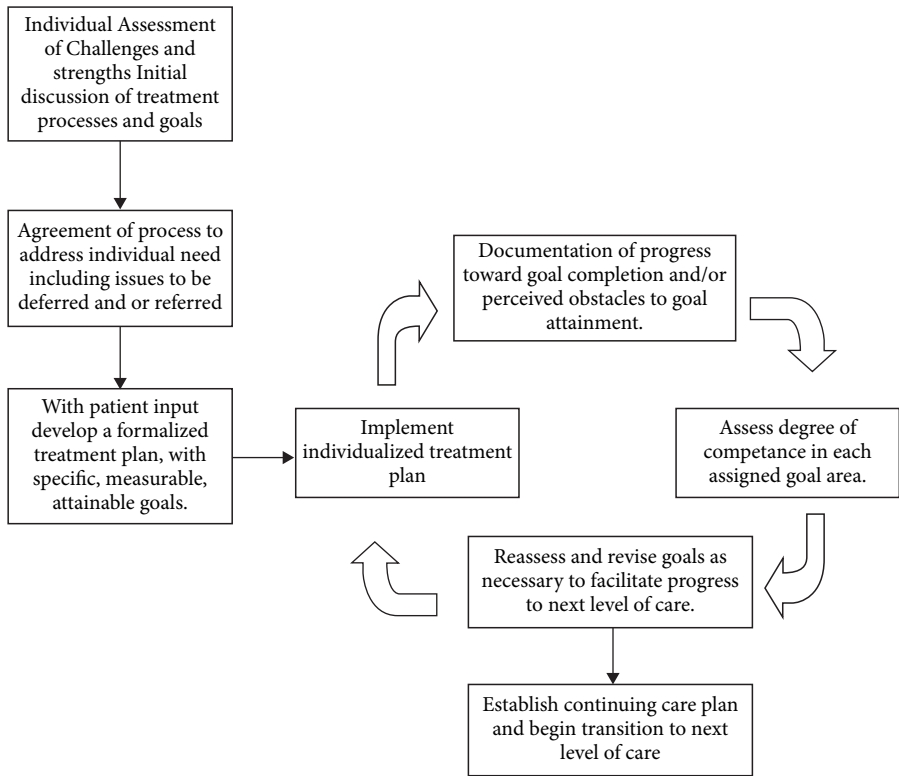


Figure 33.1

Recovery plans are like a good roadmap. They should be clear, list who will do what and when, and what the expected outcome will be. Recovery plans should also include staff efforts demonstrating a team approach to the recovery process. Interventions can range from medication treatments, to homework assignments, to linkages in the community, to housing plans, and any number of methods used to stabilize whatever co-occurring condition is being addressed. All interventions should be reflective of the interdisciplinary team approach: listing the type and frequency of interventions, the name of the person responsible for completion of the task, and a target date for completion. The recovery plan becomes a contract between persons with co-occurring disorders and caregivers, outlining specific processes and responsibilities for care. The plan should follow a logical progression from assessment, to intervention, to staff reassessment, and progress naturally to discharge planning. Effective recovery plans should meet the following qualifications:

- Is the plan reasonable?
- Is the plan person-centered?
- Will the plan facilitate the desired behavioral change?
- Is the plan attainable? The last thing an individual in early recovery needs is to be set up to fail by a plan that reaches beyond his or her ability.
- Are the goals clearly stated and free from ambiguity so the individual, family members, and other staff can understand them?

- Is the plan measurable? Does the plan clearly outline the who, what, when, and where of the care process?
- Is the plan sustainable? That is, does the plan support the person's need for the level and length of care being provided?

HOW TO IMPLEMENT A COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

So how does one go about establishing a comprehensive, continuous, integrated system of care (CCISC)? To begin this process, it is important to revisit one component of the system: that it is a system of care that is welcoming to the individual in need of treatment for psychiatric and substance-use conditions. This component is a welcoming component.

"Welcoming" at a system level implies that every level of the system—program, clinical practice, clinician competence and training, as well as outcome evaluation—is based on accepting the individuals with co-occurring conditions. Instead of assessing why the individual has returned to the center, or what failed in their treatment, or blaming the victim of the illness, people are welcomed back with the attitude of, "Great, you were able to implement your plan of care for six and a half months!" Not a viewpoint that echoes failure by asking, "Did you go to meetings? Call your sponsor? What did you fail to do that led to your relapse?" (Minkoff & Cline, 2004). Welcoming is extremely important for those immediately served and for those not immediately able to access services, as this serves to communicate a sincere desire to engage the individual in care as soon as possible. It is the beginning of an empathic and hopeful connection that is the first step in assisting this person in getting the help they need.

Welcoming is more than just an attitude. The welcoming aspect is written into policy; anchored in clinical language and programming standards. It is defined as both a clinical practice expectation and a policy requirement. Welcoming is embedded in systemic continuous quality improvement as well as outcome evaluation processes for evaluating the program. Additionally, welcoming is completely intertwined with the implementation of cultural competency and welcoming is defined as a practice that is independent of resource availability or programming eligibility. At times "welcoming" is defined as "no wrong door for entering treatment," or "no wrong reason for seeking care." The process has been described as a step-wise progression of implementation, which is outlined below:

1. Identify and empower a decision-making structure that is appropriately positioned within the service infrastructure: Frequently, systems of care are fragmented because of funding sources. Service providers work to stake out their territory and to define the scope of services offered by a particular group or agency. At times this will happen within a particular city or at the county level. At times this will be identified at a state or district level. Whatever the case, the decision making structure has to be defined as the system of care that will be the scope of the project. Once the scope of the project is defined, all program managers around the table are tasked with the power to change their own system, and only their system. It is necessary to have all on the same page moving in the same direction toward a comprehensive, continuous, integrated system of care, but it is not necessary for the system to have a uniform or merged structure. In

most systems of care, an overarching structure that brings each subsystem to the table in a common effort is necessary. However, the actual implementation of change will occur in the policies and procedures of each subsystem separately.

2. Develop a document that defines *consensus* on the CCISC model and set of implementation activities with identified priorities and incentives for clinical practice implementation within existing funding streams and existing funding constraints: These “charter documents” provide the basic structure and describe the co-occurring disorder problem (high volume, poor outcome, high costs, and poorly served populations) and describe the implementation of CCISC. The next task for development of the charter documents is to outline a set of implementation activities for each participating subsystem agency or program, usually over a year-long period. Within this process, most charters identify key elements that all stakeholders can agree upon as important to address within the first year. Most charters are developed in a manner that provides the opportunity for participants to vote on key components for of the system for the first year. The charter document may or may not be signed, but it is generally identified as requiring a sustained voluntary effort on the part of all involved. The carrot for participation is generally some incentive provided by the system, which can be in the form of financial support that is frequently an opportunity to inform or shape policy through education or research to support policy development and to later develop new programming through system supported training and/or technical assistance.
3. Identify the CCISC process as a systemic continuous quality improvement initiative, and welcoming as one of the objectives or indicators for the outcome of this process. By integrating quality indicators into the charter as outcome tools, the system becomes responsible to share data in a manner that sets the stage for cooperative exchanges of best practices toward key indicators of care. For example, if the indicator is access to care, cooperating agencies can explore and share processes for removing barriers to services. One of the components of the program is for participating agencies to develop performance indicators in relation to priority activities. By doing so, all priority activities of the charter are incorporated into routine quality improvement (QI) audit measures. This facilitates observation and accountability for the system in moving toward accomplishment of all of the key goals of the charter.
4. Identify those with co-occurring disorders as a system priority population and write a formal welcoming policy that defines the expectation that all components of the system will themselves develop formal processes to welcome individuals with co-occurring conditions into treatment. While this seems simplistic and relatively easily accomplished, it is more of a process than an event. The time frame for adoption and actual implantation of the formal welcoming policy usually occurs well into the first year of system operations. This is the result of the need to establish the clinical infrastructure necessary to make the welcoming policy implantation a reality. While this may seem like a top-down policy implementation, it really is not. This is more of an integrated process requiring efforts from both the top and the bottom to make this policy a reality. It can be tracked through the aforementioned quality improvement structure with measures such as a live person answering the phone twenty-four hours. In this day of automated telephone systems, it is both a surprise and treat to find a person rather than a machine answering the call, and nothing is more important than a live voice being there when someone reaches out for help. This is the foundation of a truly welcoming system of care.

5. Establish welcoming as a priority program standard for implementation of co-occurring capability, by charter definition, and incorporate implementation of welcoming into a continuous quality improvement (CQI) action plan that each participating program is required to develop. Expectations are a part of all charters; this one is no different. Within the charter there is to be an expectation that all programs will begin to move at their own pace toward establishment of co-occurring capability. Within this CQI action plan is a clearly outlined set of measurements to determine a welcoming process, including the presence of a welcoming policy. A written and clearly articulated mission statement or vision statement, welcoming orientation materials, a physical plant assessment for welcoming accommodations, welcoming orientation for staff of each program, and processes such as “the telephone will always be answered by a human not a machine” approach. Each program is provided the flexibility to develop its own plan for quality management, but each quality management plan is expected to be reflective of the priorities documented in the charter. Other CQI focuses should examine the application of evidence-based practices and best practices. In all, the CQI mission is to monitor system change activities and to assure that system policy development is aligned with the existing program level action planning to build welcoming and other priorities contained within the charter document.
6. Each program defines and implements welcoming clinical practices and procedures for clients with co-occurring conditions that are particularly challenging. The translation from policy to reality is frequently difficult. This is a process that usually requires technical assistance to implement a change in clinical behavior. For example, the implementation of a welcoming process can be as simple as customer service training for staff around how to engage and interact with dual-diagnosis populations. Yet at times this is more difficult, such as when addressing the difficult client who arrives at the facility intoxicated and is demanding services. This requires a welcoming skill that incorporates risk assessment as well as limit setting in a way that the client is not made to feel unwelcome. It is the integration of such activities that requires practice and role playing with staff to translate a policy into clinical practice.
7. There is a systematic training plan that creates an expectation that all programs expect their clinicians to develop competency in “welcoming” and provides continuous onsite training and supervisory support to implement this competency over time for all staff. While training and competency development are core elements to development of CCISC it is important to implement any form of effective system change, this type of training cannot occur “in a vacuum,” as this type of competency development requires onsite training where the competency is tied not only to acquiring new skills but also to attitudinal changes. This will not occur in a single training session or a series of “staff retreats.” Rather, this process is one that is verbalized by administration and leadership, modeled and reinforced at all levels of the organization. It is a good idea to develop a trainer cadre in which participants who function as trainers are also functioning in the role of system change agents and are opinion leaders whose job it is to define and assist the system in the translation of policy into day-to-day front-line application skills, providing feedback to the system both when policies are not upheld, but more importantly when the system is not supporting the clinician in fulfilling the expectations of the organization policy.

8. Development and implementation of recovery-oriented co-occurring capable practice guidelines: CCISC implementation requires system-wide transformation of clinical practice in accordance with the above principles. This can be realized through dissemination and incremental developmental implementation of Quality Improvement or Improvement Sciences processes focusing on building a clinical consensus around best practices. The clinical consensus should begin with assessment and progress through treatment intervention, rehabilitation, program matching psychopharmacology and program outcomes. Obtaining input from and building consensus with clinicians prior to final dissemination of practice guidelines is highly recommended. (There are existing documents available to facilitate this process at www.bhrm.org.) Quality improvement processes can be used to monitor clinical processes and to facilitate welcoming, access and identification of those with co-occurring disorders. This monitoring process is critical to establishing and promoting empathic, hopeful, integrated, continuous relationships needed to fuel a highly successful and accountable co-occurring disorder program.
9. Facilitation of welcoming, providing access to services that includes integrated screening to facilitate the identification of multiple co-occurring conditions: This step requires an improvement science partnership that: (1) addresses welcoming and “no wrong door” access in all programs; (2) eliminates arbitrary barriers to initial access and evaluation; and (3) improves clinical and administrative practices of screening, clinical documentation, event reporting, and appropriate next step intervention for individuals and families with co-occurring conditions.
10. Implementation and documentation of integrated services: Integrated treatment relationships are a vital component of CCISC. Implementation requires creating an improvement science process in which clinicians and managers work in partnership on the process of developing and documenting and integrated treatment or recovery plan in which the client or family is assisted to make progress toward hopeful goals by following issue specific and stage specific recommendations for each issue simultaneously. This expectation must be supported by clear definition of the expected “scope of practice” for singly licensed clinicians regarding co-occurring disorders, and incorporated into standards of practices for reimbursable clinical interventions—in both mental health and substance settings—for individuals who have co-occurring conditions.
11. Development of recovery-oriented co-occurring competencies for all clinicians: Creating the expectation that all clinicians can make progress toward developing universal competency, including attitudes and values, as well as knowledge and skills, is a significant characteristic of the CCISC process. Available competency lists for co-occurring conditions, such as the 12 Steps for Clinicians, can be used as a reference for beginning a process of consensus-building regarding the competencies. Mechanisms can be developed to establish competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure and support clinician attainment of competency. (For more on competency self-assessment tools, see CODECAT-EZ, ZiaPartners, 2009, at <http://www.ziapartners.com/tools-2/tools-codecat-ez/>.)
12. Implementation of a change agent team: In the CCISC Improvement Science process, both capability development and clinician competence development occur through a

top-down, bottom-up partnership, in which front-line clinician and consumer/family change agents in each program work in partnership with leadership to effect the change. Furthermore, the change agents in a system ideally become an empowered team to represent the principles and values of front-line service delivery and service recipients in the system planning and implementation process.

13. Development of a plan for a comprehensive program array. The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or arena of competency with regard to provision of recovery-oriented co-occurring capable services for people with co-occurring conditions, within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address and identify strategies for filling those gaps.

Four important areas must be addressed in each CCISC process:

- a. *Evidence-based practice*: there needs to be a specific plan for identification of any evidence-based best practice for any mental illness (e.g., Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g., buprenorphine maintenance), or an evidence-based best practice program model for a particular co-occurring disorder population (e.g., Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that facilitates access to co-occurring clients that might be appropriately matched to that intervention.
- b. *Peer dual-recovery supports*: The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports such as recovery coaching, peer outreach, and peer counseling.
- c. *Residential supports and services*: The system should begin to plan for a comprehensive range of programs that address a variety of residential needs, building initially upon the availability of existing resources through redesigning those services with the recognition that co-occurring conditions are an expectation. The range of programs should include
 - i. Addiction residential treatment (e.g., modified therapeutic community programs)
 - ii. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities
 - iii. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
 - iv. Consumer-choice (wet) supported housing for individuals with psychiatric disabilities at risk for homelessness.
- d. *Continuum of levels of care*: All categories of service should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, hospital diversion programming, and hospitalization. This can often be

operationalized in managed care payment arrangements and may involve more sophisticated level of care assessment capacity.

CCISC implementation is an ongoing quality improvement process that encourages the development of a plan that includes attention to each of these areas in a comprehensive service array.

CONCLUSION

This chapter has reviewed processes for implementation of system-wide integrated programming for persons with co-occurring conditions. It has discussed and illustrated many methods and approaches that can be applied to address the challenges faced by care providers addressing co-occurring conditions. Some of the concepts contained in this chapter will not stand up to the scrutiny and science applied to evidence-based practice (e.g., welcoming), yet one can hardly argue that a system approach that welcomes rather than placing blame is a much more effective approach. This type of intervention is best described as a service delivery standard. Let's not forget that standards for care and service are ranked along with best practices when building effective treatment approaches. All of the best practices in the world will be less effective if delivered in a system that is not welcoming to the population it is designed to serve. Additionally, CCISC is an approach that can be applied within the general programming of any system. It has been recognized as an effective approach that has been found to demonstrate early success within a variety of systems. While it is clear that more evaluation is needed to meet the gold standard of "evidence-based" practice, it certainly can and should be considered an evidence-informed approach to the treatment and management of co-occurring conditions. I don't recall exactly when I first heard or read Dr. Paul Batalden's observation, "Every system is perfectly designed to get the results it gets," but it was an eye-opening experience. When thinking about the need to transform systems to address the ever-growing need to treat co-occurring conditions, we would strongly suggest that you ask yourselves: "Are we happy with the results our program is getting? Is the design of our program leading to the results we are getting?" and finally, "What can we do to improve the results we are getting?" If you think CCISC would help, we are here to help.

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TRANSFORMATIONAL LEADERSHIP IN MENTAL HEALTH

DALE SVENDSEN, MICHAEL HOGAN,
AND JUDY WORTHAM-WOOD

LEADERSHIP OF MENTAL HEALTH ORGANIZATIONS

Any organization requires leadership. Certainly mental health organizations are no different. Despite this, very little has been published about the special needs and challenges associated with leading mental health programs, agencies, or systems. But this is in a way counterintuitive. How can it be that there is not more instructive material available to guide those of us who are interested in this work?

Perhaps one answer is that, in the past, leaders of mental health organizations rose “through the ranks” directly from clinical positions and did not have management training to bring to this new level of work. Another possibility is that the universe of mental health organizations is relatively small, and not connected to the mainstream of organizational leadership in the business world. Leaders of mental health organizations did have significant training, but it was within a clinical discipline. And while some clinical training (e.g., in group work) is very relevant to filling leadership roles, there is more to it. We would add that mental health leadership duties nearly always used to be performed by psychiatrists who, since the middle of the nineteenth century, learned their trade as superintendents of state hospitals. But since the early 1970s, psychiatrists have moved away from such roles. In the 1960s and 1970s, most directors of State Mental Health Agencies (SMHAs) were physicians. By 2011, only three SMHA directors were physicians. State leadership roles tend now to be occupied by individuals with diverse backgrounds, with training in not only the clinical disciplines, but also management and law.

Actually, there is a vast literature on management and leadership. But most of it is focused on the business world. Much of this work may be relevant, but the mission and methods of leading mental health organizations are not exactly the same as those involved in operating a business. There has also been much written about leadership in health care, and training programs in

hospital, health care, and public health abound. But as we said, mental health organizations are not the same. We will apply case histories in this chapter to illustrate some special aspects of leadership in mental health.

There is a view in some circles that a good manager can lead any kind of organization. But we believe that, at least for mental health organizations, this is not true—or at least not exactly true. For example, Gabarro (1987) studied the transition of general managers taking on new jobs, examining patterns of “taking charge” and success factors. One of his findings was that managers coming from a different field and taking over organizations needing a “turn-around” did not do as well as those who had specific experience in the industry.

A more recent study by Anthony and Huckshorn (2008) reported on leadership factors of mental health organizations and systems. Their methodology was first to review the leadership literature generally, but then to interview a large number of individuals identified as leaders in the field, in search of common patterns. Their study yielded eight principles of mental health leadership, summarized in Table 34.1 below.

Table 34.1 Principles of Mental Health Leadership

1. Leaders communicate a shared vision
2. Centralize by mission and decentralize by operations
3. Create an organizational culture that identifies and tries to live by key values
4. Create an organizational structure and culture that empowers their employees and themselves
5. Ensure that staff are trained in human technology that can translate vision into reality
6. Relate constructively to employees
7. Access and use information to make change a constant ingredient of their organization
8. Build their organization around exemplary performers

Anthony and Huckshorn, 2008.

In another discussion of mental health leadership, Brown, Isett, and Hogan (2010) discussed “stewardship”—a proxy for leadership—in mental health policy. They concluded that stewardship requires trust, wisdom, and a place to exercise leverage, or an “institutional home.” This view reflects their observation that government responsibility for mental health care has become diffuse, with many agencies at many levels of government having some level responsibility. They also noted that the ingredients of good stewardship/leadership include authority, analysis, and advocacy.

Both of these papers on leadership in mental health identify aspects of leadership that seem intuitive. They focus on common-sense principles, on mission and vision, and emphasize the proactive nature of leadership work. Schwartz (1989) points out that learning to be an administrator bears a resemblance to learning to be a parent. It takes supervised experience, just like being a parent requires having had decent parenting. In other words, good mentoring is necessary for creating skilled mental health administrators.

One critical element often missing in the literature is the notion of teamwork. In our view and experience, *work carried out by teams* is perhaps the most significant aspect of leadership in mental health. Vandiver and Corcoran (2012) discuss leadership and working in teams within the framework of “quality management and program evaluation” in the organization. This can be found in Chapter 36 in this volume. Burti et al. (2012) in Chapter 6 in this volume focuses on “the community team acting as a whole with all the workers involved in the case in the various phases of the treatment plan.” It is our belief that teamwork is needed at all levels in mental

health care and administration; the clinical, the consumer and family perspective and the management and administrative leadership levels.

OUR LEADERSHIP EXPERIENCE

In our case discussions, we offer the leadership experience we had working together in administration in the state of Ohio. *Transformational leadership* was first defined in the business literature by James Macgregor Burns in his book *Leadership*, in 1978. Burns said, “The function of leadership is to engage followers, not merely to activate them, to commingle needs and aspirations and goals in a common enterprise . . .” We believe our experiences will serve as an example of transformational leadership as it applies to mental health.

Our shared experience as part of a state mental health leadership team took place over a decade and a half (1991–2007). Our roles were as director (Mike), medical director (Dale) and deputy director for policy and programs (Judy) in the Ohio Department of Mental Health (ODMH). Mike and Dale worked together for this entire period, and Judy served with us for most of the last 10 years. Our belief from this experience is that successful leadership of mental health organizations is not well-suited to a “Lone Ranger” model—a single leader. Rather, we believe leadership of mental health organizations is a “team sport.” This has many implications: finding a shared direction when team members have different styles and roles; blending diverse perspectives and points of view, and balancing different responsibilities. Mental health agencies and organizations of any size are complex and challenging. Leadership teams, like treatment teams in the clinical setting, have differing perspectives that must be considered. Clinical knowledge and leadership that reflects the core healing role of the organization, general management, and the consumer and family perspectives must all be considered and involved in the leadership process as distinct important points of view.

Figure 34.1 is an oversimplification, but it illustrates the merger of various stakeholders with important principles, timing, and hoped-for outcomes. Usually more roles and perspectives than these three core roles are involved. On the “clinical side” of a mental health organization—like on a multidisciplinary team—the different mental health disciplines often have a role. Quality assurance and improvement and program development have clinical aspects. And management and administration in mental health also has many components: budget and fiscal management,

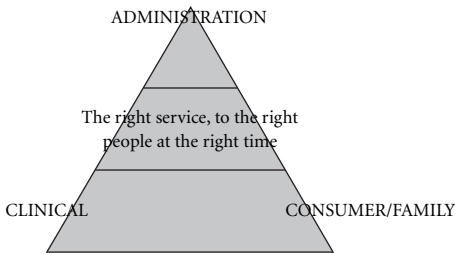


FIGURE 34.1 Leadership in Mental Health

human resources, facilities engineering, and information technology, for example. We do not believe that there is a single or “right” way to organize a mental health agency. But we do believe that mental health organizations inherently involve team leadership, and that the three perspectives of clinical, overall management, and the consumer perspective should all be reflected in mental health leadership teams.

LEADERSHIP CHALLENGES

We were fortunate to be at the helm of ODMH for a considerable period—especially since the average tenure of SMHA directors (like that of other state agency leaders and big-city school superintendents) is two and a half to three years. This long perspective meant that we were at the helm long enough to deal with very different challenges that confronted our organization. We will describe experiences with leadership under different circumstances. First, there was the challenge of leading during a tumultuous period of externally directed change—like the period of health care reform that we are now in. This might be described as *leadership during stormy times*. Whether the external challenge is changes in funding, major policy shifts, or other mandates imposed on the mental health organization, people in the organization look to their leaders in stormy times. They want reassurance and support, but mostly, they want to know that there is a direction for change that can address the challenges and lead to organizational success—and possibly to greater stability after the changes have been confronted. We will describe challenges for team leadership that we confronted during stormy times of change.

A very different set of leadership challenges arises when, so to speak, *the seas are calm*. These are times of relative stability in the external environment: funding levels, policies, and mandates are somewhat stable. Perhaps some may feel that it is unlikely we will ever face calm seas in mental health care—but all things are relative. After emerging from a period of tumultuous change into relative stability, very different challenges for leadership will start to emerge. What is our direction and vision when it is not being set for us? What will challenge us when things are going relatively smoothly?

LEADERSHIP DURING STORMY TIMES

The early phase of our experience at ODMH was during the tenure of George Voinovich as Governor of Ohio (1991–1999). The “storm” during this period resulted from legislation (Ohio’s Mental Health Act of 1988; Am. Sub. H.B. 256) that virtually turned the mental health system upside down. From a state-dominated system in which hospital care was the dominant model, the Mental Health Act envisioned a community managed system, with local mental health authorities (county based boards) responsible financially and clinically for care. The engine of change embedded in the law was giving the boards phased-in responsibility for the state hospital funds used to care for their residents and thus creating incentives to use inpatient care frugally. Implementing the law required us to deal with mandated change in an uncertain environment (e.g. budget constraints negated all of the fiscal models that had been used to plan for the law). In this tumultuous period, flexible leadership and coping with both downsizing and growth were needed for success.

Aside from the challenges of mandated change from hospital to community care and state control to local auspices, this period was stressful because of funding challenges. The legislation's feasibility was based on a projection of healthy funding increases—that would be sufficient to build new community services (especially for people with significant disabilities transitioning from hospital to community), allow for adequate care in hospitals while they were downsized, and finally to expand needed care in communities that had not used much hospital care. The goal of funding equity had been critical to securing support for the legislation from these counties—many rural or suburban and far from hospitals—because they had little to gain from resources tied to reducing hospital use.

Of course, debating issues like this was one thing, and having enough money to fund the good intentions was something else—especially since the recession of 1991–1992 reduced state revenue growth to drips, rather than the flood needed to meet mental health expectations. The pressure rapidly increased to downsize/close hospitals at a precipitous rate, to meet community expectations. The team leadership challenge we faced was how to weather this storm. The legislation could not succeed without a movement to community care. Support for reform required expanded resources to all communities, not just those reducing hospital care. And the quality of hospital care threatened to crash if downsizing was precipitous. The question confronting us was what strategies would get us through these challenges.

CASE STUDY: LEADING THROUGH ADVERSITY

The Mental Health Act of 1988 created mounting pressure to quickly downsize and close hospitals and move care and fiscal resources from state hospitals to community boards and agencies. Despite the fairly recent deinstitutionalization experiences of the 1960s and 1970s, when patients were rapidly discharged to nursing homes and inadequate community services, the promise of the new law led many to push for immediate, rapid change, ignoring the lessons of deinstitutionalization. It was inevitable that change was going to take place, but leadership was needed for a shared vision that embraced quality care, safety, and the hope for recovery. We needed a plan and a process to move ahead.

The response to these challenges required leadership on several fronts. First, while community placement and hospital downsizing were necessary, there was no plan or agreement on the desired role of hospitals—if any. Second, rapid downsizing threatened to demoralize staff, create labor conflict, and undermine the quality of care. The combination of incentives with reduced budget allocations (a result of the recession of 1991–1992) led for calls to accelerate hospital downsizing and closures to provide “promised” funding for community care.

A first response to these challenges, early in 1991, was, ironically, to slow down the pace of hospital staff reductions. This had two purposes—first to keep the quality of hospital care from “crashing,” which would have threatened reforms just as they were beginning, and second to focus attention on the shared dimensions of reform—e.g., on some commitment to hospital staff, and on sufficient budgets. This was a subtle “reframing” of the problem—not a reversal of direction, but a message that viable solutions and plans for hospital care and the pace of downsizing were needed.

The strategy eventually worked, but it was messy—as strategies in a conflicting environment often are. Stakeholders on the community side of the system—especially boards and providers—clamored for action. The demand for solutions allowed us to create Inpatient Futures, a task force (ODMH, boards, providers, families, and consumers) empowered to develop a vision for future hospital and community care. Without slowing down the pace and educating about unintended consequences, community stakeholders would not have agreed to such a “planning” exercise. They wanted action. But if planning and compromise were needed to speed up the action, they would participate. The “Inpatient Futures” group developed a proposed mission for future inpatient care (a focus, as in the rest of health care, on acute-care, stabilization, and short-stay treatment) and recommended next steps. Regional stakeholders groups would plan for the future of each hospital (anticipated capacity, within broad state parameters and the agreed mission, as well as options for downsizing, merger, or closure). The regional groups would include hospital labor representatives, giving staff a voice, and leading commitments to employ former hospital staff to run some of the new community services in each region.

Reframing the “hospital problem” from a rapid “win-lose” proposition to a shared “win-win” (or at least, “win—not lose”) approach produced a viable strategy for implementing the Mental Health Act, but it was not without its problems. The local boards that had never used hospitals much—but anticipated getting significant new resources—would have their hopes deferred. With limited resources, we directed funds from downsizing primarily to the communities that were in a position to bring their residents home. The low-use boards, upset by the change, filed a lawsuit that would not be settled for several years, until it was clear that downsizing would eventually produce significant savings. The Inpatient Futures effort worked, validating one strategic response that leadership teams may find useful in periods of intense, short-term conflict: reframing the problem from an immediate unsolvable tension to a longer-range shared solution with elements of a “win-win” approach.

Finding a solution to community funding problems and developing a long-range vision of a (reduced) hospital role was not enough to insure the quality of hospital care. Leadership and staff morale was improved somewhat, but the hospitals were still vulnerable and buffeted. In short, Ohio's state hospitals were not in good shape. The National Alliance for the Mentally Ill (NAMI) (Torrey, Erdman, Wolfe, & Flynn, 1990) sponsored report “Care of the Seriously Mentally Ill: A Rating of State Programs” had found the quality of care in Ohio's state hospitals poor, especially the quality of the medical staff. “Too much idleness for patients and staff and not enough therapeutic activities at State Hospitals” was another view expressed by the task force appointed by newly elected Governor George Voinovich to evaluate state agencies. A response to the governor and a viable role and vision for the hospitals was required.

We initiated a process to improve care in our state hospitals, places that were our direct responsibility. If we demonstrated quality care here, we believed we could credibly assert leadership for a quality-of-care agenda in community agencies. Perhaps a focus on clinical quality could also counterbalance the local desire for more money, quickly. Our state hospital approach began with a plan to focus on the quality of care through best practices and empowering medical and clinical staff. We engaged the hospital CEOs in a combined leadership role with

medical directors while also empowering other clinical leadership. Believing that clinical quality begins with leadership, we focused on the recruitment of medical staff, via affiliations with medical school departments of psychiatry. Collaboration included creating a "Professor of Public Psychiatry" (Svendsen et al., 2005) in each medical school, charged with collaborating with the public system.

We focused on best-practices initiatives, beginning with a \$1 million/year state appropriation to bring the newly available drug clozapine to hospitalized patients. The \$1 million was enough to provide clozapine for 400 long-stay (average length of stay was four years) hospitalized persons with schizophrenia, for whom previous treatments had not provided adequate relief for them to leave the hospitals. Jointly with our clinical leadership, we developed treatment guidelines for clozapine, and all staff monitored outcomes and side effects closely. Psychologists utilized the Brief Psychiatric Rating Scale (BPRS) to assess response and outcomes. Together we learned the benefits of psychosocial interventions when we discovered, for example, that not one person initially started on clozapine was discharged in the first six months. This was not because people were not improving, but because extensive habilitation was required to recover from such prolonged and serious illness and the effects of institutionalization. We also learned that when patients were discharged on clozapine, with community supports, readmission was rare, and community functioning was adequate. While outcomes for patients were the most important results of these efforts, the focus on quality improved staff focus and morale.

We responded to the Governor's Task Force criticism of excessive idleness by staff and patients and a lack of therapeutic activities by creating the Therapeutic Activities and Recovery Process initiative (TARP). We brought clinical staff from all hospitals together for the first time in memory to share their best programming. Immediately hospitals learned from each other and began benchmarking clinical approaches, and sharing continued afterwards as well. We shared clinical accomplishments and best-practices approaches in our hospitals and invited community agency partners to learn what our hospitals were doing via a TARP newsletter and a "Clozapine Next Steps" conference. Hospital morale improved, clinical teams became energized and felt valued, and community leaders, advocates, and providers took note. Hospitalized patients improved and were discharged in record numbers through the combination of expanded community services, improved treatment, and incentives to avoid hospitalization. The hospital population declined, from 2,800 in 1991, to 1,200 by 2000.

We then began a process to reengineer our hospital system to be more efficient and clinically effective (Buckley, Svendsen, et al., 1999.) The process was highlighted by periodic "reengineering retreats" over a three-year period. Hospital reengineering was also a "reframing" effort, directed this time at hospital leadership and staff. The focus was to shift energies away from reacting to externally imposed downsizing and toward an active role in competing for resources based on the quality and price of services. This focus was assisted by a statewide quality improvement initiative championed by Governor Voinovich. Quality Services Through Partnership, or QSTP, was an effort to bring the quality-improvement message of Deming (1993) to state government. Given the emphasis on quality improvement that the hospitals had learned via the

Joint Commission's accreditation emphasis on quality, state hospitals became among the most successful adopters in state government of quality management practices.

We engaged community boards, agencies, clinicians, political leaders, consumers, and families to join our central office and hospital leadership in the process. We began with an emphasis on streamlining administration to maximize the resources available for clinical care. This was an effort that hospitals could agree on. The closure of some hospitals and administrative consolidation of others resulted in a move from 14 separate hospitals to nine inpatient sites managed as five hospital systems. The savings from hospital downsizing plus closures were sufficient to persuade the boards to settle the funding lawsuit with a mediated agreement. We then improved clinical services by identifying key clinical functions and creating four service lines to improve the quality of our care. Our service lines included: 1) Forensic Services; 2) Intensive and Specialized Services for acute care of people newly admitted and for those with longer stays but high acuteness, such as those with dual diagnoses; 3) Family and Children, focusing on the needs of patient's family members; and 4) Community Support Network, the outpatient services provided by hospital-employed community staff. The "product-line" approach enabled us to focus and use data to improve efficiency in care and measure outcomes. Each product line was led by a hospital CEO and medical director with other clinical disciplines from each hospital site. We thus had a matrix system with hospital systems running clinical care at their site(s) but product lines providing administrative and best-practice guidance. The principles of mental health leadership later described by Anthony and Huckshorn (2008) were exemplified. We developed a shared vision and a culture to live by this vision; we were united by mission but decentralized by operations; there was leadership at many levels by professionals from many disciplines; staff at all levels were trained and empowered; and exemplary performers were recognized and became leaders. Data and information were used to change and guide development. Team leadership at the state level was matched or exceeded by team leadership in each hospital system. Care, efficiency, and staff morale improved. Patient and family satisfaction were frequently measured and showed improvement. Hospitals passed Medicare and JCAHO surveys with impressive scores. Also in contrast to the 1990 NAMI evaluation of state mental health systems when state hospitals were singled out for the poor quality of care, the 2006 NAMI report ranked Ohio's mental health system as the best in the country, and the quality of care in hospitals was not even mentioned.

TRANSITIONAL LEADERSHIP: SETTING THE STAGE FOR FUTURE DEVELOPMENTS

Two major "getting ready," or transitional, predisposing efforts had begun during the stormy times that set the stage for future developments. The first and foremost of these was bringing the system together around a vision of *recovery*. The second was a focus on leadership development and becoming a learning organization and sharing leadership with community stakeholders. We will describe these two transitional efforts below.

CASE STUDY: LEADERSHIP IN A TIME OF TRANSITION: ESTABLISHING A RECOVERY FOUNDATION

As the Inpatient Futures process established a direction for structural change, and the focus and mission of inpatient care were shaped by the reengineering efforts, unifying themes for community care were needed. A shared goal that went beyond getting people out of hospitals and into communities was needed. Ohio's mental health system enjoyed a good foundation of "basic" services. The state had enthusiastically embraced the Community Mental Health Center (CMHC) program, so a network of CMHCs/clinics had long existed. The major services innovations promoted by Pam Hyde and Marti Knisely (the architects of the 1988 Mental Health Act) had been strengths-based case management (Rapp and Goscha, 2006) and supported housing termed "housing as housing." These models were adaptive in that they provided more flexibility and structure than traditional clinic services for people with long hospital stays, without imposing new institutional structures or unsustainable costs. Ohio had also developed a network of Consumer Operated Services, providing peer-directed alternatives on a modest scale in many communities.

This basic array of services (clinical, case management, housing) was both common-sense and functional. But by the 1990s, more focus and inspiration were needed. William Anthony's paper (1993) proposing "recovery" as the organizing principle for community support provided a springboard to position this emerging paradigm as an organizing and motivating vision. But "recovery" did not have a foothold in Ohio, except as a concept in the addiction system—a partner/competitor. People were not ready to embrace a concept viewed as the property of addiction treatment.

Leadership to develop "mental health recovery" as a theme for Ohio was provided by Wilma Townsend, head of the Community Support/Consumer Services office in ODMH. A social worker with the instincts of a community organizer, Wilma designed a multistage "bottom-up and top-down" change process to make recovery a central theme in Ohio's mental health system. The first stage was launched in April 1994, when ODMH convened a "recovery dialogue" to explore the new concept's relevance for Ohio. National and state leaders spent two days exploring recovery. The conversation planted a seed that needed to be nurtured. The second stage was to conduct recovery dialogues in every region of Ohio. ODMH leaders participated with board and agency staff, families, and consumers. Each dialogue, conducted in the late afternoon or evening to facilitate participation, began with a local individual describing their personal recovery journey, and guided inquiry into the meaning of their experiences. Then participants broke into smaller groups to brainstorm ways to advance recovery.

The themes and energy from the regional recovery dialogues were used to launch three rounds of competitive, mid-sized (e.g., \$100,000/year per funded project) recovery demonstrations. Each project was "owned" and operated by a local consumer group, with the sponsorship and support of the board. The solicitation was open-ended; communities could propose alternatives that in their view best advanced a recovery vision. Borrowing from Jean Campbell's Well Being Project

(1993), each project included a participant driven evaluation project, mentored and overseen by a university faculty member. A learning community process supported the demonstration projects. Papers from the evaluation (e.g., Bullock, Ensing, & Alloy and Young & Bullock at the University of Toledo and Wishnick and Stefan et al. at the University of Cincinnati published in 1998–1999) added to the conceptual and evidence base of the emerging recovery concept.

The Department's Community Support Program (CSP) Advisory Committee took the lead in synthesizing the themes that emerged from this multistage innovation (Beale & Lambric, 1995). It was useful to have this diverse group of advisors work on a "real" project, and to balance concerns developed by staff. In 2000 recovery learning was synthesized in *Emerging Best Practices in Mental Health Recovery* which became a widely cited resource in the United States and the United Kingdom.

The effort to develop a recovery framework for Ohio illustrates several aspects of change management. First, the leadership in the effort came from senior staff (principally CSP leader Wilma Townsend and Evaluation/Research Director Dee Roth) at a time when the top leadership team of ODMH was caught up in the challenges of implementing the Mental Health Act. With the support of the top leadership team, these staff entrepreneurs were not caught up in the challenges of hospital downsizing, funding lawsuits, and the like. But they were dedicated and competent to lead an initiative that started small but would become a state and national vision. By that time the system would become calmer, the resource of recovery would be well enough developed to become a strategic imperative.

CASE EXAMPLE: LEADERSHIP IN A TIME OF TRANSITION: LEADERSHIP TRAINING

In the mid-1990s, our ODMH leadership team engaged the expertise of the Ohio State University School of Public Administration faculty to assist us with our work. They joined our leadership team at times and helped us develop processes and to engage many throughout our organization in learning projects. The theoretical model and the coursework first involved the use of the text *The Fifth Discipline: The Art and Practice of the Learning Organization* (2000), by Peter Senge, a senior lecturer at the Massachusetts Institute of Technology. The goal of this approach is for the organization to become a "learning organization," a term used to describe an organization that facilitates the learning of its members and continuously transforms itself. The consultation and the model assisted a cultural change process. It emphasized group problem-solving using systems thinking to become a learning organization.

Our public administration consultants provided classes for enrollees with homework and applications provided from within our mental health organization and system. People were educated in the Senge's five main disciplines: systems thinking, personal mastery, mental models, shared vision, and team learning. These theories and methods helped us foster aspiration, improve reflective conversation, and better approach and understand complexity.

As a learning organization we also engaged with our consultants and often on our own in other management and organizational models and approaches. Our consultants provided Myers-Briggs testing for personal styles and how these might work with others on the team. One specific course for interested staff included the use of data to make decisions. Another embraced the Steven Covey book *The Seven Habits of Highly Effective People* (1989). A third approach, following Margaret Wheatley's *Leadership and the New Science: Discovering Order in a Chaotic World* (1999), focused on the value of personal relationships in leadership, change, and becoming a "self organizing" organization. Participation was voluntary, but many leaders and managers at different levels participated, and our entire mental health department became more of a learning organization.

Our university consultants worked regularly with our leadership team for an initial time period, but after a two- to three-year period, consultation ceased. However, the approaches we learned were continued; for example, the Leadership Team continued to have quarterly retreats to review, anticipate, and set direction.

Our mental health department also provided funding to bring university-based mental health leadership programs to mental health leaders throughout the local and community system. Mental Health Leadership Programs (2005) included the Ohio State University Leadership 2000+ Academy and the Case Western Reserve Mental Health Executive Leadership Program (MHELP). Each enrolled mental health leaders for monthly full-day or more learning opportunities over an academic year. Class work focused on issues such as finance and marketing in health care, performance improvement and quality strategies, updates on legal issues in mental health care, value-based management and leadership, public policy and legislative issues, strategic thinking and planning, finance, marketing, evidence-based practices- and consumer/recovery-focused care.

One of the measurable outcomes of these leadership efforts was familiarity with business planning and the requirement that all who received technical assistance grants from ODMH would submit a business plan. This aligned our processes and encouraged reflection and careful planning and evaluation of mental health programs throughout our state. Another example is the shared leadership that developed as both state and community partnerships came together. One example is the program known as Solutions to Ohio's Quality and Compliance, popularly termed SOQIC. This multi-stakeholder effort created and implemented a set of standardized documentation treatment forms for Ohio's mental health system. Another example of shared leadership is described in the next section of this chapter in the case example "Recovery Efforts Provide Direction."

LEADERSHIP WHEN THE SEAS ARE (TOO) CALM

The third major phase of our leadership experience followed the period of structural change implementing comprehensive reform legislation. This period paralleled the administration of Ohio Governor Bob Taft (1999–2007). The transition from hospital care and a state-centered system had been largely completed. The hospital system had shrunk from 16 facilities to five hospitals providing care at nine sites, and from roughly 2,800 inpatients to about 1,200. The mission of the hospitals had shifted to acute and high-urgency care; resources were relatively

stable; and the quality of care was improved. Community care had been greatly expanded, and most local systems had adapted to the dimensions of change that had been thrust on them (responsibility for serving people with the most serious illnesses; careful management of hospital utilization).

No major external challenges confronted the system during this period. Funding was tight, but manageable. Healthcare reform was a decade away. The trend toward Medicaid managed care that swept up many states largely passed Ohio by, except for a failed effort to gain control of and manage Medicaid inpatient psychiatric care. Litigation by the county boards related to implementation of the Mental Health Act of 1988 had been resolved with successful hospital downsizing and cost control.

Viewed strategically, the major challenges in this period were not primarily of external origin. Rather, the major issue was to create an agenda that would bring people together in the absence of a dominant threat. The transitional predisposing efforts of a vision for recovery and a focus on leadership development had begun. The major themes during this time revolved around expanding a vision of recovery. Team approaches and shared management approaches were our methods. Clinically, our focus was on developing a clinical quality agenda, paying attention to outcomes and quality improvement, and bringing evidence-based mental health practices to our hospital and community system.

CASE EXAMPLE: RECOVERY EFFORTS PROVIDE DIRECTION

During this relatively calm period, we were able to focus more explicitly on installing a vision of recovery as a foundation for the mental health system. The work done in the recovery demonstration projects and documented in *Emerging Best Practices in Mental Health Recovery* was ready for the mainstream. This was validated when the President's New Freedom Commission on Mental Health focused on recovery in their Final Report (2003). *Emerging Best Practices* outlined nine essential components of recovery (clinical care, family support, peer support and relationships, work and meaningful activity, power and control, stigma, community involvement, access to resources, and education) and four stages that many people in recovery would experience (moving from being Dependent and Unaware to Aware but Dependent, to Aware and Independent, and finally to Aware and Interdependent). The dissemination process included a statewide Recovery Conference, followed by numerous local recovery conferences, presentations with consumers sharing their experiences and recovery journeys at board meetings, and consumer organization meetings.

ODMH also used its leadership staff to reinforce the recovery and resiliency practice and policy. The area directors functioned as regional "account managers" with community mental health key stakeholders; i.e., community mental health boards, community mental health agencies, consumers and family members, as well as other constituencies. Leaders in staff roles also exercised leadership, especially the Consumer Services Office, who provided comprehensive leadership and partnership with consumers, family members, and their respective associations.

The culture of ODMH as a learning organization assisted the dissemination of recovery principles. Team members sought new learning to become empowered with theory, knowledge, and tools to support dynamic system change. Employing staff retreats, referred to as “advances,” theoretical approaches, including the work of Margaret Wheatley and Peter Senge, provided supplemental learning and leadership tools. This information supported change as a constant ingredient in the organization. ODMH strived to become a “leader-full” organization.

Recovery Centers

Recovery in practice at local levels was best exemplified by the developing Recovery Centers throughout Ohio. Several of the Recovery Centers had emerged or grown as a result of the recovery demonstration grants. Others were funded by county boards. Recovery Centers were local programs governed predominantly by a consumer board. They provided peer support, consumer-operated services such as transportation, housing and employment, and opportunities for consumer empowerment and hope. Recovery Centers were a self-directed alternative, building on consumer-operated services, which had existed in Ohio since the 1980s.

As the demand for consumer-operated services increased, ODMH redirected community capital project funds, which had previously been used only for treatment facilities and housing, to support Recovery Centers. Consumer-operated services (COS) have been described as “peer-run service agencies that encourage and support persons with mental illness who have been underserved and require assistance to obtain vital services through peer advocacy.” The local models for recovery centers and consumer-operated services varied, from a small organization providing peer support or a drop-in center, to a fully staffed consumer recovery center providing a full range of consumer services, including housing and employment. Some examples include The Main Place, in Newark, Ohio; and The Thomas M. Wernert Center in Toledo.

Glenn Hopkins, executive director of The Main Place, developed a toolkit, *Poverty: Breaking the Trend, Livin’ the Dream—A Guide to Overcoming Mental Illness and Poverty*. Hopkins states that the “toolkit is a starting point and reference for thinking about the impact of poverty on your life, a learning tool, a teaching tool, and as a stepping-stone to enhance your recovery” (Hopkins, Voelkle, and Bauman, 2009). The curriculum and training material enabled consumer-operated service centers to share practices for program development in other communities. Ohio’s Consumer-Operated Services grew from two drop-in centers to over 60 during the past three decades.

We also found that community recovery practices needed additional support. ODMH did not have the staff to provide this, but enthusiastic, mission-driven organizations would provide this with modest support. We developed a range of “extenders” to highlight and disseminate new practices. These included the Consumer Recovery Network, a project to promote use of Wellness Recovery Action Plans (WRAP), a cultural competence initiative led by Multi-ethnic Advocates for Cultural Competence (MACC), a Housing Initiative, and a project to support Advance Directives. There was a natural synergy between recovery as a concept and value and these allied technical assistance entities that helped make recovery an integrated and mainstream activity.

CASE EXAMPLE: EVIDENCE-BASED PRACTICES (EBPS) IMPROVE CLINICAL CARE

The recovery paradigm inspired and motivated many people in the system, including many clinicians, but it spoke most directly to consumers. Activities to organize and motivate clinicians and providers were also needed. A clinical quality agenda based on goals of recovery for adults and resiliency for children and adolescents became our project during these calm times, focusing on quality improvement, outcomes measurement, and evidence-based practices. Our evidence-based practice initiatives were especially successful, and many of them continue as important and viable tools.

By the late 1990s, evidence-based practices were fast becoming the approach in all of medicine and community mental health was no exception. Structural reform, such as had occurred in Ohio, was found to be helpful and perhaps necessary but by itself did not improve outcomes for consumers (Morrissey et al., 1994; Bickman et al., 2000). Mental health services research, however, was demonstrating improved outcomes for individuals using multidisciplinary interventions like Assertive Community Treatment and Supported Employment. Bob Drake had worked with colleagues in New Hampshire to create a partnership with providers to test and support these evidence-based practices, and Scott Henggler had developed the Family Services Research Center at the Medical University of South Carolina to support and study implementation of evidence-based children's services in community settings. Fidelity to the model was essential for successful outcomes, and training of multidisciplinary staff was essential. However, sending hundreds of clinicians to New Hampshire or South Carolina was not going to work. Also, the EBP "movement" was stirring up some reactions. For example, critics wondered about good approaches that the researchers had not yet validated. We needed an approach for Ohio—one that would install the proven best-practice models but one also that would help providers modify and improve their own programs, and one that would be broad enough to support different strategies.

For people with serious mental illnesses, such as schizophrenia, the evidence-based practices were usually multidisciplinary team approaches such as Assertive Community Treatment. By their very nature they were complex, and they required fidelity to the model to be effective. Adopting agencies needed to see a benefit from installing them—such as financial savings or reduced hospitalizations. EBPs needed to be salient to a significant portion of the serious mental illness (SMI) population. "Requiring and mandating" was not considered a doable option, so we needed a method to "encourage and promote." The shared vision to get there became our "Quality Agenda," which was defined as achieving recovery and resilience through evidence-based practices while measuring outcomes and promoting quality improvement.

After consultation with Robert Drake and others from New Hampshire (Drake et al., 2001), we began with the Integrated Dual Diagnosis Treatment (IDDT) model for co-occurring mental illness and substance use disorders. ODMH partnered with the Ohio Department of Alcohol and Drug Addiction Services and together funded the Case Western Reserve University Departments of Psychiatry and Social Work to offer the IDDT model to community providers and state hospitals. Bob Drake and his colleagues would guide the initial development of

the Coordinating Centers of Excellence, referred to for short as the CCOE. The Coordinating Centers would provide free consultation and technical assistance, including initial assessment of the risks and benefits of adopting the EBP, initial training of staff, ongoing education, evaluation tools, and consultative supports. By 2007, over 60 agencies in Ohio were employing IDDT, reaching persons with a co-occurring mental illness and substance use disorder.

ODMH did not have the expertise or the resources to bring evidence-based practices to community providers. However, by building on the success of the IDDT partnership, typically with university and/or community partners, other salient coordinating centers of excellence (CCOE) were developed, and most flourished. All CCOEs developed skills at consulting and providing technical assistance to agencies about EBPs. These included extensive consultation with leadership and staff in the getting-ready or predisposing-factors phase, when an agency considers whether to proceed with adopting an EBP into its structure and evaluates its likelihood for success. CCOEs also provided training and technical assistance with the implementation phase, as well as assistance in reinforcing and sustaining success over time. Many CCOEs included not only clinical and administrative partners, but consumer partners as well.

For most EBPs, fidelity measurement and evaluation was a frequent component of the CCOE technical assistance process. Adoption and implementation of EBPs was studied by an ODMH research initiative, The Innovation Diffusion and Adoption Research Project (IDARP), described by Panzano and Roth in 2006.

Ohio Coordinating Center of Excellence initiatives proved to be quite successful. They began in 2000, and most are still thriving today. The CCOE strategy was highlighted in the 2006 NAMI *Grading the States* report as “impressive”; and “other states would do well to take notice of Ohio’s approach.” The list of Ohio’s CCOEs included:

- Integrated Dual Diagnosis Treatment (IDDT)
- Supported Employment (SE)
- Cluster-based Planning Alliance (Clusters)
- The Ohio Medication Algorithm Project (OMAP) (This CCOE was discontinued.)
- Multi-Systemic Therapy (MST)
- Mental Illness/Mental Retardation (MI/MR, and now Mental Illness/Developmental Disability [MI/DD])
- Wellness Management and Recovery (WMR)
- Assertive Community Treatment (ACT)
- Advanced Directives (initially in partnership with the ODMH Office of Consumer Services and later outsourced to the State Consumer Advocacy organization)
- Criminal Justice CCOE (CJ CCOE)

REFLECTIONS ON TRANSFORMATIONAL LEADERSHIP

In reflecting back on our shared leadership experiences over many years, several major principles and lessons come to mind. It should be said that we did not begin with a focus on the term *transformational leadership* of the mental health system—but in retrospect, the concepts

and approaches do fit. We did, however, begin our work together with the transformative task of implementing the Mental Health Act of 1988—to move mental health services and funding from a centralized authority to shared responsibility with local authorities, while safeguarding or improving clinical quality and consumer outcomes. Our next transformational task was guided by a shared vision of recovery for those experiencing a mental illness. We believe our case examples describe our transformational approaches.

The function of transformational leadership, according to Burns (1978), “is to engage followers, not merely to activate them, to commingle needs and aspirations and goals in a common enterprise . . . of both leaders and followers.” Clearly this is what Mike Hogan did from the beginning. He came into his leadership role with the clear goal of implementing the Mental Health Act of 1988. This was the stated mission also for Dale when he was hired as medical director; as well as to focus on improving clinical care, beginning in the hospitals. Mike accepted this challenge and shared his vision for implementation and engaged many, including a leadership team, to adapt (i.e., reframe as needed) and to adopt this vision and its specific goals. Later, with a vision of recovery from mental illness, Judy Wortham Wood took a major lead in focusing the system on recovery while working with others on the leadership team. Together with Mike, we shared the transforming message and implementation strategies throughout the organization and with other leaders and followers in the state to bring the shared visions into reality.

How well did Ohio do during our leadership time in transforming its mental health system? Two things come to mind.

- The best outside evaluation of our efforts was described in the 2006 National Alliance on Mental Illness evaluation of state mental health care systems. Ohio received an A grade in information access, a B in infrastructure, a B in services, and a B for recovery supports. Ohio received recognition for recent innovations in consumer and family roles in the system, impressive implementation of EBPs and criminal justice system initiatives and strong state-level leadership in various branches of government. Overall, Ohio received a grade of a high B, which was one of the two best grades for state mental health systems.
- A second accolade was that Mike Hogan was chosen to lead President Bush’s New Freedom Commission on Mental Health. Its 2003 report, *Achieving the Promise: Transforming Mental Health Care in America*, describes a strategy for mental health care transformation to ensure services and supports that actively facilitate recovery and build resilience. The report identified six goals of transformation and showcased model programs to illustrate these goals. The Mental Health Commission report has similarities to many of the approaches we had been doing in Ohio.

Some of the principles that guided us through rough, transitional, and calm times are stated below. We believe our case histories provide examples of these principles.

- Keep your eye on the star.
- “Taking care of business” is job one. Managing the mental health department with its clinical care, regulatory compliance, and funding must be done first and done well. To demonstrate this, Mike Hogan shared his mom’s rule: “clean up your room before you go out and play.”
- Share the vision and develop it further with others.
- When the problem seems impossible to resolve, try reframing the issues.

- Mental health leadership is a team sport.
- Mental health leadership focus includes consumer, clinical, and administrative perspectives.
- “Do the right thing”: A value-based approach leads to trust.
- You can’t do just one thing. Change takes action on many fronts at the same time.
- Lead, follow, or get out of the way.
- Seek outside consultation to assist. Examples include university assistance in leadership training and evidence-based practice assistance.
- Partner with your best resources. Examples include consumers to help establish recovery or universities to assist with implementing evidence-based practices.
- Schedule time to consider, gather input, and set direction. Hold large retreats to seek input and set strategic direction; and quarterly leadership team retreats to evaluate, consider, and define new directions.

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PSYCHIATRIC RISK MANAGEMENT

*Efforts to Reduce Unforeseen Outcomes*LESLIE A. WINTERS, GREGORY B. TEAGUE, AND
KENNETH R. YEAGER

As part of our daily living, each one of us takes on risk. All of our daily activities involve a certain amount of risk. Just in driving to work, we could be hit by another car and injured, but most of us are willing to assume that risk. We make decisions on the level of risk we consider acceptable and act accordingly. At times, if we cannot control the level of risk involved in our activity, we may have the option of deciding whether or not to forgo that activity—for example, deciding not to have evening appointments if we would be the only mental health professional on the premises. But there are risks inherent in many professional activities we cannot forgo.

As a mental health professional, not only are you exposed to the risks you decide to undertake, but you are also exposed to those risks your clients decide to undertake, such as their not taking their prescribed medication despite the resulting delusional thoughts. Controlling both types of risks can be a challenge, and the consequences can have a significant impact, not only (and most importantly) on the well-being of the client, but also on you and other professionals involved in treatment.

This chapter is intended to identify a range of approaches to manage those risks. We will identify approaches to risk management in three general categories: first, we will describe considerations for development of a general crisis management plan, focusing on aspects of facilities and operations that may raise or lower risks for patients. Next, we will highlight clinical strategies within treatment that reduce the risk that patients will pose a danger to themselves or others. Last, we will identify additional strategies for reducing risk to either patients or professionals. We will close the chapter with a brief list of best practice take-away points, followed by references and other resources, grouped by topic.

CRISIS MANAGEMENT PLAN

In this day and age of reduced mental health services, it is more likely than ever that the community mental health professional will have to deal with a patient in crisis. Without planning for the management of patients in crisis, it is more likely that there will be an unexpected or adverse patient outcome. Couple the professional desire to avoid unexpected outcomes with the propensity of the members of our society to try to hold someone else accountable for all bad outcomes, and it is in everyone's interest to do as much as possible to avoid the adverse outcome. Again, we do that by attempting to manage our risk. Whether you have a one-person clinic or manage a community-wide crisis center, it is important for all mental health professionals to have a crisis management plan for their facility and their patients.

There are three main components to a good crisis management plan. They are recognition of the risks, management of the risks, and responding appropriately to incidents. The first component of the plan involves recognition and analysis of potential risks, which can involve a multitude of pathways such as the risks to the patient, the risks to the family, or the risks to the clinician and staff. Once the risks have been clearly specified and analyzed, the second component comes into play, in the development of a plan to manage each of them by either eliminating or controlling the risk. The third component is the development of a plan to respond to each type of situation should it occur. If these three components are developed in detail prior to a crisis, clinicians will know how to recognize and respond to a situation if it occurs. A timely and appropriate response will be more likely—and avoiding the bad outcome will also be more likely. Following is a description of each component of the crisis management plan in more detail.

RISK ASSESSMENT

Whether a sole practitioner or the member of a team from a larger facility, clinicians should consider the risks they face with their particular patient population. It is important to consider risks associated with both the stable patient and the patient in crisis, as the same patient may need to be assisted in both states. A multidisciplinary approach to risk assessment will result in the broadest recognition of the potential risks.

Facilities

Begin with an assessment of the facilities in which you are treating the patient. Do a walk-through of the facility and consider the risks to the patients, visitors, and staff. For example, consider where the doors are in relationship to the location of the treatment team member. Will the clinician always be able to get away from the patient? If the patient will be left alone in the treatment room, look at all the ways the patient might injure themselves. Are there hanging points? Are there items the patient could use to wrap around their neck such as a telephone cord, sheet, or trash bag? It is important to look high and low, as the patient can sit on the floor and use a waist-high handrail as a hanging point. What medications are kept in the area? Can the patient get to them? Are there tools kept in the area that could be used as a weapon? Are the windows locked? If the patient tried, could they jump out of the window? Would it break away?

While many of these types of questions seem rather basic, we often work in an environment without really noticing all of the risks. It takes a conscious assessment to try to determine the risk factors associated with a facility. Consider an annual walk-through with the safety, quality, risk management, facilities, and housekeeping staff. In a small office, bring in all of the staff and maybe the property manager. Consider asking the police or a regular contractor to assist in providing those additional eyes. Try to think like a patient in crisis. Look for ways to hurt yourself or someone else. That will help you find your facility's risk points.

Don't forget to consider family waiting areas. In times of crisis, the family can be extremely agitated. If a family member becomes violent or agitated, is there a way to protect the staff? Are there items that might become weapons? Are there ways to keep the patient and the family separated if need be?

In addition to looking for facility issues that might pose a risk, look at the facility with the outlook of whether the environment might over-stimulate a patient. Are there ways to create a more calming environment for the patients and families?

A single facility assessment, however comprehensive, is insufficient. The assessment needs to be repeated regularly, particularly in conjunction with all construction projects or changes in the use of the space. Over time, new items can be brought into an area without anyone thinking about the hazards. Likewise, spaces can be given new uses without a risk assessment. A regular program of reassessment will avoid creating new problems.

Once the facility assessment is done, the decision can be made to either eliminate the danger or manage the risk. It is important to note that it is not always cost-effective or physically possible to eliminate all facility risks. For example, equipment that poses a danger may be needed for operational purposes. However, many risks may still be managed. For example, the risk that cannot be eliminated but can be managed is by using additional staffing to control the activity in an area. There may be many doors that cannot be secured, but can the reception desk be placed near the doors? If an internal courtyard is used for patients, is there a way to prevent patio furniture from being used as a ladder to scale the walls? Another simple fix might be to lock an area, eliminating patient and family access.

Operations

Once you have finished a facility assessment, it is time to consider the risks associated with your operations. For example, the sole practitioner will most certainly need to meet with patients in crisis. Since that is the nature of the services provided, the risks associated with that type of situation cannot be eliminated. In a community mental health facility, there will often be patients in crisis who are awaiting transfer to another mental health facility. These types of operational risks have to be recognized so that a plan can be developed on how to manage the risk. What steps can be taken to minimize the safety risks for the staff, the patients and the public? Does it make sense to take patients out of the facility even if for therapeutic reasons? Is the screening of visitors for contraband appropriate? Should a patient be placed in a gown? What should the staffing ratio be? Look at all aspects of the operation and develop a list of potentially risky situations. Again, using a multidisciplinary team is the best way to do an operational assessment.

Part of the operations plan should include knowing how to address legal issues when they arise. Staff should be familiar with the local commitment procedures, duty-to-warn requirements, and how guardianships are obtained. The facility should have specific guidelines on how

those issues will be addressed within the particular facility, as well as how staff will be kept current on the issues. Expectations about communication and documentation should also be clearly defined (we will discuss these topics in more detail below).

Policies should be developed to formalize the relationship between the patients, families, and staff. The relationship between the mental health clinician and the patient is not evenly balanced. The clinician is typically seen as being in a position of power. Additionally, the patient may have cognitive issues that impact their perception of their relationship with the clinician. For those reasons, the relationship between the clinicians and the patients and their families should always be strictly professional—within, of course, the context of an appropriate and effective working or therapeutic alliance. The policies should set boundaries on the relationships such as prohibiting fraternization outside of the workplace. They should also restrict social networking (communicating on Facebook, Twitter, and such sites), calling, or emailing outside of the clinical relationship. The type of gifts that may be accepted, if any, should be spelled out. As part of the operational plan, there should be consideration given to how patients will be addressed. Will patients always be called by their last name? Using a first name may be seen as inconsistent with a professional relationship in that setting and may be misinterpreted. Some staff may have the tendency to touch patients. Normally that would not be permitted, but there are times when your facility might find it acceptable. Those guidelines should be spelled out for both clinicians and staff. By thinking about these issues in advance, mental health providers may avoid making a mistake in a crisis.

Not only is fraternization a concern, but the policies should advise staff on ways to deal with the patient who is sexually preoccupied. All clinicians and staff need to have awareness of such propensities, and have support for the staff who have to care for those patients, such as a two-person team or an open setting when dealing with those patients. Likewise, if your facility has inpatient beds, how will those patients be kept from preying on another patient?

THE MANAGEMENT PLAN

Once the team has thought through the risks associated with both their facilities and their operations, it is time to develop a plan to manage the risks. The management plan should take into consideration capital improvement projects, policies, and staffing. In a separate section below, we discuss a number of approaches that can be built into both the general way of providing clinical services, and more particularly, a specific patient's treatment plan; these may reduce the likelihood that a crisis situation may arise in the first place. Things such as scheduling might be part of the management plan. For example, if you know you are seeing a patient who has a dual diagnosis of autism and bipolar disorder, who regularly strikes out at staff, can that patient be scheduled at times when there is less commotion in the facility, when there are more staff in the facility, or when a specialist is in the facility?

In terms of the facilities, begin by looking at the easiest things to fix, such as removing items from the patient areas and securing dangerous items in non-patient areas. Address minor facility issues such as removing hooks, changing door knobs, eliminating beds with cords. If housekeeping carts contain chemicals, can they be locked away? Can the cleaning crew switch to cleaning products that are not hazardous if they are ingested or thrown in someone's eye? Develop a plan for addressing major facility issues over time as the budget reasonably allows. If fixes are not readily available or apparent, consult with other facilities to see what they might have developed.

If a facility has a large number of exit points, and escape is a risk, you may not be able to eliminate all of the risks associated with the doors without creating a fire-safety hazard. In cases like that you must consider staffing patterns. When risk factors cannot be eliminated, staffing must be increased to control the risk.

Policies need to be developed to teach staff how to monitor the situation. For example, how often should your staff do safety rounds? If a patient has to be given a dangerous item, such as a razor that is needed for shaving, what is the policy for monitoring its use? How will the staff remember to secure the item following the patient's use of it? The policy should address how these situations will be handled. Once the policy has been implemented, routine checks should be done to monitor compliance with the policy. There should also be a way for staff to report violations or lapses in policy enforcement. In the event of a serious lapse or one resulting in an injury, an analysis should be conducted to determine why the policy failed.

Part of the management plan should also include consideration of how outside resources will be utilized for support. When will police or security be called to assist with a patient situation? Do the local police understand the nature of your operations and the layout of your facilities? This type of information could be crucial in a crisis situation. Likewise, are internal resources available to call for assistance? Does the reception desk have a panic alarm? Is there an overhead paging system?

The team should understand what type of police support is available to support them in the event of a crisis. Many cities have police teams that are specifically trained in managing critical incidents with mental health patients. Other cities use teams of social workers to assist the police. The type of system provided in your city should influence your plan on how to manage a patient in crisis. Consider inviting your critical incident responders to your facility for a dialogue on your needs. Those relationships can be of value in a crisis situation.

One often overlooked component of the management plan is how to include all staff in the management of the patient. For example, at a facility that boards patients, how will all staff know someone is a patient and should not be allowed to leave? Do the patients wear any specific type of gown that would identify them as someone who may not leave? Are the patient's critical issues identified as part of the shift report? Does the dietary technician know the patient shouldn't be given silverware? It is helpful if the entire unit or office has the same understanding regarding a patient crisis. You don't want a nurse to stand by while the patient walks out the door just because she lacks the knowledge that the patient must not leave.

Developing patient-specific crisis plans is an excellent way to avoid an adverse outcome. The entire treatment team should consider the potential crisis issues and develop a plan to manage the risk. These plans may be very different depending on the type of crisis being addressed. Is staff trying to prevent a suicide, to prevent someone from swallowing a foreign object, or to prevent a patient from assaulting another patient? A different type of plan would be needed for each of these situations.

The operational plans should consider ways to avoid a situation from escalating. Have staff been trained in verbal interventions to de-escalate aggressive or other dangerous behavior? Some situations may require medicating the patient. Is there a medication plan for the patient in crisis that can be executed quickly? Are the medications available in a location where staff can get to them? How will the medication orders be obtained from the physician? If the mental health facility doesn't have a physician on staff at all times, the team should consider the ability to obtain medication orders to address crisis situations. In determining what can be done with

standing orders, it is important to consider the state licensing regulations. Some states do not allow nurses to administer medication using a standing order.

Even if staff are well trained in de-escalation, in an extreme situation it still may be necessary to restrain the patient temporarily, or to take the patient to the floor. This can involve the risk of physical injury for both the patient and the staff. The operational plan should include training on the rules regarding restraint. Facilities that are covered by the Center for Medicare and Medicaid Services (CMS) guidelines must know how to comply with the CMS rules on restraint. The plan should also include how staff will be trained to execute a takedown. That training should include simulation of crisis situations. It should also include refresher training. Consideration must also be given to where a patient will be placed following physical restraint. If they are still violent, is there a location to seclude them? Is that area free of items that could injure the patient? While a crisis facility may have regular seclusion rooms, what is available in the small clinic setting? If there isn't an appropriate room, then training has to be provided so that staff recognize a patient who is escalating and know how to either get help or get the patient to a crisis center.

For patients who are known to have a propensity to violence, it is important to gather as much information as possible about their home life, the places they frequent, and the names and numbers of friends and family. A patient may walk out of a facility but still be willing to answer their cell phone and talk to a clinician about their status. All of this information may prove useful when trying to determine whether the patient is in danger or whether there is a threat to another person. Having family involved in the treatment plan, and obtaining appropriate releases allowing you to contact family and friends, will give the clinician the tools to make an appropriate assessment of the danger. The operational plan should set out mechanisms for gathering this information in a standardized manner.

RESPONDING TO A CRISIS

Despite planning to avoid crisis situations, they will occur. The nature of mental health care treatment is that providers will have to deal with patients and families in a crisis situation. A patient may come in for treatment who is known to be chronically suicidal, but now has a plan to carry out their ideations. Or a patient may be having a psychotic episode. Prior to this happening, the facility and operational evaluations should have been completed, and the management plan developed, so staff should know the risks they are facing and how to respond. At this point it should be a matter of implementing the plans that were developed. If clinicians and staff have been trained on the operational plan, they should be able to execute the plan without an issue.

Each person on the response team should know their role. That should include an understanding of what they can do to safely manage the crisis within the scope of their license. Staff needs to understand that they may not exceed the scope of their license, even in a crisis situation.

One way to know a facility is ready to manage the crisis situation is to have practice drills simulating the crisis. Create a scenario to which staff must respond. Have a staff member play the part of the patient in crisis. Once the mock scenario has been completed, and the crisis resolved, the entire team should evaluate their performance. Adjust the response plan as needed.

There is no better way to learn where you need to improve your crisis management plan than to review a real crisis incident. Any time a patient has a crisis and it results in an adverse outcome for the patient or an injury to staff, a team should be put together to assess what went

wrong. In a no-blaming environment, the team should be able to look for the root causes of the incident. They should begin by interviewing the staff involved and look at the physical area where the incident occurred; then begin mapping a timeline of the event. Once the timeline has been established, look at each piece of the timeline and determine where there was a failure in the system. For each of those incidences or occurrences, ask why the system failed. Then ask why again. Only when you cannot ask why again do you have the root cause of that inappropriate act. Once the causes of the failure are determined, put together an action plan to remedy the problems. The action items should be measurable. The outcomes should be reviewed after implementation to ensure they are working to prevent future problems.

Normally in healthcare we have put in place multiple barriers to prevent a problem from happening. We also have a highly trained staff capable of preventing breakdowns in our processes from occurring. When doing a root-cause analysis, don't look just at individual failures but also review your systems for failure. James Reason developed what is known as the "Swiss cheese model." He explained his model, saying most entities have put barriers in place to prevent bad outcomes. The barriers can include such things as policies, automated equipment, staffing models, or facility design changes. Any one of those barriers might stop the bad outcome from happening. It is only when there is a breakdown in multiple barriers, or the holes in the Swiss cheese line up, that something bad can happen (Reason, 2000). When we review an incident to look at the root causes, we have to consider what happened to allow our multiple barrier breakdown. Do we have staffing issues; is the environment overly chaotic; are the appropriate records unavailable on a timely basis; do the staff not have orders when they need them; have we not trained staff on managing the patient in crisis? All of these types of system issues need to be reviewed. A practice is always safer when the clinicians involved acknowledge the potential for errors and build in error-reduction strategies.

CLINICAL APPROACHES TO REDUCING RISK

In the foregoing section we have presented a generally external and objectifying view of patients. Despite recent advances in articulating concepts and practices in the context of recovery as a guiding principle for mental health care (e.g., see <http://partnersforrecovery.samhsa.gov/>), some contingencies require consideration of strategies for strictly exogenous management. However, even in acute care settings, most patients are not in crisis most of the time, and strategies for treatment may be applied that involve engaging patients and families in such a way that they become active participants in reducing the risk that patients will harm themselves or others. Retrospective reports from patients following crisis events underscore the degree to which patients experience themselves as out of control, and coercive interventions exacerbate this phenomenon (e.g., see Substance Abuse and Mental Health Services Administration, 2005). In this section we highlight some key approaches that empower the patient with greater control over situations and their own behavior.

SHARED DECISION-MAKING

It is now generally accepted by practitioners in general healthcare that decisions about medical treatment are made with some degree of collaboration between doctors and patients.

Incorporation of patient preferences in treatment plans is a recognized component of evidence-based medicine (Drake et al., 2003). Partly because of cognitive impairment that can follow from some mental disorders, and partly because of more generalized stigma, this recognition has come more slowly in the treatment of psychiatric conditions.

Nonetheless, shared decision-making is increasingly recognized as a potentially powerful component of the treatment planning process in mental health. A Substance Abuse and Mental Health Services Administration publication (SAMHSA, 2010) provides a guide to current knowledge and practice. By engaging patients in determining their care, clinicians gain access to relevant information; patients' unique balance of preferences and needs is taken into account, yielding a treatment plan for which they can feel a sense of increased responsibility; and patient-provider relationships can be strengthened.

When families are available, they too should be involved—necessarily with minors, but more generally in view of potential impairments to a patient's decisional capacity. When determining the treatment plan for a patient, whether the patient is in a crisis situation or not, it is imperative that clinicians try to obtain the input of family members. The family can serve as eyes and ears for the treatment team, providing valuable information to assist the clinician in determining the patient's safety and the potential risk to others. Family input should be solicited. If a patient refuses to allow a clinician to consult with family or friends, the clinician must consider what, if anything, the patient is not sharing with the treatment team. A patient may not be safe to go home if the patient will not allow the clinician to talk to their family. At the very least, the patient's behavior is a reason to reassess the situation to insure the appropriateness of the clinical decision.

If a family member is concerned about their safety, those concerns should be considered. In these times of scarce resources, it may be easier to allow the patient to continue in outpatient therapy despite the family's fears for their own safety, but that may or may not be the best decision. If a clinician learns of family safety concerns, the patient's medical record should indicate that those concerns were heard and analyzed. The clinician should attempt to obtain as much information as possible about the behaviors that have made the family feel unsafe. The courts have held clinicians responsible for the injuries to third parties when they have not appropriately responded to the family's fears. The clinician should document the protective factors that lead the clinician to feel the family was safe in spite of their fears. If the clinician agrees with the family, they need to document the steps taken to protect the family from the patient, including any obstacles they encountered. For example, if the patient refused to be admitted to a hospital, did they try to commit the patient through the probate courts? If the decision is made that a patient won't be admitted to a psychiatric hospital, what is the plan to manage the patient on an outpatient basis? What are the factors that are going to make that plan successful? Is the family in agreement with the plan? All of those points must be considered and documented.

A shared decision-making model can help a clinician provide better-quality care for the patient as well as reduce the risk of a malpractice claim in the event of an adverse outcome. Allowing the patient and family to have input into the care plan fosters a sense of trust and satisfaction. It can also lead to better outcomes. If the family has agreed with the physician on the course of treatment, they are less likely to bring a suit against the provider if there is an adverse outcome.

PSYCHIATRIC ADVANCE DIRECTIVES

One way to involve the patient in the shared decision-making model is to work with the patient to complete a mental health care advance directive. Laws authorizing these documents have

been passed in almost every state. (See the National Resource Center on Psychiatric Advance Directives [NRC-PAD] at www.ncr-pad.org for state-by-state information, as well as general help in developing and using advance directives.) It was the intention of the mental health advocates who pushed for passage of these laws that psychiatric advance directives would be used as a résumé of sorts, outlining the patient's complete history and providing guidance on which medications and treatments would work best in a crisis situation. The document can also outline which medications have resulted in an adverse reaction and what treatments the patient is not willing to undergo. The document can be kept on file with providers and family. In the event of a crisis, the treating physicians then know exactly what the patient wants. They understand what they are authorized to do and can work out the appropriate treatment plan.

The documents need to be completed while the patient has the capacity to make decisions. If an outpatient provider is working with a patient on the completion of a psychiatric advance directive, the clinician should include documentation that the patient had capacity at the time of completion of the document. This will eliminate future problems, because when it actually needs to be used, the patient won't have the capacity to sign a legal document.

When advocates pushed for the passage of the laws to authorize psychiatric advance directives, they envisioned all mental health patients having one. In reality, very few have been completed. Studies have found patients are more likely to complete them if they are given guidance on how to complete them in a structured setting and, again, have indicated they are a good format for decision-making discussions between the patient and the provider.

BEHAVIOR THERAPY

The evidence for two common approaches to reducing seclusion and restraint—regulatory imperatives and staff training in verbal de-escalation—shows that, although use of seclusion and restraint has indeed declined, the incidence of violent behavior among inpatients and of staff injuries has not. On the basis of social learning theory, Robert Liberman (2011) argues that the social interaction involved in the verbal interventions designed to calm patients down has the inadvertent effect of reinforcing the original aggressive and otherwise dangerous behavior. A more effective alternative, therefore, would be to include as a treatment, behavior therapies that reinforce other positive behavior.

Interventions based on behavioral learning principles are applied within a behavior analytic framework. Antecedents to dangerous behavior in both the environment and the individual are analyzed and monitored over time as potential causal factors. Interventions that address the individual situation are then applied, and their effectiveness in shaping the desired behavior is tracked closely over time to guide decisions about continuation or change of treatment strategies. Such alternative interventions may include social skills training, which can entail teaching appropriate interactions with others; social learning modalities involving positive reinforcement of adaptive behavior, including token economies or credit incentive systems; positive programming or activity scheduling; or "time out" from situations that reinforce aggressive behavior.

These approaches to reducing the risk of aggression, destructive behavior, and self-injury using behavior therapy are not alternatives to traditional pharmacotherapy but are provided in conjunction with it. They also require substantial training, ongoing supervision and monitoring, and administrative support. However, facility- or program-wide as well as patient-specific

interventions of this type can substantially reduce the risk of patients' exhibiting the kind of behaviors that put themselves or others at risk and invoke coercive interventions.

OTHER APPROACHES TO REDUCING RISK OF ADVERSE OUTCOMES

DUTY TO WARN

Most states have passed legislation codifying the "duty to warn" obligation. While state laws may vary, the majority follow some of the most publicized cases. The *Tarasoff* case is the most commonly cited case. In *Tarasoff*, the court looked at whether an injury to a third party was foreseeable. While they believed there normally is no duty to control the behavior of another, in the case of a mental health provider they found a special relationship that supported an affirmative duty. The court recognized that the clinician would not always make the correct decision regarding the actuality of the patient's carrying out a violent act, but felt a few warnings about potential threats that did not come to pass was a small price to pay for the safety of individuals.

A mental health provider who has a patient who presents a danger to another person must make a decision on how to respond. The clinician has an obligation to both the patient and the potential victim. The obligation to the patient is to keep their confidence. By warning the potential victim, that patient-physician confidentiality is broken, so it must only be done in the most extreme circumstances. It is up to the clinician to determine whether an actual threat exists and whether the patient has the means to carry out that threat. If the patient has no means to carry out the threat, there is no danger, and the duty to warn would not apply.

It is important to know your state law on duty to warn. The varying state positions include: saying a physician has a duty to warn an identifiable victim of a patient's violent intentions; saying the duty to warn expands to an entire identifiable group of potential victims; saying that duty to warn exists even if the threat isn't explicit; saying the practitioner has a duty to take reasonable steps to avoid the violence from happening; imposing no specific duty to warn but saying it is more factually based; and finally, in some states they have not acknowledged the duty to warn but have allowed a waiver of the patient confidentiality. You can see there are various options, all requiring different actions on the part of the clinician; thus a clinician must understand the rules of their state or risk violating patient confidentiality.

CORROBORATING SOURCE MATERIAL

Many mental health patients see multiple providers. Some have had multiple inpatient admissions in a variety of hospitals. When making decisions on the appropriate treatment plan for a patient in crisis, it is important that the clinician have as complete a picture of the patient's diagnosis and treatment history as possible. To gather that information, the clinician should attempt to secure as much of the patient's treatment history as they can. The patient may not have all of this information or may not be willing to share the information. Family members may have treatment information that they can share. That information can then be discussed with the patient. If possible, the medical records from outside entities should be obtained. Calls should

be made to other providers to gather their input into the current situation. By gathering all of this information about the patient, the clinician can make the best possible decision on a treatment course. Additionally, it is much harder to say the clinician failed to meet the standard of care relative to their diagnosis and treatment plan when they took the time to gather a complete picture of the patient's condition.

At times a patient who is relatively unknown to the clinician will present in crisis. In those cases, it is particularly important to reach out to other providers to provide clinical information on the patient's history of treatment and symptoms. Those providers may have information that would be critical to the decision-making process.

DOCUMENTATION

A key to the appropriate management of risk is appropriate documentation of the clinical decision-making process. As workloads continue to increase, it is easy to let this part of the practice lapse; but whenever there is a bad outcome, good documentation in the record will be what protects the clinician from liability. This is especially true in the mental health field. There are no laboratory tests or physical procedures that can determine what is going on in the patient's mind. This is also a field where patients will regularly withhold information from the clinician or try to fool them about their diagnosis. On top of that, even when the clinician has a clear picture of the patient's clinical picture, the patient's mental state may change the moment the patient leaves the office and encounters the stresses of everyday life.

It is known that not all clinicians are going to make the correct decision on whether to allow a patient to continue as an outpatient or to require admission. In some instances, the incorrect decision will result in the death of a patient. One of the biggest mistakes a clinician can make is failing to document their clinical decision-making on how they got from the patient with a suicidal plan to a patient who was safe to continue as an outpatient. There should be documentation of a full investigation of the patient's current suicide plan and past attempts at suicide. Also, document information on why the patient may have thought about committing suicide but decided against it. Document all of the known protective factors such as family support or a strong religious belief. Finally, document the safety plan that will allow the patient to continue as an outpatient. Were any items in the home environment secured? Did the family take a protective role?

While lawsuits against psychiatrists and other mental health professionals are not that common, they do occur. Suicides are the most common reason for a lawsuit. Irwin Perr stated that it is only in psychiatry that a physician is held responsible for the actions of their patient. While suicide can be considered an adverse outcome, or an inappropriate result of treatment, a suicide alone does not mean the mental health professional was negligent in their treatment of the patient. A treatment outcome can never be guaranteed, nor can all suicides be predicted (Perr, 1965).

A malpractice lawsuit is often avoided if the medical record indicates the clinician was thorough in their assessment. If a clinician thoroughly assessed the situation, and documented a logical decision-making process, even if the clinician made the wrong decision, many malpractice lawyers won't even take the patient's case. If the case does go to trial, the jury is going to try to determine whether the suicide could have been foreseen. The clinician isn't going to be held to the standard of absolute knowledge of what the patient might do, but rather, to the standard

of having performed and documented a thorough assessment and then reached a logical clinical plan based on that assessment.

Documentation should always be done contemporaneously with the care being provided, whether it is an office visit or a phone call. At the very least, the documentation should be done on the same day. If it isn't documented in a timely fashion, it shouldn't be done at all. Documentation after the fact is not viewed favorably by juries, but rather, is looked at as an attempt to protect the clinician.

The old saying that "if it isn't documented it wasn't done" still holds true. If you don't document your assessment or the rationale for why you decided on a course of action, the jury isn't likely to believe you actually did the assessment or thought about the course of action. In a *Journal of Psychiatric Practice* article by plaintiff's counsel Simpson and Stacy, they wrote, "There is always information that a physician felt compelled to enter into the chart that was far less critical than a dialogue regarding suicide. Since suicide is one of the worst possible outcomes for a psychiatric patient, most juries conclude that if a psychiatrist actually conducted a suicide assessment, he or she surely would have documented it" (Simpson and Stacey, 2004). They also stated that they believed good documentation improved the quality of care the patient received. They felt having to document the assessment forced the clinician to review their thought process, both considering the thoroughness of the assessment and the validity of their clinical formulation of a treatment plan.

Assessments are particularly important any time there is going to be a change in the level of care the patient is receiving or the level of observation the patient is under. These are times that are stressful for the patient, and the impact of that stress on the patient needs to be considered. The documentation should include information on the patient's plan to deal with the stress. Documentation of the decision-making process is particularly important whenever the level of patient risk is going to increase as a result of the decision. Document the clinical benefits of the decision to give the patient continuing or additional freedom.

Patient autonomy has to be respected. As noted earlier, it is recognized that patients should have the right to make decisions about the care they receive. At times this will mean that a patient will decide not to follow the recommendations of the treatment provider. Patient non-adherence should be documented in the medical record; such documentation can provide a defense against a malpractice suit.

The documented medical record also serves to provide a historical guideline for other caregivers in your absence. It can assist an outside provider, such as an emergency physician. It gives them guidance on medications and treatments that have or have not worked. It can provide a complete history of the patient's past treatment record, often conveying better information than the patient is willing or able to share. In the event of an emergency situation or when another physician is covering for you, it is less likely that key information will be overlooked. Again, this leads to better patient outcomes and less risk for the mental health provider.

STANDARDIZED HANDOFF COMMUNICATIONS

Almost every adverse outcome involves a communication failure. According to the most recent reports of the Joint Commission on Healthcare Accreditation, a national accrediting body for hospital facilities, 82 percent of reported sentinel events involved a communication failure. In fact, for the last three years reported, communication has been one of the top three root causes

in suicide events. It has been the only consistent root cause in suicide events. (Joint Commission, 2011). Thus, to manage risk, mental health professionals must manage the communications between the team members.

Each time the care of the patient transfers from one individual to another, there should be a transfer of the pertinent information relating to the patient's care plan, commonly known as a "handoff." The handoff communication or report tells the new caregiver what went on while the current team member was providing care and gives them an idea of their responsibility in the care of the patient. It gives the entire care team a shared picture of the patient's condition and the critical issues to be addressed. Failures in either the oral or written handoff communication can lead both to knowledge gaps within the team and medical injuries.

Gaps in the handoff process can lead to situations where providers don't have the information they need to make the correct decisions for patients. Studies have shown that where there is a knowledge gap there may be a delay in care. Alternatively, a provider may make an intelligent guess at the appropriate treatment. Either of these options can lead to a bad outcome.

Each member of the treatment team will gather slightly different information from the patient. The patient may deny suicidal thoughts to one member of the team and then clearly declare a plan to commit suicide to another member of the team. For that reason, it is important to have a standardized communication tool for handoffs between staff members. For something as important as a suicidal plan, there should be specific ways the information is to be communicated to the team. The situation where one clinician thought they told another of a plan, as they usually tell them, serves no one well in the event of a bad outcome. Nor does the belief that everyone will read what you documented.

By standardizing the handoff process, the clinician will develop the habit of addressing the key diagnostic and treatment elements every time. By doing this they are less likely to miss an element. The handoff becomes a checklist. This standardization not only includes the use of commonly understood terminology but also includes communication in a format that is legible

It has been determined that checklists or templates are highly effective communication tools. They establish a standardized way of communicating that is followed each and every time. They are particularly helpful at the time of a handoff. Atul Gawande, the best-selling author of *The Checklist Manifesto*, talks about how complicated medicine has become and how easy it is for a clinician to forget a step in a process while under stress. He advocates using checklists as a way to "hardwire" a process for a clinician or a team of clinicians. He believes we can improve outcomes if we do so (Gawande, 2009). While these tools are not regularly utilized in the mental health field at this time, they are very useful tools that should be considered. Each facility would develop a checklist that would list each of the steps in a process and indicate who is responsible for each step. Required fields of information would be included in the template.

In highly specialized fields such as aviation, which has been compared to medicine in terms of having highly skilled individuals involved in stressful situations where they have the life of other individuals in their care, the skills needed to improve communications are guided by checklists, and the processes are practiced. Every member of the team is encouraged to speak up in the event they see the potential for an error or bad outcome. In fact, the team leader is required to tell the team it is their obligation to speak out if there is a safety or process issue. Using these methods, system errors are detected and either prevented or mitigated by staff. By using these guidelines, aviation has been able to reduce its errors. Recently, these same skills have been implemented in medical facilities as a way to reduce errors.

This type of training could be very helpful in a treatment team setting, as each member of the team would be required to state their agreement with the plan and to raise any safety issues that were not being adequately addressed. This type of environment would reduce the instances where only one member of the team knew the information provided by the patient. It would also be a useful tool for recognizing issues that might have been left unresolved at the time of discharge.

Not only is team communication important, but clinician to patient communication is critical. Skills must be developed to provide information to patients and families in a way that they understand. Issues with “medical literacy,” the ability to understand complicated medical information, need to be considered. The cognitive difficulties of the patient need to be considered when deciding the appropriate terminology to be used. The stressfulness of the situation is another factor to be considered. Patients understand less of what we say to them when they are in a stressful situation. Some studies say they only retain 10 to 15 percent of what is said to them. If there are concerns about a patient’s understanding of information, bring in an additional family member or use handouts. The teaching tools are a good way to assist the clinician in getting the information across to the patient. The “teach back” method is another option. Using that method, the clinician gives the patient the necessary information and then asks the patient to repeat the information back to them, thus showing an understanding of what they have been told.

By doing the risk-management planning set out in this chapter and following some of the other suggestions, your community health facility, whether large or small, will provide better care for your patients, will be a safer place for staff to work, and will have fewer legal problems. Many of these steps are easy to implement; they just take a little time and planning. Make good risk management a priority for your organization. Develop good habits, and things will go better when your patients are in a crisis.

BEST-PRACTICE TAKEAWAYS

1. Good risk management is all about the avoidance of risks. This starts with the analysis of potential risks and continues with plans to mitigate the chance of specific risky events’ occurring, including incorporation of behavioral management strategies into individual treatment plans.
2. Prior to a crisis, engage patients and their families in their care plan. Make sure there is shared decision-making about care plans, as well as the use of advance directives for potential crisis situations. Where aggressive or other intolerable behavior is anticipated, the care plan should include behavioral interventions to reduce the probability of occurrence.
3. Make sure you listen to the patient and their family. Consider the information they are giving you before you fully develop your care plan. Likewise, heed their concerns before deciding to discharge a patient or allowing a patient to remain at home.
4. Each facility should have a crisis management plan. The plan should include an environmental assessment of your facilities.
5. Not all crises can be avoided all of the time, so each risk management plan should have a plan for responding to a crisis, including the names of those involved in the response team and each member’s role.

6. Make sure staff is trained on verbal de-escalation. Have a policy for physical intervention and the use of pro re nata (PRN) medication, should those become necessary. Train the staff on the policy and the process. Simulation of events can help staff develop their skills.
7. Tabletop drills help the response team prepare to respond. The drills also point out flaws in the response plan that can be corrected prior to a real-life crisis.
8. Engage the police and other ancillary responders in your planning process.
9. Team communication is critical when caring for the mental health patient. Everyone on the care team should have input into the care plan. The team should discuss the plan of care and coordinate information that may have been given to just one member of the team. Work out any concerns that any member of the team might have.
10. Good documentation is critical to the avoidance of liability. Make sure your assessments are completely documented. Document your clinical decision-making process.
11. If a crisis occurs, don't forget about the needs of the patient, family, and staff. If a patient has been harmed as a result of a staff error, apologize. Don't go into a hunker-down mode, avoiding the patient or family. Share information on what happened and how you are going to fix the problem. Engage the family in the corrective plan as appropriate.

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QUALITY MANAGEMENT AND PROGRAM EVALUATION

VIKKI L. VANDIVER AND KEVIN CORCORAN

INTRODUCTION

Behavioral health care organizations have changed significantly over the last three decades. Fueling this change has been the expectation that organizations will increasingly deliver and evaluate the impact of evidence-based services. Oregon, for example, has a state statute mandating evidence-based practices in most social service agencies, including corrections, mental health, child welfare, and other areas. A determining force in being able to deliver effective services hinges on three core interconnected administrative components: *quality management*, via the use of *interdisciplinary teams*, which use *program evaluation* for determining quality at the agency and individual level of services. This chapter will review these components and delineate a practical approach to evaluating programs in order to manage their quality.

QUALITY MANAGEMENT

When we talk about “quality management” in behavioral healthcare settings, we are addressing a wide range of issues and concerns. There are numerous factors involved in quality management. Chief among them are how we define programs and change (theory), the codes of conduct (principles), and character (leaders and leadership). Additionally, quality management seems most likely to succeed with the formation of competent interdisciplinary teams, program evaluation, and measurement tools used to evaluate the magnitude of quality, including at the agency and individual systems levels. This section begins with an overview of theory, principles, and characteristics of leaders and leadership. Additional information is provided on an example of macro-level best practice, learning collaboratives, and the use of benchmarking to monitor best practices. We will then delineate practical program evaluation and measurement to help assure quality.

FROM THEORY TO PRACTICE

A useful and classic theory for understanding how quality management influences organizational change is *force-field analysis* (Lewis, Goodman, & Fandt, 2004). It is defined as a “systematic step-by-step process for examining pressures that support or resist proposed change” (pp. 357–358). This framework is based on the assumption that just introducing a change does not guarantee that the change will be successful. Therefore, in order to support the successful change that is necessary to integrate and evaluate evidence-based interventions into mental health practice, force-field analysis suggests four steps. These are: 1) create a shared vision, 2) communicate and share information, 3) empower others to act on the vision, and 4) evaluate the results (Vandiver, 2008, p. 384).

- **Creating a shared vision:** The very act of developing a vision helps bring awareness of the need for change and prompts discussion about forces supporting and resisting change efforts—referred to as “unfreezing.” Often organizations are “frozen” into safe and predictable ways of functioning or performing. When all stakeholders can be involved in setting a new vision, participants are more likely to work toward successful change and thus unfreeze themselves from the old way.
- **Communication:** Sharing information is a key strategy that helps gain staff support while also helping them learn. Research suggests that new behaviors are more readily learned when delivered using a variety of formats, such as verbal, written, and non-verbal messages. Therefore, a manager needs to discuss changes with the staff and continually circulate minutes and memos, and role-model the desired goals.
- **Empower employees:** Management literature now recognizes employee empowerment as a critical variable in a healthy organization. From a management perspective, *empowerment* is defined as “the interaction of the leader giving away or sharing power with those who use it to become involved and committed to high-quality performance” (Lewis, Goodman, & Fandt, 2004, p. 599). Successful organizational change can be credited to employees who have felt empowered and strengthened in the process of change. Their development is encouraged at two levels, individual and organizational. Individual development includes anything that helps an individual learn how to adapt and change, such as mentoring from supervisors and attaining more education. Organizational development refers to teaching people to interact successfully with others in the organization such as group and team training. Thus, by improving the lives of employees, the organization is improved.
- **Evaluate:** Similar to outcome measures for client change, managers also need to measure and evaluate the need for change (i.e., needs assessment) and whether the change has had the intended effects. Evaluation methods can be designed by both managers and employees, who can also set the outcome criteria.

PRINCIPLES OF QUALITY MANAGEMENT

Principles are useful guideposts for staying focused on the values and direction of an organization’s mission. Using meta-analyses of management literature, Terry (2003) identifies three core principles of effective quality management: *authenticity*, *service to others* and *shared power*—all of which speak to the character of a leader. In other words, quality management requires

leaders whose intention is to effect positive, sweeping, measurable, and memorable improvements in mental health care (Terry, 2003). Wheatley (1999) describes the principles of *relevance* and *participation*. The principle of relevance refers to starting where people are and with what is meaningful to them. The principle of participation refers to eliciting participation by staff, community, clients, and family members.

All of these principles are important for quality management because they involve a multi-stage process that mobilizes people and resources for a common purpose. These principles have excellent relevance to management because they help promote ownership in the organization while also fostering active learning by all participants—a feature that will be discussed later, in the section “Learning Collaboratives.”

CHARACTERISTICS OF QUALITY MANAGEMENT: PERSON, PROCESS, AND PRACTICES

When we use the term “quality management,” three features come to mind: person (leader), process (leadership), and practices (learning collaboratives for best practices and evaluation). Quality management involves a leader or manager who provides a certain kind of management style—quality. But quality management also refers to a process—an organization that engages in quality management practices typically has strong leadership. Quality management occurs through the process of strong leadership in which quality of care is focused on improving methods for assessing quality, concern about the effects of incentives in managed care contracts (i.e., under treatment), restricted access, and meeting the growing demand performance and fiscal accountability identified by federal, state and county governments (Chavez & Barry, 1998). Strong leaders who exhibit strong and participatory leadership skills have an easier time of bringing about organizational change that incorporates the use and evaluation of best practices.

THE PERSON GUIDING QUALITY MANAGEMENT: THE LEADER

There has been an increased expectation that mental health leaders will develop new skills and relationships to deal with a changing mental health environment. The expected model for chief executive officers has become more that of a collaborative manager who values diversity and participatory management and less that of a professional manager who is hierarchal and uses a top-down decision-making style. The leaders in today’s behavioral health environment must be ready to embrace change, encourage dialogue, use participatory decision making, instill a team-oriented culture, use and evaluate evidence-based approaches, and be able to build management teams that know how to execute the organizations mission and values. Additionally, they must have the requisite business acumen and professional skills to be effective—meaning understanding financial statements, demonstrating policy-making skills, and being able to manage individual, team, and a variety of in-house and community relationships.

A central responsibility of a leader is to help the organization and or community develop its vision and then assist in developing a flexible, strategic plan for how to get there. In essence, before mental health clinicians can be successful with clients, agency leaders must first be successful with the community. Quality management recognizes the power of communities to aid in the healing, health, and mental health of individuals and their families. Leaders within the

field of mental health are only now beginning to embrace the benefits of broad community involvement (Vandiver, 2008).

Terry (2003) describes the characteristics of leaders engaged in quality management. Leaders provide quality management using five core strategies. *First*, they lead by fiscal example. They commit at least five percent of mental health program budgets to research and evaluation. *Second*, leaders welcome scrutiny. They invite outside reviewers or evaluators to evaluate existing clinical and organizational practices to see if their policies and programs are supporting their mission and values. *Third*, leaders are active, not passive. They acknowledge and support mental health programs that demonstrate effectiveness. *Fourth*, leaders are teachers. They offer to speak to local health and mental health care organizations, business clubs, and fraternal organizations about the value of community partnerships and relationships. *Fifth* and last, leaders are collaborators for community change. They commit to working outside the mental health profession to bring together politicians and business and community leaders to create partnerships that promote community change for health and mental health (pp. 162–167).

Leaders who demonstrate quality management utilize many approaches. Perhaps we can learn from other industries, such as Google, which recently conducted a large-scale survey to learn how to “build better bosses.” In 2009, in a bold project titled “Project Oxygen,” Google statisticians gathered more than 10,000 observations about managers across more than 100 variables ranging from performance reviews to feedback surveys. Manager interview protocols were developed followed by in-person interviews. Finally, the analyzed data produced more than 400 pages of interview notes.

What did Google management learn about what employees valued? Their effort produced a report titled *Eight Habits of Highly Effective (Google) Managers* (Bryant, 2011). In priority ranking, these habits are:

- 1) Be a good coach, 2) empower your team, 3) express interest in team members’ success and personal well-being, 4) don’t be a sissy: be productive and results-oriented, 5) be a good communicator and listen to your team, 6) help your employees with career development, 7) have a clear vision and strategy for the team, and 8) have key technical skills so you can help advise the team. Basically, what employees valued most were even-keeled bosses who made time for one-on-one meetings, who helped people puzzle through problems by asking questions, not dictating answers and who took an interest in employees’ lives and careers. (Bryant, 2011, p. 1)

What makes this information practical is that it was developed in the context of the company, not through an independent, stand-alone leadership training seminar brought in to tell people how to do it. Also, what matters here is that the information emerged from within the company and therefore earned more credibility at feedback sessions to employees and managers. What Google discovered is that managers had a much greater impact on employees’ performance and how they felt about their job than any other factor. So what can behavioral mental health care organizations take away from this exercise? Have time for employees and be consistent with them.

THE PROCESS OF QUALITY MANAGEMENT: LEADERSHIP

If leaders are the WHO of quality management, then leadership is the WHAT and the WHERE. In other words, leadership (the what) is the process of what happens when an individual or

group of individuals (the who) guide the organization toward its stated goals and mission (the where). Let's look at examples of effective leadership. "Strategies" will describe "the what" and later, "learning collaboratives" describe "the where."

Strategies for Effective Leadership

Castro and colleagues (1999) identified seven factors linked with competent leadership. These included: 1) garnering support for a program from the local community and funding agency, 2) strengthening staff morale and commitment to program goals, 3) maintaining fidelity in program implementation when necessary, 4) identifying serendipitous developments that can be added to the program evaluation data to aid in documenting program development and effectiveness, 5) meeting regularly with staff to assess program activities, 6) engaging in problem solving, and 7) planning for future activities and program growth (pp. 138–145).

Effective leadership, in part, models the behaviors that are expected at the clinical care level. As described in the IOM Report *Improving the Quality of Healthcare for Mental and Substance-Use Conditions* (IOM, 2006)—The Robert Wood Johnson Foundations Initiative on Depression in Primary Care, leadership was one of six component interventions to overcome barriers to the delivery of effective care for depression in primary care settings. Teams of primary care, mental health, and senior administrative personnel were responsible for securing needed resources, representing stakeholder interests, promoting adherence to practice standards, settings goals for key process measures and outcomes, and encouraging sustained efforts at continuous quality improvement.

Effective leadership is well known to be a critical process factor in shaping organizational culture (IOM, 2006). In other words, what are the *formal* and *informal* values, rules and guidelines that influence the practices of managers and staff? In this case, "formal" refers to written policy and procedures documents that endorse and specify organizational values (mission statements) and actions. "Informal" refers to the social interactions among and between staff and leaders—which are often the most potent form of communication about policies. Both of these elements create what is commonly referred to as the "organizational culture." One way to test whether leadership is promoting a healthy organizational culture is to examine whether the formal policies (e.g., policies and procedures manual) match the informal values and practices of the agency and staff. For example, if recovery and client-centered care are priority goals, practices, and philosophies of the staff and clients, does leadership provide the resources and support for these priorities?

Leadership can help promote a healthy organizational culture by providing transparency. Transparency in leadership, according to the Institute of Medicine's *Crossing the Quality Chasm* (IOM, 2001), refers to a process in which the mental health care system provides information describing the system's performance on safety, evidence-based practice, and patient satisfaction (p. 8). This information is available not only to staff but to clients, patients, and their families. By availing themselves of it, staff and stakeholders can truly make informed decisions when choosing a health plan, hospital, agency, and provider.

Evidence-Based and Best Practices

Effective leadership is also characterized by ensuring the existence of a quality measurement and reporting infrastructure that is responsive to the agency. Much of our knowledge base of what

works (e.g., evidence-based and/or best practices) in community mental health care settings has been initially fielded and tested in health care settings. Let's look at one best-practice approach that is used in behavioral health care settings: the learning collaborative.

Learning Collaboratives

Learning Collaboratives constitute the “where” of quality management and have been used extensively to promote quality improvement in healthcare in areas such as improving chronic illness care (Cretin, Shortell, & Keeler, 2004), treatment of depression (Solberg, Fischer, & Wei, 2001), general community health (Shortell, Zukoski, & Alexander, 2002) and asthma care (Schonlau, Mangione-Smith, & Chan, 2005). They involve five activities: 1) the use of cross-discipline and inter-organizational teams, 2) working on a specific problem, 3) supporting leadership by evidence, 4) providing faculty experts, and 5) utilizing project management coaches to modify and or improve specific practices (Cretin, Shortell, & Keeler, 2004). A central goal of a learning collaborative is to grow a culture of quality in which systematic implementation of research findings can be adapted to local conditions. These approaches are designed to simultaneously solve business problems, guide quality improvement, provide training to staff, and build a foundation for longer-term change (Dückers, Spreeuwenberg, Cordula, & Groenewegen, 2009).

Learning collaboratives can range in size from three to 20 units with staff teams or organizations. Bringing these groups together is referred to as “learning sessions,” and these may spread over the lifetime of a project. Learning sessions can range from three two-day meetings over 12 months to eight to ten 1- or 2-day meetings. Between sessions, the groups implement their action steps and collect data. Technology, such as webinars and video conferencing, can be used to enable group meetings with long-distance stakeholders. Problems may be identified in advance or jointly defined. These same problems are best solved when various stakeholders identify and agree to a mutual or shared solution, rather than a series of connected problem areas. Finally, the projects with the most success are those where there is an existing evidence base in the literature and thus, readily available data.

How they Work

Dougherty (2007) provides a practical description of a learning collaborative. They work like this: Collaboratives start with an analysis of where your organization is now. The first goal is usually to “improve performance,” which occurs through a series of focused short-term interventions and improvement methods nested within a long-term goal. Next, groups of various staff members from different settings work together to define action-oriented, specific project aims, measures, and interventions. One method that has extensive testing in the field of addiction treatment is Plan-Do-Study-Act (PDSA) method. Common questions that emerge from this method are: “What are we trying to accomplish?” “How will we know that a change is an improvement?” and “What changes can we make that will result in an improvement?” This is an incremental approach to quality improvement that translates research into practice through the systematic implementation of research findings into local conditions. Barriers are identified and data are used to drive systematic improvement. Ultimately, learning collaboratives are data-based change processes that focus on quality improvement of some kind.

Examples of Learning Collaboratives

Examples of mental health and substance abuse–related collaboratives include the Robert Wood Johnson Foundation Depression and Primary Care Initiative, the California Institute for Mental Health's California Learning Collaborative, and the Massachusetts Department of Mental Health's Readmission Collaborative. The Substance Abuse and Mental Health Services Administration (SAMHSA)–Center for Mental Health Services (CMHS) has recently awarded several large grants to states to conduct learning collaboratives (SAMHSA, 2009). Examples of learning collaboratives can be seen in efforts to improve services for children. Dougherty (2007) describes a mental health collaborative that was formed to improve access to services through first-intake appointments for children requiring care for mental health conditions. The collaboratives consisted of the New York City Department of Health and Mental Hygiene, Mount Sinai School of Medicine, and the New York State Office of Mental Health. Another example of a learning collaborative for children and mental health is taken from the Mississippi State Department of Health/Child Mental Health Initiative–Pine Belt System of Care project (Jackson, Mississippi). The state was awarded a six-year (2006–2012), multimillion-dollar grant to establish a system of coordinated, individualized care for children affected by severe emotional disturbance (SED) or co-occurring SED and substance misuse. The project is sponsored by three Mississippi organizations, is based on work set by the Center's Children's Mental Health Initiative and other systems of care initiative—all of which have solid track records—to ensure its successful completion. Its primary aim is to establish a local system of care of underserved families and youth and to serve as a national model for systems of care in rural areas.

What makes a Successful Learning Collaborative?

Øvretveit and colleagues (2002) have listed four factors shown to be important to a collaborative success: 1) projects need to be practical and relevant to the organization and stakeholders; 2) senior managers are involved and supportive; 3) objectives are relevant, reasonable and measurable; and 4) there is a plan to infuse and spread the findings among the staff and throughout the stakeholder organizations. Dougherty (2007) reminds us that, ultimately, learning collaboratives are data- and information-guided ways to simultaneously solve mutually agreed upon business problems (e.g., children's lack of access to mental health services through the intake process), provide training to staff, and build a foundation for longer-term change.

BENCHMARKING AS A STRATEGY FOR IMPROVING PERFORMANCE THROUGH BEST PRACTICES

Benchmarking is a systematic process involving the search, introduction, and implementation of best practices. Although originally used in management, the concept of benchmarking is now a common practice in behavioral healthcare quality management circles. Owen (2007) describes benchmarking as:

the search for best practices that can be applied with a view to achieving improved performance. It is a systematic and continuous process of measuring and comparing an organization's business

processes against those of leaders anywhere in the world, to gain information which will help drive continuous improvement (p. 180).

Benchmarks attempt to answer the following questions: Who is doing the best? How do they do it? How well are we doing relative to the best? How good do we want to be, relative to the best? Benchmarking generally includes the following stages:

- 1) Identification of the area of operation to be benchmarked;
- 2) Identification of best practice in selected organizations or sections of organizations;
- 3) Collection and analysis to determine the common characteristics of this practice;
- 4) Development of best-practice indicators and levels to be achieved on these indicators;
- 5) Communication of best-practice indicators internally and gaining of acceptance;
- 6) Development and implementation of plans to achieve these levels;
- 7) Progress monitoring; and
- 8) Full integration of practice into the functioning of the organization

It should be noted that Stages 1–4 are the first steps in establishing benchmarks, whereas Stages 5–8 apply the benchmarks to operations of the organization. Ultimately, any organization that is using learning collaboratives to implement process change or evaluate outcomes of evidence-based practice interventions, benchmarking is one strategy that leadership will probably want to utilize.

INTERDISCIPLINARY TEAMS

As mentioned previously, learning collaboratives as well as other models of care recommended by the Institute of Medicine (2006), like the “chronic care model” (Wagner, 1998), will require professionals to shift from solo practice roles to interdisciplinary roles. Along with this shift will come an expansion of old tasks and acquisition of new tasks and skills (Gilbody, Whitty, Grimshaw, & Thomas, 2003). One method for addressing these changes is for management to support the training and structuring of interdisciplinary team models of caregiving.

We will begin with this assumption: Quality management could not exist without staff to manage, and the best staff arrangements are those that exist in an interdisciplinary team configuration. But what is an interdisciplinary team?

Definitions

Interdisciplinary work is now considered a mainstay of behavioral health care organizations. The term *interdisciplinary* refers to a systematic process of developing the ability to analyze and synthesize from the perspective of various disciplines (e.g., psychiatry, public health, social work). Its goal is to recognize and integrate the relationships between all the individual elements, synthesize and link disciplinary knowledge, and put it within a larger systemic framework. In other words, specialists may work interactively with non-specialists to study a problem, integrate their multiple viewpoints, and make recommendations to solve a specific individual, family, community, or organizational issue. Other terms that are used simultaneously to refer to this approach

are *multidisciplinary* and *transdisciplinary*. Interdisciplinary differs from multidisciplinary and transdisciplinary approaches in that multidisciplinary approaches are where several disciplines are brought together with no systematic attempt to collectively integrate or synthesize the information. A transdisciplinary approach operates from the assumption that, regardless of one's discipline, all knowledge is valuable and that dividing issues up by discipline is neither helpful nor practical for solving real world issues. As the "trans-" prefix implies, transdisciplinary approaches go beyond disciplinary divisions. In other words, problems and solutions are drawn from many disciplines in order to build understanding, content, and methodology (Cohen & Bailey, 1997; Sellamna, 2011).

Interdisciplinary work generally begins when specialists contribute their experience and disciplinary knowledge of concepts, methods, and tools, working interactively with other specialists in a team to study the problem and make recommendations to solve it. These specialists come together to form the interdisciplinary team. Cohen and Bailey (1997) define a *team* as:

a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems (e.g., mental health organization) and who manage their relationships across organizational boundaries (p. 2).

A team usually consists of at least two individuals who have specific roles, perform independent tasks, are adaptable, and share a common goal (Cohen & Bailey, 1997).

An example of an interdisciplinary team at work would be when a psychiatrist, social worker, public health nurse, and dentist work together to research key problems in supporting oral health for mental health clients with dental diseases and then provide a drop-in "Health and Wellness" class weekly at the local community mental health agency. The class may be staffed by dental technicians, run by the public health nurse, and coordinated by the social worker, with medications managed by the psychiatrist.

Steps for Establishing a Team

Behavioral healthcare organizations utilize teams that are suited to its own needs. There are three steps that any one team must establish from the get-go. *First*, establish the aim. What is the team trying to accomplish? *Second*, consider the system that the aim is addressing. What will tell us if the change represents an improvement in the system? *Third*, create an inclusive team that represents different parts of the intended change process. Who is needed from different parts of the organization—from managers to front-line workers—who can promote change toward improvement? (Institute for Healthcare Improvement, 2011).

Strategies for Interdisciplinary Work

There are four tenets of interdisciplinary work: 1) complex problems require an interdisciplinary approach; 2) teams require shared objectives; 3) teamwork involves both individual and collective activities; and 4) teamwork involves understanding the value systems of other disciplines (Sellamna, 2011). Let's explore some of these tenets in more detail as they relate to quality management and, later, program evaluation.

- Tenet 1: Complex problems require an interdisciplinary approach.

Many of the individual and systemic issues that clients and organizations face can only be studied and solved through cooperation between several disciplinary competencies. Fiscal managers (e.g., MBAs or CPAs) need to have an understanding of counseling staff's (e.g., LPCs, MSWs) clinical and time demands in order to develop realistic performance measures. One example of a complex problem is the many clients who experience the symptoms of mental illness complicated by severe health issues (e.g., untreated diabetes). These individuals may require multiple community contacts by outreach staff just to engage in services. Without an understanding of the time needed for outreach services, fiscal management could create restrictive, office-based performance indicators that have little relevance to real-time activities that constitute the work world of staff. Quality management includes opportunities for different disciplines in different departments to strategize together on mutually complex problems that are the responsibility of the agency as a whole.

- Tenet 2: Teams require shared objectives.

Part of what constitutes quality management is the notion of shared values. In all teams, it is important to have commonly agreed-upon objectives. These values should be formulated in a way that appeals to and includes all the disciplines present in the team and at which the "bigger picture" is made explicit (Sellamna, 2011). Although an interdisciplinary team may be given specific guidelines about their department's or unit's objectives, they will still need an opportunity to discuss different disciplinary viewpoints, and come to a common definition of the purpose of the team's activity and the specific outputs expected from the team. Once a common understanding is established, the team can go on to find common ground through a definition of the central issues, goals, or problems. The various viewpoints have the benefit of providing different views about the problem and different approaches to the issues. For example, mental health case managers may advocate that clients have the right to refuse medication without fear of being hospitalized against their will, whereas the medical team may strongly feel that certain clients are a danger to themselves and society without their medication, and should be hospitalized against their will if necessary. If the two sets of providers, along with the client, find a common point of understanding, such as "choice" or "client rights," then the team can better operate with shared objectives rather than competing objectives.

- Tenet 3: Teamwork involves both individual and collective activities.

Key strategies for working in interdisciplinary teams include identifying and acknowledging disciplinary contributions, individual capabilities, and variation in tasks. The goal is to find the right balance between collective and individual activities. Certain activities best done in teams are to produce ideas, exchange experiences, communicate information, and make decisions. Activities best done by individuals include gathering information, elaborating on ideas, implementing a team plan, and formulating or writing reports. For example, an interdisciplinary team may collectively agree that in-home visits are vital to the support of at-risk, medically fragile mental health consumers living independently. It is, however, the psychiatric nurse practitioner who is deemed the most appropriate person to conduct these home visits, due to the specialty health care background he possesses.

- Tenet 4: Understanding the value systems of other disciplines.

Behavioral health care organizations are composed of a rich array of staff, clinicians, and professionals. Each of these individuals emerges from different disciplines with different knowledge constructs and values. In other words, they have different concept “maps” about what they need to do. By understanding these different concepts, they can then understand and appreciate what other disciplines can offer and how they can contribute to the goals of the program, understand the specific language of their colleagues and better communicate with them and see the similarities and differences with their own specific discipline. For example, team building exercises could include a review of each discipline’s professional code of ethics. Psychologists, nurses, psychiatrists, social workers, and counselors all operate under a code of ethics specific to their discipline. These guidelines typically influence the value base of the person’s profession, which is often reflected in their practice style. By understanding your colleague’s code of ethics, you may have a better glimpse into their practice style.

What makes a Successful Team?

In order for interdisciplinary teams to be effective, actions must be taken by both management and employees. Let’s first look at the role of management. Two key management actions are needed: 1) support and active involvement by top management and 2) training in the practice of collaborative practice behaviors. Executives have to communicate a vision or key values and provide strong organizational support that stimulates employees’ willingness to change from old-practice models (i.e., solo) to team-practice models (Mills & Weeks, 2004). In order for staff to have the requisite skills to engage in interdisciplinary teams, it will be necessary for management to provide training and development in collaborative practice behaviors, such as effective communication and conflict resolution (IOM, 2006, p. 242). Collaboration is enhanced by a shared understanding of agreed-upon collective goals and new individual roles (IOM, 2006, p. 242). In addition, new communication patterns and changes in roles can be uncomfortable for behavioral healthcare professionals. It is common for staff to experience role confusion and conflict when asked to work in personnel arrangements they are unfamiliar with. Active training and support in the skills necessary for interdisciplinary work from management can help reduce these conflicts.

Employees also play a key role in how effective their teams will be. If organizational improvement often hinges on the effectiveness of its interdisciplinary teams, how do we constitute effective teams? The Institute for Healthcare Improvement (IHI, 2011) identifies three different kinds of employees that represent different kinds of expertise within the organization: *system leadership*, *technical leadership* and *day-to-day leadership*. An effective team will have a system’s leader who has enough authority to be able to cut through bureaucratic obstacles when a plan is devised and who can allocate the time and resources to achieve the aim identified by the team. A person who represents clinical technical leadership will provide credibility when it comes to knowing the subject matter intimately and can help devise methods for determining what to measure, selecting effective measurement tools, providing guidance on data collection and most critically, interpretation and display of data. A day-to-day leader can be a central player in the team in that they understand all the ins and outs of the system but also know the downstream impact of identified aims and changes in the system. Having the ability to work seamlessly and

diplomatically among disparate groups also helps a lot. One example of this model is illustrated below:

Example 1: Reducing waiting lists for intake appointments referred by Crisis Clinic.

Aim: Our clinic will improve the intake appointment time from one week to same day for all referrals sent to clinic from Crisis Team.

Team: Leader, M.D., Psychiatrist and Medical Director in charge of admissions and referrals for clinic;

Technical Expert, MSW (Master's Level Clinician)—understands process and delays related to calls, scheduling, computer referrals, and intake information and scheduling of on-call staff to cover intake schedule;

Day-to-Day Leader, PNP (Psychiatric Nurse Practitioner), Manager of the clinic, who coordinates all referrals;

Additional Team Members, front-line desk staff, on-call staff, scheduler.

PROGRAM EVALUATION: WHAT IS IT AND WHY SHOULD WE CARE?

Once an organization has instituted a robust interdisciplinary team approach to client care, a natural next step would be to determine if the services provided are needed and which ones are effective. This is where program evaluation becomes the tool of quality management. It is systematic assessment, using as valid and reliable scientific research methods as possible, that examines the processes, outcomes, or performance of an organization and/or monitors change for groups of clients (Grinnell, Unrau, & Gabor, 2011). The purpose of program evaluation is to “improve efficiencies, effectiveness and the experience of services” (Grinnell, Unrau, & Gabor, 2011; p. 522). A central theme of any program evaluation is its accountability to stakeholders groups (Posavac & Carey, 2007). It is guided by a set of philosophies and methods that aim to determine “what works” and report back its findings to various stakeholders—for example, clients, professional groups or organizations, funding bodies, and regulatory agencies. Clients value assurances that services offered are effective; professionals appreciate understanding what works for different client problems and groups; funding bodies demand accountability that allocated funds result in effective outcomes; and regulatory agencies monitor agency or program compliance with legal mandates (Bamberger, Rugh, & Mabry, 2007).

Guiding Principles for Evaluators

Program evaluation is often conducted within the context of the needs of individuals and communities or organizations. Owen (2007) reminds us of the sensitive role that evaluators assume when they are asked to assess an organization's or team's performance. He notes that the evaluator can be regarded as an outsider or insider relative to the “client” (organization), and the evaluative contributions might include that of consultant, educator, or change agent. Without clear, guiding principles, these roles can lead to conflict between the evaluator and management or between evaluator and program provider. The reputation and career of the evaluator depend on providing accurate and candid information, while a program manager's career may be bound up with the provision of successful programs, free of conflict or negative impact.

To help guide program evaluators, Owen (2007) has listed five principles endorsed by the American Evaluation Association that can serve as codes of behavior. These are summarized below:

- **Principle of Systematic Inquiry:** Evaluators conduct systematic, data-based inquiries about whatever is being evaluated (p. 156). They utilize the highest level of technical standards in order to increase the accuracy and credibility of the evaluative information they produce.
- **Principle of Competence:** Evaluators provide competent performance to stakeholders (pp. 156–157). Evaluators should practice within the limits of their profession and expertise, provide the highest level of performance in the evaluation, and actively engage in continuing professional development to upgrade skills and expertise.
- **Principle of Integrity and Honesty:** Evaluators ensure the honesty and integrity of the entire evaluation process (p. 157). Evaluators should negotiate honestly with clients and all stakeholders regarding costs, tasks, and limitations of methodology and make explicit any conflicts of interest or disclose roles or relationships that would compromise findings, as well as communicate concerns in a forthright manner.
- **Principle of Respect for People:** Evaluators respect the security, dignity, and self-worth of the respondents, program participants, clients, and other stakeholders with whom they interact (p. 158). Evaluators should attempt to foster the social equity of the evaluation such that those who gave to the process receive some benefits in return, and in the event that negative results are found, the information is shared in a manner that respects the stakeholders' dignity and self-worth while still communicating the truthfulness of the findings.
- **Principle of Responsibility for General and Public Welfare:** Evaluators articulate and take into account the diversity of interests and values that may be related to the general and public welfare (p. 159). Evaluators have the responsibility of considering, not only immediate outcomes for the agency, but how the findings are related to broader assumptions, implications, and potential side effects, and therefore, in the spirit of transparency, make available access to evaluative information by stakeholders impacted by results.

Types of Program Evaluation

Kettner and colleagues (2008) describe four common types of program evaluations that are seen in community mental health organizations. These are (1) *needs assessments*, (2) *process evaluations*, (3) *outcome evaluations*, and (4) *cost-efficiency/effectiveness evaluations* which are also known as *cost/benefit analyses*.

Needs Assessments

Two of the initial questions asked in quality management are “What are the needs of a community?” and “Are current services still needed?” A needs assessment is an evaluation whose aim is to determine the nature, scope, and locale of a particular problem, and propose practical solutions to the problem (Hatry, Cowan, Weiner, & Lampkin, 2003). Specific needs assessment questions include examining demographics (e.g., describe characteristics or profile of people to be served), history of problem (e.g., what has worked in the past), demand for services

(e.g., describes needs and service gaps of targeted clientele), and strengths (e.g., identify assets of community).

An example of a need assessment is an approach called a “context evaluation.” The purpose of a context evaluation is to develop a program rationale through the analysis of unmet needs and unused opportunities. This approach describes discrepancies between what is and what is desired. The strengths are that the program’s effectiveness is enhanced when the conceptual basis for the program (e.g., free medication for impoverished clients) is perceived needs; in other words, the program’s values match its approach. The limitation is that the target audience may fail to recognize or express needs. A sample question from an input evaluation would be: “What are the needs of low-income mental health clients who do not have access to health insurance for medication?”

Process Evaluations

Process evaluations facilitate quality management as it evaluates what is happening in a program or set of services. Its aim includes describing the nature of services (e.g., type, frequency, duration) of real-time program operations and client service activities. In other words, process evaluations try to determine what is actually done in the service delivery in order for it to be replicated by others and elsewhere. If we are not doing the service, program, or intervention correctly, then if there is any quality, it is pure luck; quality management does not want to hear “it didn’t work because we didn’t do it right!” There wouldn’t be much quality in that, and, if anything, it would be quality mismanagement.

Specific process questions include examining program structures (organizational structure of communication and decision making), program supports (what supports exist for workers to do their jobs), client service delivery (what do workers do and how often?), decision making (who makes decisions and how documented?), program integrity (determine fidelity to original blueprint and how closely it is being followed), and lastly, compliance (does program adhere to internal and external standards established by the administration, funders, and external bodies such as government or accrediting bodies?).

An example of a process evaluation is an “input evaluation.” The purpose of an input evaluation is to identify and assess program capabilities. This approach describes strong and weak points of strategies for achieving program or agency objectives. The strengths are that it provides useful information to guide program strategy and design. The limitations are that the approach can be complex and frustrating if priorities and aims are not set at the beginning and followed. A sample question from an input evaluation would be: “Are case management in-home visits or in-office appointments more appropriate for the target population the agency works with?”

Outcomes Evaluations

Outcomes evaluations are a third type of evaluation whose aim is to determine the amount and direction of change experienced by clients or participants during or after the receipt of an agency’s services (Lampkin & Hatry, 2003). Awkward as it sounds, the area is *outcomes*, plural, as few program or clinicians have a single outcome. Some specific outcomes questions examine program integrity (are benchmarks being met and goals achieved?), program effects (are clients better off after having received services than before, not worse?), differential effects (does one

group benefit over the other and if so, how and why?), causality (what's the evidence for effectiveness?), and lastly, satisfaction (e.g., client and stakeholder satisfaction with services).

An example of an outcomes evaluation is an approach called "impact evaluation." The purpose of an impact evaluation is to describe direct and indirect program or agency effects or results. This approach addresses the impact of a program on the program recipient. The strengths are that it tests the usefulness or success of a program in ameliorating a particular problem or issue. Limitations include the fact that it is difficult to establish causality using scientific methods of evaluation. A sample question from an impact evaluation would be: "Are participants able to improve their communication skills with family members after participating in a Youth Only Rap Group?"

Cost-Efficiency/Effectiveness Evaluations

Cost-efficiency/effectiveness evaluations are a fourth type of evaluation, whose aim is to demonstrate fiscal accountability of costs associated with providing services to specific populations (Newmann, 2005). Specific cost-efficiency/effectiveness questions include examining unit costs (average cost per client, per unit of service—such as intake, intervention and follow-up), cost distributions (such as percentage of costs for direct and indirect services such as therapy and administration), and cost reduction/recovery (can costs be reduced or recovered without loss of quality?).

An example of a cost-efficiency/effectiveness evaluation is an approach called "cost-benefit evaluation." The purpose of a cost-benefit evaluation is to describe the economic efficiency of a program regarding actual or anticipated costs and known or expected benefits. This approach compares program costs and program outcomes in terms of fiscal amounts. The strengths are that it is useful for convincing policy makers, funders, and regulatory decision makers that dollar benefits justify the program costs. Limitations include difficulty in quantifying multiple outcomes in monetary terms and expressing costs and benefits in terms of common program denominators. A sample question from a cost-benefit evaluation would be: "What was the total estimated savings to society as a result of client diversion from prison to state hospital settings?"

HOW TO MEASURE BEHAVIORAL HEALTHCARE QUALITY MANAGEMENT

Overview

"Quality management," as defined here, is a complex interaction of person, process, and practice to select the best evidence-based interventions. As applied here, program evaluations in general, and benchmarking in particular, are the organization's effort to provide systematic and continuous feedback about what seems to work with the particular agency, the particular clinician, and the agency's particular clients. As such, measurement is useful at the agency, program, and individual client levels. It includes needs assessments, process evaluation, outcomes assessment, and cost/effectiveness analysis, all with the purpose of managing quality to assure more effectiveness. Emphasis here will be given to the individual-client levels of measurement and process measures.

At the individual-client level, use of an evidence-based practice does not ensure effective outcomes. Clients are different in many ways, including their motivation to change and resources to facilitate change. Similarly, clinicians are humans with varying degrees of talent and training; they even seem to vary day to day over the course of a career. No two are the same, and no one stays the same. Therefore, continuous assessment ascertains what seems to work, and it is important feedback to the individual clinician and the organization. Similarly, in spite of the uniformity of evidence-based practice (EBP), its applications vary from setting to setting, from clinician to clinician, and from client to client. While EBPs tend to be more standardized in the application, they are not cookbook recipes but should be adopted to fit the form to the client's fuss.

In so doing, the agency needs continuous measures to ascertain if the client outcomes are as desired and designed by the evidence-based practice. Measurements allow the clinician and agency to determine if positive outcomes are being obtained, either by obtaining specific goals or the reduction in mental health symptomatology. Most mental health systems that strive for improvement often find themselves relying on various kinds of measures to observe change in behavioral healthcare. There are different measurement tools for whether the quality management is assessing the need, the process, outcomes, or cost/effectiveness.

Outcomes measures are from the perspective of the client or patient and determine how the system is performing as well as the impact on the client's problem. For example, at the system level, "access" is a critical measure of quality. Simply stated, the best program is of limited value if it is inaccessible for whatever reason: location, transportation, hours of operation, allied services, and so on. One access measure that clients find critical is time. This is in terms of the number of days between calling for a mental health appointment and being seen for the appointment. It also includes how much time is spent in the waiting room in advance of a scheduled appointment; few clients/consumers like being kept waiting.

Using measures of the client's progress over the course of treatment provides continuous feedback of the client outcomes and the clinician's performance. These measurement tools may be used to compare a client's progress over the course of the treatment by comparing changes in his or her scores. Alternatively, client scores may be compared with norms to determine if their scores are similar to, or distinguishable from, clinical samples and the general population. Outcome measures are best when they are short, rapidly completed, and quickly scored in order not to interfere with the limited time available for each individual client. One resource describing over 600 rapid-assessment instruments for problems of individuals, couples, families, and children is Fischer and Corcoran (2007). Using a rapid assessment tool at the beginning, middle, and end of a program or treatment provides persuasive evidence of client change and, to a lesser degree, clinician effectiveness.

Process measures are useful at the system level to determine if the public health needs are being met or are in need of particular services that are currently missing. The needs may be anything ranging from transportation, to hospital beds, to treatment programs for marginalized populations such as immigrants, teen moms, the unemployed; and the list continues.

Additionally, process measures enable the organization to determine whether specific parts or steps in the system are performing as planned. One example is staffing. Continuous assessment is necessary to determine how many clinicians and support staff members are available each day to see the number of clients requesting services, which itself varies from day to day and over the course of a year. At the clinician level, process measures facilitate determining if the treatment complies with the evidence-based practice procedures. These measures are

known as a “fidelity checklist.” A fidelity checklist enumerates the critical components of the program and describes them so others can determine if they are true to the program they are trying to replicate, whether with a new client population or a new setting. They typically accompany evidence-based practice manuals or are published separately (Smock, Trepper, Wetchler, McCollum, Ray, & Pierce, 2008).

Balancing measures are from the perspective of looking at a system from different directions or locations to determine if changes in one part of the system caused unintended consequences in another part. One example is involuntary admissions. The quality management issue might well be whether admissions to long-term units are going up as a consequence of diverting mentally ill people from jail and into diversion programs that provide indefinite hospital stays. While a hospital is sometimes a preferable facility for treating mental illness, it comes at a cost, and quality management is needed to correct any adverse impact. Similarly, do drug courts result in less use of treatment and more reliance on crime, punishment, and restitution? And if so, how is the quality of services managed? One common example of the concern for balancing measures is putting the desired “speed bumps” in streets of neighborhoods with children, until there is a need for ambulances as the neighbors get old; slowing traffic down is good for children and bad for someone with a heart attack.

LIMITATIONS IN MEASUREMENT

“You can’t improve what you can’t measure” is a common maxim in behavioral healthcare, which was heralded nearly four decades ago (Hudson, 1978). Measuring the quality of care provided by individuals, organizations, and health plans and reporting the results is linked both conceptually and empirically to reductions in variations in care and increases in the delivery of effective health care.

Uses of measurement in practice, whether at the individual client and clinician level, are not without limitations. First of all, there is no general agreement in behavioral healthcare about which measures to use. In health care, there is a consensus that blood pressure, temperature, pain, and problems with intake or output are indicators of health concerns and are routinely ascertained using standardized assessment procedures. The behavioral healthcare industry does not have such uniform indicators of mental health or mental health condition. Indeed, depression and anxiety are related to many if not most mental health conditions, although there is no agreement on the best assessment procedures.

Moreover, limitations in measurement are just not an agency-specific challenge or due to lack of instruments, but also due to the separation of mental illness and substance use from physical health care. The whole behavioral healthcare industry is challenged. For example, the National Healthcare Quality Report (AHRQ, 2003) identified mental illness as a clinical area lacking broadly accepted and widely used measures of quality. They found that, of 107 measures of the effectiveness of health care, only seven addressed mental health: three were for the treatment of depression in adults, one for suicide, and three for management of delirium and confusion in nursing homes. None addressed the quality of care for substance-use problems and illnesses. And yet compendiums reprinting hundreds of measurement tools are available (e.g., Corcoran & Fischer, 2014) and have been for over 30 years. The big issues are lack of quality measurement and reporting infrastructure; so what can management do about this? One source of answers is the Institute on Medicine report *Improving the Quality of Healthcare for Mental and*

Substance Use Conditions (IOM, 2006). This stellar report advances eight functions for effective measurement of quality:

1. Effectively measuring quality and reporting results to providers, consumers and oversight organizations requires structures, resources and expertise to perform several related functions:
2. Conceptualizing the aspects of care to be measured
3. Translating the quality of care measurement concepts into performance measure specifications
4. Pilot testing the performance measure specifications to determine their validity, reliability, feasibility and cost
5. Ensuring calculation of the performance measures and their submission to a performance measures repository
6. Auditing to ensure that the performance measures have been calculated accurately and in accordance with specifications
7. Analyzing and displaying the performance measures in a format or formats suitable for understanding by multiple intended audiences such as consumers, health care delivery entities, purchasers and quality oversight organizations
8. Maintaining the effectiveness of individual performance measures and performance measure sets and policies over time (p. 181).

These functions require a coordinated approach that maximizes the efficiency and effectiveness of various efforts. These useful and government-endorsed guidelines are delineated in detail, and yet in summary, measurement instruments should be selected judiciously as performance measures of quality. Examples of quality performance measures include reducing the waiting list time for the crisis center and increasing client service satisfaction.

In spite of the limitations of measurement, remembering that scores are merely *estimates*, numerous instruments exist for almost every client problem and agency or program goal. The biggest problem remains what it has been for decades—clinicians simply don't use them! In order for program evaluation to actually be a tool of quality management, the task remains how to get instruments to be used *routinely*. Without measurement tools, there are no program evaluations, and in turn, quality is not managed.

FUTURE DIRECTIONS

So far we have illustrated how quality management is a function of leadership, "teamship," and the use of program evaluation as a tool for assessing quality. Program evaluation is taking a more front-and-center role in the interdisciplinary movement toward evidence-based practice in behavioral health care organizations (Mullen, Bellamy, & Bledsoe, 2005). Why? One way to explain this movement is what appears to be a future trend toward an increase in governmental audits and program reviews. Given the increasing climate of distrust shared by taxpayers and certain political affiliates toward any form of government-supported services (think Social Security and Medicaid), program administrators will be increasingly asked by funders and or politicians to provide more data and "proof" that their programs are working. This will require

more standardized evaluation techniques, a differently trained workforce, and a management team that is both nimble and ready to provide critical data. Program evaluation will no longer be considered either a luxury or a nuisance, but a necessary prerequisite to the acquisition of (renewed) funding. Behavioral healthcare organizations must be prepared to rise to these new expectations, and they themselves set the standard for what is quality.

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A SOCIAL SYSTEMS PERSPECTIVE ON LEADERSHIP IN SYSTEMS OF CARE

PHILIP CASS, GRAYCE M. SILLS, AND LAURA WEISEL

This book is filled with information about a wide variety of best practices thought to be useful in the work of community mental health. However, a central issue remains. How does one work from this plethora of information to implementation of new practices and ideas in the workplace?

Numerous case examples have been provided to richly illustrate the benefits of the many practices described. We have been given the benefit of the described experience of system changes at the state level in Chapter 34, “Transformational Leadership in Mental Health” (Svendsen, Hogan, Wortham-Wood). We have been enlightened by the excellent work in the chapter “Psychiatric Risk Management: Efforts to Reduce Unseen Outcomes (Winters, Teague & Yeager). The chapter on trauma-informed care and treatment brings to the cutting edge of contemporary understanding the phenomena we treat under the rubric of mental health care. The two chapters presenting differing perspectives on medication management give us some insight into the complexity of this critical element of treatment. So in a sense this text has provided a library of rich and varied musical compositions but has yet to address how that music comes to life in a real-world performance.

What follows in this final chapter is an effort to explicate some additional answers to the question of how these best practices can be brought to life in the milieu of community treatment and care. How can we move beyond best practices, co-creating innovation and the future of community mental health? Can we make the music come to life—as a soloist, an ensemble, or a full-throated orchestra in collaboration with each other, the conductor, and the composer?

The argument made here is that leaders must have a clear sense of purpose, an enlightened understanding of one’s own sense of self and being. That is thought to be necessary, but not sufficient, to lead sustainable changes within systems. One must also have a systems view/perspective

that leads one automatically to veer from blame-and-shame attributions as the source of problems but rather to a broad examination of multiple perspectives on the problem or issue at hand.

In this chapter, we present practices that augur well for a future that will require the best efforts from all the participants in the process to engage with one another in ways that may be new and unfamiliar. As we know, comfort lies in the familiar. We hope this chapter may create some discomfort *and* that on the way you find new and energizing ways to create and sustain system-change.

THE BLIND SPOT OF OUR TIMES

“The blind spot of our times,” is a phrase that Otto Scharmer coined in his book *Theory U—Leading from the Future as It Emerges* (Scharmer, 2009b). There is a plethora of leadership literature that helps us understand the importance of clearly defining and measuring the results we are trying to achieve. There is even more literature written about the processes needed to achieve those results. However, there is a third dimension required in the equation that describes social reality, and that is the dimension of “who.” It is this inner place from which leaders operate that Scharmer defines as the *blind spot* of our times. How we pay attention affects how things emerge, or as Scharmer said, “I pay attention this way, therefore things emerge that way” (Scharmer, 2009b, p. 228). Using the formula $r = f(a)$, where “r” is social reality and “a” is awareness, awareness becomes the key intervention point in work designed to shift social reality (Scharmer, 2010).

All one needs to do for this to become obvious is to do an inventory of the people whom we hold in the greatest esteem. These may be people we directly know (a favorite teacher, professor, parent, grandparent, mentor, supervisor, etc.) or people about whom we’ve read (Gandhi, Martin Luther King, Abraham Lincoln, the Dalai Lama, etc.). When we ask ourselves, “What was it about these people that made a difference in me and in the lives of others?” we discover that these people seem to operate more consistently than most from their highest possibility. Those operating from this highest possibility almost always seem to have characteristics that include large ego/no ego, personal power/personal humility, self awareness/awareness of others, knowing/not knowing, the capacity to be present/the capacity to suspend, wanting/not wanting. Somehow, the individuals whom we hold in great esteem developed the capacity to hold, work with, and transcend the great paradoxes of life in a way that makes a difference in people’s lives. And, somehow we discover ourselves in them, and they simultaneously embody us within themselves. They are transcendent leaders. Transcendent leaders go beyond transformation (changing structures, appearance, or character) and invite us to be our highest possibility.

Is this capacity to transcend (exceed the usual limits) really the key element in leadership? What makes this characteristic of transcendence the “road less traveled?” Again, in his book *Theory U*, Scharmer (2009) posits the notion that this is related to three different internal voices that we carry with us:

- The Voice of Judgment, which shuts down our capacity to operate with an Open Mind
- The Voice of Cynicism, which shuts down our capacity to operate with an Open Heart
- The Voice of Fear, which shuts down our capacity to operate with an Open Will (Scharmer, 2009a, p. 42).

In a world where we live day to day with a Congress that is stuck, an economic world order that is stuck, organizations and systems (both for profit and not-for-profit) that are stuck, and even personal relationships that are stuck, what are the necessary practices that transcendent formational leaders need to be engaging in? Perhaps what is even more important is what are the collective transcendent practices that groups of committed people can engage in that will make a difference? Albert Einstein suggested that “the world we have made as a result of the level of thinking we have done thus far creates problems we cannot solve with the same level of thinking which created them.” What are the individual and collective practices that develop higher-order consciousness in individuals and in groups? We will come back to these questions and some possible directions after we first explore two worldviews: the machine worldview and the living systems worldview.

TWO WORLD VIEWS: MECHANISTIC AND LIVING SYSTEMS

Wheatley (2006) laid out the tremendous influence that Newtonian thinking has played in almost all of our current organizations. Since the days of Newton and Descartes, we have seen the world, including ourselves and all of our organizations, as a “vast and complex machine that had been entrusted to our care” (Wheatley, 2006, p. 30). Newton and Descartes’ world is linear, can be objectively measured, and the whole understood by summing its parts.

We have been taught that if we can understand an organization and all of its parts through measurement, then we can understand its ultimate laws and can control it. This view, along with the early interpretation of Darwin’s theory of evolution, is based on “survival of the fittest” as opposed to the more contemporary understanding of the “survival of fit.” This belief has given rise to much of our economic theory, organizational theory, and leadership theory. Hierarchy (there are people who know and people who don’t know) and bureaucracy (a way that is thought to control resources and decision making) are some of its manifestations. While both Newtonian and Darwinian theory have been helpful in many ways, these theories don’t always serve us well in a world that is populated by human beings who do not behave by these same laws. As living beings we behave in a “living systems” kind of way. It also stands to reason that anything developed by humans will look like, behave like, and adhere to principles aligned with living systems and not aligned with machines. Organizations, built by human beings that are based on mechanistic principles to do things, are not “human” by their nature. Yet our organizations inescapably are living systems and incur great challenges when constantly confronted by mechanistic principles.

It should be no surprise that social media have become central to how we operate in today’s world. Social media are made up of some of these same characteristics (cells connected into networks) that are the building blocks of humans. What social media do is make visible already connected but invisible networks of human beings. These same kinds of networks are the building blocks of our human-made organizations and frequently go unseen. Nonetheless, they are there, operating within all organizations. We may think that we are leading our organizations in accordance with the structure, policies, and procedures that are documented in a manual, but that is seldom what is really going on throughout the organization. When we attempt to lead our organizations as though they are machines, we then can observe what goes on in behavioral healthcare organizations and in most organizations in general.

So, what appear to be the principles of living systems and the principles that can grow and sustain innovation and transformation, and reflect a real responsiveness to the people in organizations and communities? Margaret Wheatley and Myron Kellner-Rogers (Wheatley & Kellner-Rogers, 1999, p. 2) shed some light on this when they articulate the following:

- A living system only accepts its own solutions (we only accept those things we are a part of creating).
- A living system only pays attention to that which is meaningful to it here and now.
- In all nature, including ourselves, there is constant change without change management.
- Nature seeks diversity—new relationships open to new possibilities. It is not survival of the fittest but everything that is fit—as many species as possible. Diversity increases our chances of survival.
- Tinkering opens up to what is possible; here and now—nature is not intent on finding perfect solutions, but rather those that are workable.
- A living system cannot be steered or controlled; a living system can only be teased, nudged, and titillated.
- A system changes identity when its perception of itself changes.
- All the answers do not exist “out there.” Sometimes we must experiment to find out what works.
- Who we are together is always different and more than who we are alone. The range of creative expression increases as we join others. New relationships create new capacities.
- Human beings are capable of self-organizing, given the right conditions.
- The act of self-organizing shifts an organization’s work and culture to a higher order.

Here are some questions to consider if the future of behavioral healthcare lies in shifting the work and culture to a higher order.

- Based upon these characteristics of a living system, what are the individual and collective leadership practices needed to effectively lead and transform behavioral healthcare organizations/communities into a living systems framework?
- What are the individual and collective practices that develop higher-order consciousness in individuals and groups?
- Can these practices, i.e., the individual and collective practices, address the “who” in transformational/transcendent leadership?

LEADERSHIP TOOLS FOR WORKING WITH LIVING SYSTEMS

Beck and Cowan’s work on spiral dynamics (1996), which built upon the earlier work of Clare Graves (Cowan and Todorovic, 2005), suggested that there is a sequencing of stages of consciousness that is the result of the interaction between the human being and the environment in which they exist. Graves once said, “The development of the human being is an unfolding or emergent process marked by the progressive subordination of older behavioral systems to newer, higher order systems. Clearly we have a powerful and dynamic mind, one that can recalibrate itself.”

In view of the challenges and the opportunities in transforming behavioral healthcare and the leadership needed to both develop and co-create a viable future for behavioral health, are there practices that can assist leaders in all sectors of the behavioral healthcare system in the development of higher-order consciousness? We believe there are practices that do create the inner capacity for higher-order consciousness and hence move toward the ability to see a new, emerging, and different view of what it will take to “lead for the future as it emerges” (Scharmer, 2009b). What follows is a presentation of a few, if not all, of the useful practices and guides to a higher-order future.

INDIVIDUAL AND COLLECTIVE PRACTICES THAT FOCUS TRANSFORMATIONAL LEADERS AND INNOVATE TRANSFORMATIONAL CHANGE WITHIN HUMAN NETWORKS

First, as West meets East, ancient practices like mindfulness meditation are being subjected to the scrutiny of scientific inquiry and passing with flying colors (Williams and Zylowska, 2009). Individuals who consistently practice mindfulness meditation will attest to the long-term impact on their lives of “meeting their mind” every day. Developing the capacity to rest one’s mind on the breath and to see yourself and others in a larger context is available to us all. While the world is in constant flux, humans can personally practice slowing down, breathing with consciousness, taking the time to see the world more clearly, and make decisions from a cultivated inner space. Practicing mindfulness meditation shifts the place of awareness (the intervention point) of the person (the “who”) as leader as the intervener.

Mindfulness meditation is only one form of reflective practice. Tai chi, yoga, qigong, and the various martial arts are all gifts from the East that one can decide to learn and practice. Many people from many cultures have developed other reflective practices, including the practice of regular journaling. It was the practice of many of our grandparents to sit in prayer, say the rosary, or go to a place of worship on a daily basis. Harry Truman was known for his morning walks, and when you dig into the lives of the world’s most revered leaders, you almost always find that they engaged in some form of regular personal reflective practice.

The point is, we can develop various forms of reflective practice or contemplation that can aid in the development of our own levels of consciousness that have a direct effect on leadership and therefore impact the people and organizations where we are charged with leadership. It is suggested here that learning and adopting a form of personal reflective practice may be a requirement for those espousing to be transcendent leaders. Brian Arthur (1999), the legendary leader of the Hanover Insurance Company, is noted to have said, “The success of an intervention depends on the interior condition of the intervener.”

What are some collective practices that can aid in shifting the consciousness of groups of people (families, organizations, communities) that are living systems?

Over the past twenty years or so numerous dialogic processes have been developed and named that have their own ancient roots. These processes are being convened individually and together under the mantle of “participatory leadership” and include: Circle, World Café, Open Space, and Appreciative Inquiry. Each of these processes has an author, and an overview will be offered below.

Within the past fifteen years, leaders such as Toke Moeller and Monica Nissen from Denmark, along with numerous others, have brought these four practices together and offer them as “The Art of Hosting Conversations that Matter,” which they also refer to as “The Art of Participatory Leadership” (see “Art of Hosting,” www.artofhosting.org). They have demonstrated this practice in places as diverse as the European Commission; Columbus, Ohio; a village in Africa; Australia; New Zealand; Japan; across Europe; Canada; the United States; South America; and Mexico.

Weisel (2011) and others have brought these processes into learning, multidisciplinary education settings, and professional development as “participatory learning.” Together, these practices set a framework for building individuals and professionals who can respectfully work together on teams, organizations, advisory boards, learning communities, and in the development of social capital skills such as collaboration, problem solving, advocacy, leadership development, listening skills, creativity, and creating innovations.

In the context of organizations, Cass (Wheatley and Frieze, 2011) implemented these four “human technologies” as both an operating system for four non-profit medical organizations and in work with a statewide task force in the state of Ohio to redesign and create an innovative framework for transforming youth psychiatric service delivery.

CIRCLE

Baldwin and Linnea (Baldwin, 1998; Baldwin and Linnea, 2010) have been practicing, teaching, and writing about the ancient practice of “the Circle” for individuals and groups all over the world. The circle is an ancient form of meeting that has brought human beings together in conversations of respect for centuries. For many cultures, circles are part of their foundation. “What transforms a meeting into a Circle is the willingness of people to shift from informal socializing or opinionated discussion not a receptive attitude of thoughtful speaking and deep listening” (Nissen, Moeller, Cass, and Weisel, 2011).

WORLD CAFÉ

Juanita Brown and David Issacs have worked together in the development and evolution of a process called “the World Café” (2005). Café is a “method for creating a living network of collaborative dialogue around questions that matter in real life situations” (Nissen, Moeller, Cass, and Weisel, 2011). Café is a metaphor for how individuals, families, and communities have come together to share experiences, solve problems, and find common ground.

Café has a set of operating principles, assumptions, and etiquette for how to engage a group of individuals in gathering around tables and addressing questions that can both drive meaningful conversations and build on the shared experiences and ideas of everyone in the group. Multiple café tables, with four members per table, address a common question. The richness of these conversations is derived from the initial conversation and the hybrid of the conversations as participants move from one café table to another.

OPEN SPACE

The goal of “open space technology” is “to create time and space for people to engage deeply and creatively around issues of concern to them” (Nissen, Moller, Cass, and Weisel, 2011). The agenda is set by the individuals who have the desire and power to see the meeting as a tool to engage in conversations that are on topics related to a common issue. Open Space meetings result in transformative experiences for individuals and groups involved. Open Space is a simple and powerful way to catalyze effective dialogue and invite organizations to thrive in times of change (Nissen, Moeller, Cass, and Weisel, 2011).

Open Space operates with a set of principles and one law that clearly define the process. They work together to support an individual's passion around a matter of importance to them. The process of Open Space is an excellent framework for groups engaged in co-creating a strategic direction, conflict resolution, community planning, inclusion of multi-stakeholders, collaboration, and deep learning about issues and perspectives of multi-stakeholders.

APPRECIATIVE INQUIRY

Cooperrider developed “appreciative inquiry” in 1985 as a strategy for intentional change (Cooperrider and Whitney, 2005). Rather than looking at “what is,” Appreciative Inquiry seeks to pursue possibilities by looking at “what could be.” Appreciative Inquiry works with a “4-D” process:

1. Discover the “best of what is”—they identified where the company's processes worked perfectly.
2. Dream “what might be”—they envisioned processes that would work perfectly all the time.
3. Design “what should be”—they defined and prioritized the elements of perfect processes.
4. Create a Destiny based on “what will be”—they participated in the creation of the design.

Appreciative Inquiry is based on several guiding principles, including that a positive focus tends to deliver a positive effect. This principle of accentuating the positive goes beyond conventional business wisdom, which says the best way to overcome a major challenge is to focus on what you're doing poorly and determine how to improve (Kinni, 2003).

Some derivatives of these, such as the Pro-Action Café and the Story Harvest Process, have emerged as people have been working with these processes on a massive scale around the globe. These practices are being used by couples, in families, in meetings both large and small, in very large group settings, within organizations, and even within in whole communities. Using these processes as a framework for gathering groups of individuals together has been exploding all over the world because of the hunger within people to be in more meaningful relationships with each other. These collective practices can be taught and learned by all of us. However, like the individual reflective practices written about earlier, these, too, take discipline and practice, and are the most effective when hosted by people who have developed their own cultivated inner space.

Several pathways exist for developing one's capacity to cultivate their inner space. One such is The Presencing Institute, formed by C. Otto Scharmer (www.presencinginstitute.com) and his colleagues at MIT. They have developed practices such as learning journeys, sensing interviews,

and solo experiences in nature that facilitate individuals' moving away from their own self (as the sole reference point) to walking in another's shoes and beyond that to sensing from the whole what is wanting to happen in the future.

Others, including Block (Block, 2009) and again Wheatley (Wheatley, 2006) have been encouraging all of us to seek our answers in community. All of this does suggest that the transcendent leader may need to shift from being the *lone wolf* to being the *host* of the intelligence that already exists within his/her organization.

STORIES OF TRANSFORMATION

Like the practices that transcendent leaders utilize (previously described in this chapter) that are cultivated over time, transformation itself may sometimes appear to happen overnight, or subtly show over a prolonged period of time; the following stories tell us about several "root system" developments and some that are starting to show flowers.

SHIFT THE QUALITY OF CIVIL DIALOGUE IN A COMMUNITY

In 2005, in a Midwestern city, 36 leaders were trained in the "Art of Hosting Conversations that Matter." This initiative began with a long-term purpose by a small group of people to shift the quality of civic dialogue in their community. As of this writing, the small initiative has now grown into a major movement with over 600 trained individuals.

The process of hosting meaningful conversations has become part of the culture of a major university that is seated in that community, and is now being incorporated into numerous organizations including the Health Department, food bank, organizations serving people who are homeless, the Medical Association and free clinic, physicians' offices, the State Board of Regents, the Community Shelter Board, a child advocacy agency, city government, medical practices, the Chamber of Commerce, United Way, behavioral healthcare leadership development, the state Psychological Association, an MBA program for nonprofit leadership, and many more. In these settings and more, it is easy to find all types of meetings being held that are consciously hosted using the processes of Circle, World Café, Open Space, and Appreciative Inquiry.

A not-for-profit organization is finding great success with system changes in the delivery of primary healthcare. By simply instigating conversations that matter through good invitations to participate in conversations, this organization that holds no actual power—government authority, sanction by business, or legal authority—is being highly successful in creating significant systemic changes related to creating patient-centered medical homes. The not-for-profit organization was influenced by a set of ten public dialogues or assemblies on sustainable health hosted by a small group of committed citizens using the technologies comprised in *The Art of Hosting* along with key elements from Theory U (Scharmer, 2009). In *Walk Out/Walk On*, authors Margaret Wheatley and Deborah Frieze (2011) offer a complete story of this ongoing transformation.

CHILD AND ADOLESCENT PSYCHIATRIC CARE IN THE STATE OF OHIO

Similar to almost every state in the United States, Ohio has only a small portion of the child and adolescent psychiatrists needed to serve the needs of its citizens. The Ohio Department of Mental Health first commissioned a study to document this problem. One of the recommendations from that study was that a multi-stakeholder task force be established to investigate this issue more thoroughly and to deliver a set of recommendations to the director and to the governor on how to improve on this situation. A core team was selected to develop the question that was to be directed to the task force. The core team's question was, "What is required to increase access to child and adolescent psychiatric services across the State of Ohio?" The multi-stakeholder task force, comprising 25 volunteers, reflected the diversity of perspectives represented in this issue and included professionals as well as families of children and adolescents with psychiatric problems. The director of the Ohio Department of Mental Health appointed a chairperson for the task force. The chairperson proposed to use a "Change Lab" process based on the Theory U work of Otto Scharmer (2009a).

The Change Lab engaged all 25 task force members to first complete a review of the literature on increasing access to child and adolescent psychiatry services. Once steeped in the information from this literature review and from their own personal experiences, task force members were trained to do "sensing interviews" (Scharmer, 2009). These are two-hour in-depth interviews, are designed to help the interviewer and the interviewee get beyond what is on the surface of the issue, and help to develop a deeper understanding of the issue from a larger systemic and worldview. Sensing interviews are typically done in the context of the interviewee so that the entire experience of the interviewee can be taken in and the interviewer has a better context for understanding the issue from the interviewee's perspective. Sensing interviews took place with families, children, judges, mental health professionals, general healthcare professionals, directors of programs related to providing services to children with mental health challenges, child welfare professionals, along with many others who participated across the state of Ohio. All twenty-five task force members conducted at least two of sensing interviews. Once the interview process was completed, the task force met for a two-day residential retreat.

At the residential retreat, task force members spent time re-hearing the *voices* (what they actually heard) in the interviews and participated in some solo time in nature to reflect on what they were sensing *was wanting to happen*. Following the solo time, they did some "modeling" (rapid prototyping) using modeling clay, pipe cleaners, and other objects to quickly build three-dimensional models of what a future system of child and adolescent care could look like. Out of this rapid prototyping, three models emerged:

- A more holistic and integrated delivery system of care
- A more integrated funding system for care
- A model of a new advocacy effort to support children and adolescents and their families who struggle with these issues.

Following the retreat, the core team reconvened and wrote a draft report for the whole task force to review. Once the task force members made their changes, the report was finalized and sent to the director of the Ohio Department of Mental Health and to the governor. The report was finished just at the time when the governorship was changing hands in Ohio, so the report

had to be reintroduced in a new administration. A number of changes have been reported as a result of this work.

Because of the task force's work and recommendations, the integrated model of care became the main emphasis for mental health system reform, not just for the child and adolescent system but for the whole system of behavioral healthcare. At this time, the integrated model for child and adolescent psychiatric care is being experimented in a number of settings across Ohio. One interesting outcome of the task force's work is a collaborative project of all three Children's Hospitals in Ohio. From the task force study it became clear that it was not useful to spend an inordinate amount of resources trying to recruit more child and adolescent psychiatrists, but that the existing talent could be used more effectively in an integrated way. This collaboration has resulted in a 1-877-PSY-OHIO phone number that assures any pediatrician or family practice physician in Ohio of a child and adolescent psychiatric consult within thirty minutes, 24/7. This represents both innovation and transformative change!

REPURPOSING A 119-YEAR-OLD COUNTY MEDICAL SOCIETY

Similar to most trade associations, the Columbus Medical Association (CMA) has, for 119 years, worked very hard to meet the needs of physicians of all specialties residing in Columbus, Ohio. This particular medical society has a long and proud history of being entrepreneurial in meeting both the physician community's and public's needs. Historically, the medical society's core task has been to physically bring physicians together so that physicians experienced being part of a physicians' community. This sense of community had many and different benefits to its members over time. Through needs surveys and good intuition, the staff of the medical society was able to provide both professional and social functions that had resulted in reasonable membership numbers as well as revenue from sponsors and advertisers wanting to gain the attention of physicians. However, when the CMA took a closer look, an awareness developed that signaled that this trade association model was no longer sustainable.

Rather than trying to tinker with a formula for trade associations that has been used for a very long time, the CMA's board of directors asked a more fundamental question: "What would be the purpose, functions and structure of an organization that supported physician's highest aspirations?" The CMA board of directors even went as far as to question the need for the existence of a local medical society in the twenty-first century; a brave question indeed.

As with the earlier example, the CMA board chose to use a Theory U Change Lab approach to its strategic planning. The board and staff first reviewed the literature on what was happening in the world of medical societies and other trade organizations. In their review of the literature they discovered that they were as contemporary in their thinking and in their offerings as anything they could find in the literature.

Board members and staff were then trained to do the sensing interviews. It was decided that 50 demographically well-stratified interviews would be needed to "sense the whole" of the physician community in Columbus. These are two-hour intense interviews. An important question was whether they could succeed in attracting 50 physicians to sit for two hours and be interviewed. When the invitation was sent out to the membership, 150 physicians indicated a willingness to be interviewed. This response alone was valuable information that suggested that there was some unmet need that this process was tapping into. Staff and board members

conducted fifty interviews (the board is composed entirely of physicians), yielding the following generalized results.

- *Connectivity*: Physicians feel very disconnected from each other—there is no sense of a community of physicians any more.
- *Dissatisfaction*: Physicians are not feeling satisfied with how they are being required to practice medicine, which is leading to depression and other health risks.
- *Respect*: Many physicians are feeling a lack of respect from places such as insurance companies, the institutions they work for, and sometimes from their patients as well.
- *Generational Differences*: There are significant differences between how older physicians were trained and view the practice of medicine and the way younger physicians are trained and view their practices.
- *Fragmentation*: Just as patients often feel the effects of a fragmented health care system, so, too, do physicians; and things like making referrals to colleagues can be very challenging.
- *Health Literacy*: Physicians often feel frustrated with the lack of patient compliance with treatment regimens and the influence of drug advertising.
- *Machine Health*: Physicians are increasingly feeling like pieces and parts (cogs in a wheel) of the machine called “health care.” This they weren’t trained to be.

In looking at the results from these interviews, the board and staff asked themselves what a local medical society could do to help physicians deal with these very negative experiences that physicians were having.

At the planning retreat, based upon a literature review and the physician interviews, the board and staff created three-dimensional models of what a future local medical society could look like. Three models emerged. Staff then took the models and built a single hybrid model. This model was then tested with the board. Additional details were added, and the model was tested by focus groups of physicians. After several focus groups, some additional changes were made to the model and a business plan was developed and subsequently approved by that fundamentally repurposed CMA.

The new CMA’s purpose is “to create the conditions for connecting, convening and operationalizing the physician’s highest aspirations to improve the health and healing of physicians, individuals and the community” (CMA Strategic Plan, 2011). Getting into the details of the new CMA is not the task of this chapter, but the outcome of transforming and innovating an organization is the purpose of this chapter. Based on the organization’s work with Theory U and the change lab, the new model included a new future for how physicians and patients/clients work together. Using a private social media technology a twenty-first century, model includes developing a medical community with physicians positioned at the center of the community. The social media will also include space for physicians to communicate with other physicians about issues that are critical to their practice, and a new way to be in community with their co-workers and patients. As one physician said, “this is a community of physicians with their patients” (CMA, 2011). Results already starting to emerge:

- Six physicians came together for a discussion on Accountable Care Organizations that resulted in a webinar for the whole membership.

- Four physicians came together to discuss physician wellness, which led to the creation of a physician wellness column in the monthly newsletter, made up of tips for wellness by their own colleagues.
- A summit was called at which 36 physicians explored how to improve the referral relationship between primary care physicians and specialists, with a set of principles as the product of that discussion.
- Twelve physicians are exploring whether it is time to develop a local leadership academy for members.

The Columbus Medical Association is now an organization about physicians taking responsibility for their own futures, supported by technology.

A CALL TO ACTION

A recently published article was titled “It’s Time for the Heroes to Go Home” (Frieze and Wheatley, 2011). The authors argue that the world is just too complex for the hero model of leadership to hold any possibility of working in the modern world in which we live.

There are no simple answers, and no single individual can possibly know what to do. Not even the strongest of leaders can deliver on the promise of stability and security. But we seldom acknowledge these complex realities. Instead, when things go wrong, we fire the flawed leader and begin searching for the next (more perfect) one. (Wheatley and Frieze, 2006b, pg. 27)

Perhaps it is time for the heroes to go home. In a world that has always been connected but now realizes it (i.e., using the Internet and social media for easy connections to information and people), perhaps the concept of a leader as host needs to emerge. Host what? That is the question. Most leaders have secretly wished that they could unload these unreasonable expectations. The culture of organizations and the training of leaders has not offered existing leaders the skills or knowledge needed to engage their entire workforce differently in helping to solve the tough problems like service delivery in today’s new reality of politics and financial support for community-based services. Learning how to “host” the intelligence of the entire organization may be the most important thing a leader can do today. Servant leadership has gained a great following based on the writing of Greenleaf (2002). Perhaps *hosting* includes the skills servant leaders need to carry this concept to fruition.

Individuals who are being asked to lead multidisciplinary, integrated approaches in health care, or any other field, must be purposefully educated in the skills necessary to support these approaches, because the old command and control leadership practices seldom work in today’s world. Individuals with a new set of hosting skills need to be involved. Such an individual needs to be someone who sees the importance of every person in the group and who knows, very clearly, the processes needed to help the group realize its potential. These hosting skills are the skills referred to earlier in this chapter about collective practices (Circle, World Café, Open Space, and Appreciative Inquiry, etc.).

However, while collective practices are beneficial and powerful in and of themselves, this same set of hosting knowledge and skills can also be used in ways that are not beneficial to an

organization or to society at large. As one person recently put it, “networks and collective intelligence is not benign” (Nissen, Moeller, and Cass (2011). This is where individual consciousness practice becomes critically important for leaders. When a person establishes a habit, a practice, of meeting themselves every day, it doesn’t take long for that person to realize that they are only part of a much bigger picture. It is from that realization that consciousness and conscience begins to diminish the shadows (i.e., negative aspects) in people and organizations and where the light of highest aspirations can be realized. It is necessary for leaders to develop personal and collective practices in order to serve as leaders in a world that so desperately needs these kinds of leaders.

Finally, and perhaps as important as anything shared in this chapter, the transcendent leaders of today need people who support their courage, their humanness, and who participate with them in continuing to co-learn. This notion of leader as host is a work in progress. If done correctly, it will always be a work in progress *because that is the nature of things*, i.e., always emerging. We can refer these as “communities of practice”: places where people continue to learn together and practice their practices in real relationships. After all, it is these relationships and continuous lessons that may well be the bottom line anyway. It is always about relationships.

“In the end, it is the reality of personal relationships that saves everything,” said Thomas Merton (Forest, 1991).

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DIRECTORY OF INTERNET RESOURCES

American Association of Community Psychiatrists The professional organization dedicated to public and community psychiatrists. They offer publications, conferences and training. www.communitypsychiatry.org

American Association of Suicidology was founded in 1968 as an organization for all those who work in suicide intervention, prevention, or who have been affected by suicide. The organization supports research and provides resources, training, and an annual conference. <<http://www.suicidology.org>>

American Case Management Association is an organization for hospital case management professionals. ACMA offers resources, certification, conferences and career networking. <http://www.acmaweb.org/>

American Foundation for Suicide Prevention supports research into suicide prevention, educational campaigns, demonstration projects and policy work. AFSP is growing a network of community based chapters and organizes grassroots campaigns to advocate for state and federal legislation to advance suicide prevention. <<http://www.afsp.org>>.

American Counseling Association was founded in 1952 as the national organization for professional counselors. ACA provides resources, publications, conferences and policy advocacy. www.counseling.org

American Distance Counseling Association a professional organization that advocates for safe online education and mental health treatment. ACDA provides resources and support for distance counselors. <http://adca-online.org/index.html>

American Psychiatric Association was founded in 1844 and is the world's largest organization dedicated to psychiatry. APA supports research, education, advancement of the field, and provides publications, resources and a charitable division. www.psychiatry.org

American Psychiatric Nurses Association the professional organization dedicated to the advancement of psychiatric mental health nursing. APNA provides resources, continuing education opportunities, networking and publications. www.apna.org

American Psychological Association is the largest organization representing the field of psychology in the world. APA provides resources, publications, policy advocacy, career networking and supports education and research. www.apa.org

American Telemedicine Association is the leading international resource for advancing the use of remote medical technology. ATA advocates for public policy, and provides continuing education, meetings, and training program accreditation. www.americantelemed.org

Annapolis Coalition The mission of the Annapolis Coalition is to improve the quality of life of individuals and communities by strengthening the effectiveness of all who work to prevent, treat, and support recovery from mental and substance use conditions. The AC provides resources and assistance to non-profit organizations as well as state and federal agencies. www.annapoliscoalition.org

Assertive Community Treatment Association This site offers much information about the ACT model including fidelity standards, annual conference proceedings and a bibliography. <http://www.actassociation.org/>.

Assertive Community Treatment (ACT) Evidence-based practices (EBP) kit. This is a “how to” manual for providers interested in implementing this evidence-based practice. <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Association for Academic Psychiatry is focused on education in psychiatry from medical school through lifelong learning for medical professionals. www.academicpsychiatry.org

Association of American Medical Colleges provides leadership and publications for the academic medical community. www.aamc.org

Behavioral Healthcare A news journal that provides contemporary articles on all matters of behavioral healthcare <http://www.behavioral.net>

Business Dictionary www.businessdictionary.com

Case Management Society of America is the professional organization for Case Managers in the healthcare fields. <http://www.cmsa.org/>

Center for Evidence Based Practices at Case Western Reserve University provides consultation, training and evaluation for service innovations that improve the quality of life for people with mental illness or co-occurring disorders. www.centerforebp.case.edu

Center for Psychiatric Rehabilitation Boston University provides research, training and service dedicated to improving the lives of persons with psychiatric disabilities. www.bu.edu/cpr/

Centers of Excellence in Ohio, Pennsylvania, and Florida The goal of the Ohio Criminal Justice Coordinating Center of Excellence is for each county in the State to develop an array of programs that will divert people with mental disorders from jail and keep people with mental disorders in treatment through the utilization of the Sequential Intercept Model. <http://cjcccoe.neomed.edu/>

Child Trauma Academy is a non-profit organization that works to improve the lives of high-risk children through service, research and education. <http://www.childtrauma.org/>

CIT International is a non-profit organization whose purpose is to facilitate understanding, development and implementation of Crisis Intervention Teams. <http://www.citinternational.org>

Coming Off Medications provides information about psychiatric medication and the withdrawal process. www.comingoff.com

Council of State Governments Criminal Justice/Mental Health Consensus Report national nonpartisan effort to bring together state leaders for vigorous and collaborative dialog to initiate innovative changes supported by research and public policy. CSG, in collaboration with local, state, and federal stakeholders, created the Criminal Justice/Mental Health Consensus Project Report, a document designed to make specific recommendations to improve the criminal justice system's response to people with mental illness. <http://consensusproject.org/>

The Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center at the University of South Florida, Florida Mental Health Institute, provides technical assistance to counties in preparing a grant application, assists applicant counties in projecting the effect of the proposed intervention on the population of the county detention facility, disseminate and share evidence-based and best practices among grantees and statewide, acts as a clearinghouse for information and resources related to criminal justice, juvenile justice, mental health, and substance abuse. <http://www.floridatrac.org/>

Dartmouth IPS Supported Employment Center provides resources about Individual Placement and Support (IPS) supported employment. www.dartmouth.edu/~ips

EASA Early Assessment & Support Alliance provides information and support to young people in Oregon who are experiencing symptoms of psychosis for the first time. <http://www.eastcommunity.org>

Florida CIT <http://www.floridacit.org/>

Georgia Mental Health Consumer Network is a non-profit organization founded by consumers of state services for mental health, developmental disabilities and addictive diseases. <http://www.gmhcn.org/>

Georgia Certified Peer Specialist Project implements peer support services, Assertive Community Treatment Teams, Community Support Individuals and other services to assist peers in their recovery journeys. www.gacps.org

Harm Reduction Guide To Coming Off Psychiatric Drugs, by Will Hall, published by Icarus Project and Freedom Center, 2007 www.willhall.net/comingoffmeds

Health Resources and Service Administration (HRSA) Health Professionals Shortage Area Directory <http://hpsafind.hrsa.gov/HPSASearch.aspx>

The Icarus Project is a network of people living with or affected by experiences that are often diagnosed or labeled as psychiatric conditions. www.theicarusproject.net

Institute for Healthcare Improvement A web based resource that provides a series of modules and white papers discussing health care improvement and patient care. <http://www.ihl.org>

Institute of Medicine of the National Academies is an independent, non-profit organization that works outside of the government to provide unbiased and authoritative advice to decision makers and the public. www.iom.edu

International Critical Incident Stress Foundation provides leadership, education, training, consultation and support services in comprehensive crisis intervention and disaster behavioral health services to the emergency response professions, other organizations and communities worldwide. <http://www.icisf.org>

International Early Psychosis Association is an international network for the study and treatment of early psychosis. <http://www.iepa.org.au>

International Society for Mental Health Online is an international community that explores and promotes mental health in the digital age. <https://www.ismho.org/home.asp>

The Judge David L. Bazelon Center for Mental Health Law a national organization with a longitudinal history of effective legal and social advocacy opposing involuntary civil commitment based on individual rights to liberty and access to treatment in the least restrictive environment necessary. <http://bazelon.org>

Justice Center A project of the Council of State Governments, the Center is a national nonprofit agency designed to help improve the response to individuals with mental illness who come in contact with the criminal justice system by providing technical assistance, information dissemination of new research, program, and policy developments in the field, and educational presentations pertaining to mental health and criminal justice. The Center promotes data informed practices to create practical solutions to address public safety and cross-systems issues at the local, state, and federal level. <http://www.justicecenter.csg.org/>

Liaison Committee on Medical Education The Liaison Committee on Medical Education (LCME) is the nationally recognized accrediting authority for medical education programs leading to the MD degree in the United States and Canada. The LCME is sponsored by the Association of American Medical Colleges and the American Medical Association. www.lcme.org

Madness Radio www.madnessradio.net

Medicaid and Telemedicine <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

Mental Health First Aid a collaborative education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities—the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. http://www.mentalhealthfirstaid.org/cs/program_overview/

Mental Health A Report of the Surgeon General, reports on the scientific research along the continuum of mental health and mental illness across the lifespan. Addresses treatment, administration and policy, costs, consumers, privacy and confidentiality, ethics and values, and future visions. <http://www.surgeongeneral.gov/library/mentalhealth>

Mental Help A quick resource providing tips on how to address a wide variety of mental health challenges. This site also provides the opportunity to chat online with a psychiatrist. <http://mentalhelp.net/>

National Alliance on Mental Illness (NAMI) a national organization with state and affiliated local chapters providing advocacy, education, and support for individuals and family members including a succinct primer on mandated treatment options for many states. <http://www.nami.org>

National Association of Case Management This site provides case managers, service coordinators, supervisors, and program administrators with an opportunity for professional growth and for the promotion of case management. <http://www.yournacm.com/>

NAMI CIT Resource Center <http://www.nami.org/template.cfm?section=CIT2>

The National Archives (Veterans' Service Records) This site provides the opportunity to request military service records, research using military records, and the opportunity to browse WWII photos and many other resources online. www.archives.gov/veterans

National Association of Addiction Treatment Providers has assumed a strong leadership role on behalf of treatment providers in areas such as treatment standards, education, research, and advocacy of legislative, regulatory and reimbursement positions supported by the field. www.naatp.org

National Association of Social Workers This site provides resources, and guides for social workers, it is designed to facilitate professional growth and development of NASW members. www.socialworkers.org

National Association of State Mental Health Program Directors This organization provides national representation and advocacy for state mental health agencies and their directors and supports effective stewardship of state mental health systems. <http://www.nasmhpd.org/>

The National Association of County Veteran Service Officers This site is a one-stop shop for county veteran service officers assisting with linking with resources, documents forms and to keep providers informed of changes in legislation impacting veteran services. www.nacvso.org

The National Board for Certified Counselors This resources provides information on certification, advocacy efforts updates for the profession as well as resources for certification and career advancement. www.nbcc.org

National Collaborating Centre for Mental Health The National Collaborating Centre for Mental Health (NCCMH) is one of four centres established by the National Institute for Health and Clinical Excellence (NICE) to develop guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales. It provides guidelines, updates of events, and publications of interest. www.nccmh.org.uk

National Institute for Health and Clinical Excellence This site provides guidance for improving quality of care through access to quality standards, practice guidelines and educational links. www.nice.org.uk

National Institute of Mental Health (NIMH) Provides links to health topics research and funding as well as clinical resources on a variety of mental health topics, treatments and research. www.nimh.nih.gov

The National Center for PTSD Provides sites to veteran services, education and support, benefits and services and well as information on a variety of health and well-being topics. <http://www.ptsd.va.gov/>

The National Center for Trauma-Informed Care SAMHSA's National Center for Trauma-Informed Care (NCTIC) is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services. <http://www.samhsa.gov/nctic/>

National Child Traumatic Stress Network Provides forums for parents, care givers, families, professionals and educators on issues of traumatic stress in children including treatment services, a variety of support networks, education on a variety of trauma topics. <http://www.nctsn.org/>

The National Reentry Resource Center A project of the Council of State Governments, was established by the Second Chance Act (Public Law 110–199) to provide education, training, and technical assistance to state, local, tribes, territories, nonprofit agencies, and correctional institutions working on prisoner reentry. <http://www.nationalreentryresourcecenter.org>

New Research in Mental Health <http://mentalhealth.ohio.gov/what-we-do/promote/research-and-evaluation/publications/new-research-in-mental-health.shtml>

Ohio's Coordinating Centers of Excellence Provides resources for a variety of professionals promoting jail diversion alternatives for people with mental disorders. It provides information on crisis intervention teams, jail diversion research and links to a variety of resources designed to promote jail diversion. <http://www.mh.state.oh.us/what-we-do/promote/coordinating-centers-of-excellence.shtml>

Ohio Criminal Justice Coordinating Center of Excellence <http://cjccoe.neoucom.edu/>

Orygen Early Psychosis Prevention and Intervention Center (EPPIC) This website is a training and education resource for early psychosis clinicians and researchers. <http://www.eppic.org.au>

Peer Support and Wellness Center <http://www.gmhcn.org/wellnesscenter/>

Permanent Supportive Housing Evidence-Based Practices (EBP) Kit http://store.samhsa.gov/product/SMA10-4510?WT.ac=AD20100918HP_SMA10-4510

The Pennsylvania Mental Health and Justice Center of Excellence is a collaborative effort of Drexel University and the University of Pittsburgh to work with Pennsylvania communities to reduce the involvement of people with serious mental illness and often co-occurring substance use disorders in the criminal justice system. The Center uses the Sequential Intercept Model to identify points of interception for diversion, implement programs, provide information to promote use of evidence-based practices, and serve as a resource for technical assistance and training. <http://www.pacenterofexcellence.pitt.edu/index.html>

Portland Hearing Voices Portland Hearing Voices is a community group to promote mental diversity. We create public education, discussion groups, training, and community support related to hearing voices, seeing visions, and having unusual beliefs and sensory experiences often labeled as psychosis, bipolar, mania, paranoia, schizophrenia, and other mental disorders www.portlandhearingvoices.net

President's New Freedom Commission on Mental Health <http://store.samhsa.gov/product/Achieving-the-Promise-Transforming-Mental-Health-Care-in-America-Executive-Summary/SMA03-3831>

Project GREAT webpage hosted by the Department of Psychiatry and Health Behavior of Georgia Health Sciences University—includes links to Project GREAT publications and resources for consumers and practitioners. Available: <http://www.georgiahealth.edu/medicine/psychiatry/projectgreat.html>

Recovery to Practice Resources Center for Behavioral Health Professionals—Webpage provides practitioners with information about recovery and recovery-oriented practice. Information available: <http://www2.dsgonline.com/rtp/resources.html>

The Royal College of Psychiatrists Provides resources and links for psychiatrist in the UK, including fact sheets, resources and tools, support services and career development for those practicing psychiatry. www.rcpsych.ac.uk

The Schizophrenia Patient Outcome Research Team (PORT) treatment recommendations for schizophrenia. Available: <http://www.state.sc.us/dmh/clinical/port.htm>

Substance Abuse and Mental Health Services Administration (SAMHSA) Provides links to research education, publications, grant information and strategic initiatives. It is devoted to providing information to assist persons to act on knowledge to promote mental wellness www.samhsa.gov

SAMHSA's GAINS Center for Behavioral Health and Justice System Transformation A nationally recognized center that addresses system- and service-level issues for individuals with co-occurring disorders involved in the criminal justice system with an emphasis on evidence-based practices. <http://gainscenter.samhsa.gov/>. For a complete explanation of terms and components of the criminal justice system, see the National GAINS Center monograph "Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers Need to Know." http://gainscenter.samhsa.gov/pdfs/jail_diversion/Massaro.pdf

Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities is a National Rehabilitation Research and Training Center, Funded by the National Institute on Disability and Rehabilitation Research. www.tucollaborative.org

The Texas Medication Algorithm Project for Schizophrenia Available: <http://schizophreniabulletin.oxfordjournals.org/content/30/3/627.full.pdf>

Trauma Informed Care Resources is a page of resources compiled by The Anna Insititute. <http://www.theannainstitute.org/TIC-RESOURCES.html>

Trauma Informed Webliography http://theacademy.sdsu.edu/programs/BHETA/trauma_informed_webliography.pdf

Treatment Advocacy Center (TAC) a national organization with a longitudinal history of policy and social advocacy for advancement of individual and public mental health interventions including involuntary civil commitment. <http://www.treatmentadvocacycenter.org/>

United Nations Enable The Convention in Brief <http://www.un.org/disabilities/default.asp?navid=13&pid=162>

The United States Department of Veterans Affairs www.va.gov

University of Kansas School of Social Welfare Office of Mental Health Research and Training <http://www.socwel.ku.edu/mentalhealth/projects/promising/supporthousing.shtml>

University of Memphis CIT Center <http://cit.memphis.edu>

University of Verona Department of Public Health and Community Medicine Section of Psychiatry and Clinical Psychology <http://www.psychiatry.univr.it/>

Vet Center Readjustment Counseling Services www.vetcenter.va.gov

Wellness Recovery Action Plans-Mary Ellen Copland www.mentalhealthrecovery.com/

ZiaPartners, Inc www.ziapartners.com

GLOSSARY

ALLOPATHIC the term used by alternative medicine advocates to refer to the practice of conventional medicine, which uses pharmacological or physical interventions.

ASSERTIVE OUTREACH involves frequent visits to consumers in their home or other community settings to offer services and supports, rather than waiting in an office for consumers to show up for services.

BOUNDARY SPANNING Collaborative professional teamwork that attempts to engage and employ the combined talents of individuals who previously operated independently due to perceived systemic, cultural, or institutional divisions

CASE MANAGEMENT A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's holistic needs through communication and available resources to promote quality, cost-effective outcomes.

CERTIFIED PEER SPECIALIST a person in recovery from a serious mental illness who has completed training in how to offer self-help and other supports to their peers.

CIVIL COMMITMENT as defined by state law, the civil process for admitting (usually involuntarily) someone to inpatient or outpatient psychiatric treatment.

CLEAR AND CONVINCING EVIDENCE the median of three legal standards by which evidence is established with at least 75 percent judicial certainty. The standard is applied to civil commitment and other circumstances to which civil liberties and individual freedoms are determined. "Clear and convincing evidence" compares to standards of "preponderance of the evidence"—51 percent certainty (more likely than not) and "beyond a reasonable doubt"—90 to 95 percent certainty. The "clear and convincing evidence" standard specifically weighs "the individual's interest in not being involuntarily confined indefinitely and the state's interest in committing the emotionally disturbed [person]."

CLIENT-CENTERED APPROACH insures that treatment is designed to address the unique strengths and needs of the individual served.

COGNITIVE BEHAVIORAL THERAPY (CBT) CBT is a type of talk therapy that focuses on changing faulty thought processes to bring about improvement in negative emotions and dysfunctional behaviors.

COLLABORATIVE CARE sharing of mental health and medical care information between medical and mental health care settings so that care may be coordinated. It involves working with the consumer and all others involved in their care and treatment toward the achievement of a mutually agreed-upon goal or goals: "Nothing about me without me!"

COMMUNITY INTEGRATION involves the opportunity for a patient to live, learn, work, and socialize in natural community settings with others who may or may not have a disability.

COMORBIDITY The occurrence of a mental disorder and another disorder in the same individual at the same time. Examples include: a mental disorder and a physical disorder; a mental disorder and a substance-use disorder; a mental disorder and a developmental disability disorder.

CONTINUITY OF CARE while hospital psychiatry is based on individual episodes of care, community psychiatry is based on the ongoing responsibility toward the individual patients in their charge. The structure of the service and programs, the organization of community teams, and the style of intervention aim at maintaining a continuous relationship. This reinforces the therapeutic relationship and ideally transforms it into a therapeutic alliance, which is usually difficult to establish in the public system and with the most severely ill patients.

CRISIS An acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there is evidence of distress and functional impairment. It is the subjective reaction to a stressful life experience that compromises the individual's stability and their ability to cope or function.

CRISIS EVENT A subjective response to external stimuli involving stress or a traumatic life event, or series of events, that are perceived by the person as hazardous, threatening, or extremely upsetting, which is not resolved by using the person's inherent coping mechanisms.

CRISIS INTERVENTION TEAM (CIT) A police-based mental health response model designed to pair specially trained law enforcement officers to assist individuals experiencing a mental health crisis.

CULTURAL COMPETENCE the ability to interact effectively with people of different cultures, values, and belief systems.

DD214 Department of Defense Form 214 is a "Certificate of Release or Discharge from Active Duty" that is given to a military veteran upon being discharged from active duty with the military. The document verifies a veteran's rank, time of service, dates of service, awards, military occupation, and the character of his service.

DEINSTITUTIONALIZATION refers to the movement of persons with severe mental illness from large institutions into the community, and the full or partial closures of these institutions. This change has been credited to the development of chlorpromazine (Thorazine), the first effective antipsychotic medication.

DISCRIMINATION the prejudicial treatment of an individual based on their membership in a specific group.

DUAL DIAGNOSIS a term commonly used to describe a combination of an alcohol or substance-use disorder and a mental disorder.

DURATION OF UNTREATED PSYCHOSIS (DUP) The period of time during which an individual who is experiencing psychosis first receives treatment from a mental health clinician.

EARLY INTERVENTION Specialized treatment provided during the at-risk period or prodromal state or the first episode of acute psychosis.

EARLY PSYCHOSIS Refers to a stage of illness that is considered either an at-risk stage of developing a major psychotic disorder or the first episode of a major psychotic disorder.

ETHNOCENTRISM the belief that one's own cultural or ethnic group is central; evaluating all other groups in relation to one's own culture.

EVIDENCE-BASED PRACTICE (EBP) an intervention that has been empirically researched using randomized controlled trials and has been found to consistently produce positive outcomes.

FACILITATOR A person designated to provide support and guidance to the person with mental illness to ensure that s/he actively participates in the service planning process, that the interdisciplinary team understands her/his perspective about all components of the plan, and that the person understands the team's perspective.

FAMILY-AIDED COMMUNITY TREATMENT (FACT) FACT integrates all the treatment components for a person with a psychotic condition into one coordinated system. The treatment includes:

community-based counseling and case management, employment and education support, medication management, occupational therapy, and family support and counseling. This integration of all the components, including family support, reduces the likelihood of contradictions, collusion, and disagreements among those who are invested in the recovery of the individual (McFarlane, Stastny, & Deakins, 1992).

FIRST EPISODE OF PSYCHOSIS The term is used to denote the first onset of full acute psychotic symptom(s). It may not be clear what the specific diagnosis is during this period; the individual is distressed or impaired by the clear presence of the symptoms, is modifying their behavior based on psychotic symptoms, and is unable to engage in active reality-testing.

FIRST RESPONDER A public safety professional initially dispatched to or arriving at the scene of a crisis or emergency; oftentimes a police officer, firefighter, or paramedic.

GRASS ROOTS A movement or action of and by the ordinary people, as distinct from a movement instigated and led by the active leadership of a party or organization.

GROUP PSYCHOTHERAPY a time-limited process, with the therapist's role and group process derived from a specific theoretical approach (dynamic, supportive, or specialized focus).

HEALTH HOME A provider or team of health professionals who provide integrated health care for an individual. In a Health Home, all providers coordinate treatment based on shared information.

HOMEOSTASIS A natural state of equilibrium that all people seek. An individual is more amenable to intervention when in a state of disequilibrium caused by an acute event.

HOPE Hope is the catalyst of the recovery process. Recovery provides the essential and motivating message of a better future, that people can and do overcome the barriers and obstacles that confront them. Hope is an internal state; but it can be fostered by peers, families, friends, providers, and others.

INTERDISCIPLINARY TEAM a group of professionals representing various clinical specialties who contribute their individual expertise to the treatment of mutual clients.

INTERPROFESSIONAL working with individuals of other professions while maintaining a climate of mutual respect and shared values.

ITALIAN PSYCHIATRIC REFORM This reform was passed in 1978 when a small, but very active, radical party issued a national referendum to repeal the existing mental health law that supported the system of the state mental hospitals. The government quickly summoned a commission to draw up a new law, which incorporated a number of the ideas and treatment modalities developed in the previous two decades by the deinstitutionalization movement, whose most famous representative was Dr. Franco Basaglia.

MANAGED CARE Any arrangement for health care in which an organization, such as an HMO, another type of healthcare mental healthcare network, or an insurance company, acts as an intermediary between the person seeking care and the care provider.

MEDICAL MODEL a Western approach to health care that focuses on symptom-reduction through the use of medication.

MICRO-AGGRESSION brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of other races.

MICRO-INSULTS communications that convey rudeness or insensitivity and demean a person's racial heritage or identity.

MONOCULTURALISM actively preserving a culture; excluding external influences.

MULTICULTURALISM the appreciation, acceptance, or promotion of multiple cultures.

MULTIDISCIPLINARY TEAM a group of professionals representing various clinical specialties working independently with a mutual client. Little communication and coordination occurs among the team members.

NORMALIZATION a principle insuring that people with psychiatric disabilities have the opportunity to participate in life activities that are as close as possible to what society typically offers to all its citizens.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD) member organization representing state executives responsible for the \$36.7 billion public mental health service delivery system serving 6.8 million people annually in all 50 states, four territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors' Association.

NATIONAL MENTAL HEALTH ACT OF 1946 signed into law by President Harry S Truman, this created a significant amount of funding for psychiatric research and education, leading to the founding of the National Institute of Mental Health (NIMH) in 1949.

OSTEOPATHIC MEDICINE a branch of medicine with a historical emphasis on primary care and holistic health.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF MARCH 2010 signed into law in March 2010, it reformed specific aspects of the private health insurance industry and public health insurance programs. Features include mandatory insurance, increased coverage of preexisting conditions, and increased access to health insurance to previously uninsured Americans.

PEER a self-disclosed consumer of mental health service with lived experience with mental illness who works in service settings as an equal with non-consumer employee-colleagues.

PEER SUPPORT Mental health consumers providing support to peers in order to promote wellness and bolster skills needed to work toward recovery.

PERSON-CENTERED APPROACH A non-directive approach to being with another; which believes in the other's potential and ability to make the right choices for himself or her self, regardless of the clinician's own values, beliefs, and ideas.

PREJUDICE making a judgment or assumption about someone or something before acquiring accurate information.

PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH (2003) the first Presidential Commission (President George W. Bush) on mental health convened since the Carter administration, it was charged with assessing the state of mental health care in the United States. The Commission made sweeping recommendations and called for fundamental transformation of mental health services.

PROGRAM EVALUATION a form of appraisal, using valid and reliable research methods, that examines the processes and outcomes of an organization or program.

PSYCHIATRIC ADVANCE DIRECTIVE a legal instrument developed by a competent person defining specific instructions and preferences regarding recovery and future mental health treatment.

PSYCHIATRIC REHABILITATION Mental health service that focuses on developing skills and supports needed to function in a specific residential, vocational, educational, or social role of the individual's choice.

QUALITY MANAGEMENT a multidimensional concept that generally refers to leaders and leadership who demonstrate an array of characteristics such as accessibility, assurance, communication, competence, courtesy, durability, humaneness, performance, security, reliability, responsiveness, and tangibles.

RECOVERY A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Through the Recovery Support Strategic Initiative, the Substance Abuse and Mental Health Services Administration (SAMHSA) also has delineated four major dimensions that support a life in recovery:

Health: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.

Home: A stable and safe place to live.

Purpose: Meaningful daily activities, such as a job, school, voluntarism, family caretaking, or creative endeavors; and the independence, income, and resources to participate in society.

Community: Relationships and social networks that provide support, friendship, love, and hope. (SAMHSA, 2011)

REHABILITATION MODEL an approach to health care that focuses on developing adaptive functioning through skills training and environmental supports.

SERVICE-CONNECTED DISABILITY an injury or illness that was incurred or aggravated during active military service.

SHARED DECISION-MAKING an approach to treatment planning that promotes the consumer's role in the process through discussion of intervention options and their personal values and preferences related to these options.

SOCIOECONOMIC STATUS (SES) a sociological measure of a person or family's economic position in relation to others, factoring in income, education, and occupation. Typically sorted into high, middle, and low SES.

STEPPED CARE Monitoring physical and mental symptoms in order to inform adjustments to services to either a higher or lower intensity, as needed.

STIGMA Refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness.

THERAPEUTIC CASE MANAGER the worker in charge of a patient acts as the principal therapist and case manager at the same time. He has his own decision power when there is no time to consult the team, but can also count on all the other members of the team and on other health and social agencies in the area where he can refer his patient. In some systems, instead of a formal referral, the worker in charge prefers to accompany his patient to the colleague or other agency if necessary, so acting as a guide and mentor.

TOKENISM the practice of making only a symbolic effort to include an individual to prevent criticism or give the appearance of equal treatment, involvement, or participation.

TRANSDISCIPLINARY TEAM A group of professionals from various backgrounds who may work collaboratively and across disciplinary boundaries to offer knowledge and skills to mutual clients. A great deal of information-sharing and coordination occurs among the team members.

TRAUMA the experience of violence and victimization, including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism, disasters, and natural disasters.

TRAUMA-INFORMED CARE care that is organized around a contemporary, comprehensive understanding of the impact of trauma that emphasizes strengths and safety, and focuses on skill development for individuals to rebuild a sense of personal control over their life.

TREATMENT MALL a physical entity, usually in a central location, offering a variety of services and resources with the aim of enhancing recovery.

QUALITY MANAGEMENT a multidimensional concept that generally refers to leaders and leadership who demonstrate an array of characteristics such as accessibility, assurance, communication, competence, courtesy, durability, humaneness, performance, security, reliability, responsiveness, and tangibles.

WAIVERS Vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid.

VBA The Veteran Benefits Administration is the agency of the Department of Veteran Affairs that administers access to and distribution of benefits to veterans or qualifying family members.

VETERAN SERVICE OFFICER (VSO) a person trained to assist a veteran accessing benefits. The VSO will have knowledge of the various benefits and agencies that offer assistance to veterans and will know the process to apply for these benefits.

VETERANS HEALTH ADMINISTRATION (VHA) The Veterans Health Administration is the agency of the Department of Veteran Affairs that provides healthcare for qualifying military veterans.

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