Evidence Based And Promising Practices for TAY
Gay Teurman, Brain Salada, Noel O'Neil

PURPOSE: The purpose of this chapter is to Explain Evidence Based and Promising Practices as They apply to the treatment of Transition Age Youth and their families.

OUTLINE

A. Overview
   1. Evidence Based Practice defined
   2. Promising Practice defined
   3. Transition Age Youth Development in conjunction with EBP's

B. Evidence Based/Promising Practices-Individual Based Treatment
   1. Cognitive Behavioral Therapy (CBT)
   2. Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
   3. Dialectable Behavioral Therapy (DBT)
   4. Aggression Replacement Therapy (ART)
   5. Transition to Independence (TIP)
   6. Supported Education (SE)
   7. Assertive Community Treatment (ACT)
   8. Illness Management and Recovery
   9. Integrated Dual Diagnosis Treatment
   10. Seeking Safety
   11. Supported Employment
   12. Motivational Interviewing

C. Evidence Based/Promising Practices-Family Based Treatment
   1. Multisystemic Therapy (MST)
   2. Family Psychoeducation
   3. Wraparound
   4. Functional Family Therapy (FFT)
   5. Therapeutic Behavioral Services (TBS)
   6. Brief Strategic Family Therapy (BSFT)

D. Myths And Facts Of Mental Illness

E. Conclusion

F. References

A. OVERVIEW

1. Evidence Based Practice Defined

Evidence Based Practice (EBP) is defined, as the use of treatment methodologies for which there is scientific data collected with supporting evidence that the modalities (s) are effective treatment measures. Historically, the Institute of Medicine (2001) defines EBP as the integration of best research evidence with clinical expertise and patient values.

Areas such as medicine, mental health, and youth violence prevention are increasingly relying on the identification and delivery of practices that are supported by strong scientific research. They are also relying on the active integration of research evidence into day-to-day service provision. While some fields have embraced this movement toward evidence-based practice for decades, there is reason to believe that it still takes years to spread scientifically proven practices into everyday practice across the country. (Institute of Medicine, 2001).

2. Promising Practices Defined

Promising Practices are those that are judged to be clinically sound, designed to meet high priority needs of consumers, and are associated with positive outcomes. Promising Practices are rich sources of guidance for prevention, treatment, and rehabilitation practitioners and designers. However, such practices lack sufficient scientific-based evidence and, as such, promising practices are often the subject of on-going research to prove their efficacy.

Promising Practices though have been implemented and evaluated sufficiently, and are considered to be scientifically defensible. They have demonstrated positive outcomes as in the prevention of substance abuse and related behaviors. They have not yet been shown to have sufficient rigor and/or consistently positive outcomes required for "Effective Program" status. Nonetheless, Promising Practices are eligible to be elevated to "Effective" status subsequent to review of additional documentation regarding program effectiveness. They also originate from a range of settings and span many and diverse target populations.

Implementation of evidence-based or promising practices entails a significant system change. It is important to be mindful to use well-known strategies, standardized models, and consultants when incorporating these practices in community based systems.

With regard to Transitional Age Youth conceptually EBP and Promising Practices are in their formative stages. Typically research has not been considered specific to the TAY age range therefore we do not mention any program specific to transition age youth. However, practices will continue to be refined as clinicians, researchers, consumers, and academicians continue efforts to expand the knowledge base and evaluate the effectiveness of the myriad of treatment models in the field of psychology. As multicultural communities call for treatment that reflects their unique needs, researchers have the obligation to deliberately incorporate diverse communities in studies. As with the need for

age-specific research for TAY, so too are successful models of care needed for multicultural TAY.

For specific information related to female transition age youth, please refer to the Policy and Practice Brief developed by the Women's Mental Health Policy council at: http://www.cimh.org/downloads/Policy_and_Practice_Brief2.pdf

Supported Employment, Assertive Community Treatment (ACT), Family Psycho-Education, Illness Management and Recovery, and Integrated Dual Diagnosis Treatment are examples of Evidence Based Practices. Although these practices are supported with evidence and research, issues refuting the rationale often influence their popularity. Some of the issues causing resistance in the field are lack of clinical support; difficulties in converting clinical guidelines into actionable performance measures; poor use of available technologies or tools to gauge gaps in performance and inadequate integration of findings into daily operations. Program administrators also identify cost factors as a concern. Consumers also weighed in with their concern that EBP's may not be consistent with the recovery principals and multicultural guidelines. For example, EBP's such as Cognitive Behavior Therapy and Brief Strategic Family Therapy tend to be prescriptive, whereas, recovery philosophies are more consumer driven.

It is important to understand, however, that identifying EBPs or promising practices is just one vital step in the process of implementing these practices in the real world of transitional age youth. In fact, the process of implementing new practices with fidelity in an established system is extraordinarily challenging. While each practice and each community present unique concerns, there are some common issues to consider when selecting a practice to adopt.

3. Transitional Age Development In Conjunction With EBPs.

Biology and experience determine the developmental trajectory of a child. Modern neurobiological understanding of the interdependence and developmental interpenetration of these two dimensions has superseded the historical question of "nature vs. nurture." Indeed, according to modern neurobiologists, that dichotomization is misleading: experience affects brain development and the developing brain affects how the environment is experienced and processed. Therefore, future behaviors in response to a given set of environmental circumstances, cues, or stimuli can be traced to genetic/biological factors (temperament, biological predilection, or vulnerability) and experience (internal, familial, interpersonal, and environmental). Insofar as a principal concern of the juvenile justice system is social behavior, its proper focus is on familial and social factors that impact behavior. In this context, social-learning theory and developmental neurobiology are relevant for framing developmental issues that inform effective sanctioning of children and adolescents who are still developing.

Research using magnetic resonance imaging of the brain demonstrates differences in the way adolescents and adults think and feel and the way they process information before they act. Adolescents tend to process emotionally charged decisions in the limbic system, the part of the brain charged with instinctive (and often impulsive) reactions. Most adults use more of their frontal cortex, the part of the brain responsible for reasoned and

thoughtful responses. This may be one reason why adolescents tend to be more intensely emotional, impulsive, and willing to take risks than their adult counterparts. These are marked differences in rates of brain development in adolescents. Thus, chronological age is a poor index of neurobiological and emotional mentality. (Institute of Medicine Washington, DC, USA: National Academies Press; 2001)

Furthermore, within the transitional age youth populations there are enormous differences between, for example, a twelve-year-old and a seventeen-year-old. Also, there are vast differences in the emotional development of children of the same chronological age (e.g., among thirteen-year old boys). There is also evidence that earlier-maturing girls and later-maturing boys tend to have more problems than adolescents with average ages of onset of puberty. For example, the Institute of Medicine reports that early-maturing females appear to be at increased risk for victimization, especially sexual assault, which may contribute to their greater likelihood of problem behaviors compared to girls who mature (physically) later. Principles of child development and children's mental health can help guide decision-making in the design and implementation of more effective interventions for youth are transitioning from youth to adulthood.

The most effective program models are those that address the personal, familial, and societal variables that are essential to healthy transitional age development. These programs are community-based whenever possible. Virtually all effective evidence-based practices occur in the community and the home. These programs help the transitional age youth in developing increased personal competence and connectedness to pro-social elements of a larger community. (California Institute for Mental Health (CIMH); 2005).

B. **Evidence-Based/Promising Practices-Individual Treatment**

Following are descriptions of several EBPs that may be applied when working with transition-age youth, as well as with their families and/or caregivers.

1. Cognitive-Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is a psychotherapeutic approach that focuses on the relationship between a person's beliefs, emotions, and behaviors. The central hypothesis of CBT is that irrational beliefs can contribute to painful emotions, such as anxiety and depression. Moreover, these same beliefs can contribute to a variety of other mental health difficulties, including eating disorders, substance abuse problems, and sleep disorders, to name a few. The goal of CBT is to assist clients, through the process of "guided discovery," to examine these irrational beliefs and to help them develop more adaptive, alternative ways of viewing their lives and corresponding challenges. Also, CBT helps clients to learn problem-solving skills and related strategies toward the resolution of problems they are currently facing. This approach can be uniquely helpful for TAY who by definition are going through a transitional phase and need to develop their decision making abilities in important aspects of their lives and their futures.

Albert Ellis was one of the original modern day theorists who conceptualized that the internal self-talk of people contributed to their emotional experiences. This self-talk was often based on one's belief system. Changing negative self-talk can lead to a change in painful emotions and dysfunctional behaviors. This form of psychotherapy is referred to as

Rational-Emotive Therapy. More recently, Aaron Beck has developed Cognitive Therapy, which focuses not only on one's irrational beliefs but the distorted schema or "core beliefs" which are seen as underlying the client's negative self-talk. Thus, CT also addresses significant past events, such as trauma or internalized negative messages from caretakers that are presently influencing the client's well being. Finally, another clinical psychologist, Donald Meichenbaum, made significant contributions to CBT by emphasizing the development of cognitive coping strategies through stress inoculation to assist clients' in the process of guiding themselves through challenging situations. This final emphasis served to highlight the behavioral aspect of CBT and the concept of "homework assignments" that is now incorporated as standard in CBT approaches.

Meta-analysis of research conducting comparing CBT with other forms of psychotherapy and psychopharmacology has indicated this approach is the "treatment of choice" for a variety of disorders, including depression and anxiety disorders, substance abuse and eating disorders, relationship difficulties, substance abuse, trauma, sleep disorders, problems with social skills, shyness, passivity and feeling "stressed" out (Carr, 2000, Bush, 2006). CBT has also shown to be effective in the treatment of depression in adolescents (Kaslow & Thomson, 1998, Reinecke et al, 1998). Other studies have also shown that CBT can enhance the therapeutic effect of medication in the treatment of anxiety and depression. (March et al, 2004, Rupke et al, 2006).

There are basic principles or guidelines involved in using a CBT approach in treatment. First, CBT is a collaborative process involving the therapist and client working together to identify problems and solutions. Also, CBT tends to be more present focused in terms of time frame and helps client identify current thought patterns, beliefs and emotions. CBT is usually brief and goal oriented, with observable and measurable outcomes identified at the onset of treatment. Clients are routinely taught to maintain records of their thoughts, moods and behaviors throughout treatment, thereby allowing for an ongoing measure of treatment progress. Finally, CBT is a very strength based approach, which highlights clients' efforts toward their goals, their successes along the way and the courage they endeavor to surmount their difficulties.

As previously indicated, CBT has not only been shown to be helpful in changing dysfunctional thought processes but also instrumental in adopting new ways of thinking about challenging situations. In this sense, CBT is helpful with problems associated with impulsivity, such as ADHD, behavioral and impulse disorders. In these conditions, the clients' tendency is to behave prior to giving sufficient thought to the consequences of their actions. Consequently, their actions may be detrimental to their welfare as well as that of their family and friends. Through the use of "stop and think" approaches in self-instructional training, Kendall (1978, 1979, and 1980) has shown that teaching youth who have ADHD to practice guiding coping scripts helps them to inhibit impulses and think before they leap.

The combination of the illustrated benefits of CBT, as well as the ease of utilization and brief time orientation, indicate that this treatment is a best practice approach that should be included in every therapist's clinical "toolkit". Clients cannot only learn to resolve their behavioral and emotional difficulties, but also how to approach similar problems in the future toward their successful resolution. This is especially crucial for TAY as these rational ways to resolve difficulties are just beginning to develop at this stage. Finally, superheroes,

and even helpful friends and family, are not always available to walk them through the challenges of life. It is useful for TAY to develop their reasoning powers at these critical junctures to know which path to take.

2. Trauma Focused CBT (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences.

The focus of the TF-CBT model is to reduce symptoms of Posttraumatic Stress Disorder (PTSD). PTSD is characterized by problems with managing trauma-related negative emotions and physical reactions caused by memories or reminders of the trauma that may lead to maladaptive coping such as avoidance of reminders. These reactions often interfere with functioning at home, in school, and in interpersonal relationships.

TF-CBT was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies that focus on enhancement of interpersonal trust and empowerment. The program can be provided to children 3 to 18 years of age and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family. The program also has adaptations for 18-25 year olds to meet the specific needs of this age range. The program targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. The program model also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use.

There is strong scientific evidence that this therapy works in treating trauma symptoms in children, adolescents, and their parents. A parent treatment component is an integral part of this treatment model. It parallels the interventions used with the child so that parents are aware of the content covered with the child and are prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended.

TF-CBT is a short-term treatment approach that can work in as few as 12 sessions. It also may be provided for longer periods of time depending on the child's and family's needs. Individual sessions for the child and for the parents or caregivers, as well as joint parent-child sessions, are part of the treatment. As with any therapy, forming a therapeutic relationship with the child and parent is critical to TF-CBT.

The specific components of TF-CBT are summarized by the acronym PRACTICE:

- Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions.
- Parenting skills are provided to optimize children's emotional and behavioral adjustment.
- Relaxation and stress management skills are individualized for each child and parent.

- Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.
- Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings and behaviors. This helps children and parents modify inaccurate or unhelpful thoughts about the trauma.
- Trauma narration, in which children describe their personal traumatic experiences, is an important component of the treatment.
- In vivo mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which remind them of the original trauma.
- Conjoint child-parent sessions help the child and parent talk to each other about the child's trauma.
- The final phase of the treatment, Enhancing future safety and development, addresses safety, helps the child to regain developmental momentum, and covers any other skills the child needs to end treatment.

TF-CBT also teaches children how to examine their thoughts, feelings, and behaviors and how to change these in order to feel better. It also provides children with tools such as relaxation and deep-breathing techniques, problem solving, and safety education to help them manage stressful situations in the future.

For successful replication of TF-CBT, it is highly desirable that the child's parent or primary caretaker is available to participate in treatment. This intervention is typically provided in outpatient mental health facilities but has been used in hospital, group home, school, community, and in-home settings. (NCTSN.org 2004)

3. <u>Dialectical Behavior Therapy</u>

Dialectical behavior therapy (DBT) is a type of cognitive behavioral therapy. The main goal of DBT is to teach the patient skills to cope with stress, regulate emotions and improve relationships with others. DBT is derived from a philosophical process called dialectics. Dialectics is based upon the concept that everything is composed of opposites and that change occurs when one opposing force is stronger than the other. DBT combines the basic strategies of cognitive-behavioral therapy with eastern mindfulness practices. DBT is based on the idea that opposites can coexist and be synthesized. In more academic terms DBT is based on: thesis, antithesis and synthesis.

DBT was developed in the late 1970s by Dr. Marsha Linehan and colleagues when they discovered that cognitive behavioral therapy alone did not work as well as expected in patients with borderline personality disorder. Dr. Linehan and her team added additional techniques and developed a treatment which would meet the unique needs of these patients.

DBT is designed for use by patients who have urges to harm themselves, such as those who self-injure or who have suicidal thoughts and feelings. It was originally intended

for people with borderline personality disorder, but has since been adapted for other conditions where the patient exhibits self-destructive behavior, such as eating disorders and substance abuse. DBT has been widely used in the adolescent population, particularly teen females. DBT helps with the problematic actions sometimes used to deal with extreme emotional intensity. DBT emphasizes taking responsibility for one's problems and helps the person examine how they deal with conflict and negative feelings. The goals of the DBT groups include identifying maladaptive coping patterns and providing students with adaptive coping strategies to promote healthier lifestyles and psychological well-being. Using this strategy in thought is found to be very useful, especially with teen girls experiencing mood deregulation and impulsivity.

DBT patients are empowered with a portable skill set that enables them to improve the quality of their life and sustain these changes into adulthood. DBT emphasizes a nonjudgmental, validation approach to treating transition age you and their families. Some of the benefits are as follows:

- Focus on treating behaviors not diagnosis
- Validating, nonjudgmental approach
- Self-assessing skills and improved self-knowledge
- Portable skill set: Targeting emotional dysregulation, interpersonal effectiveness, distress tolerance, and mindfulness
- Behavioral consultation team
- Empirically based
- Individual, family and group therapy protocols
- Emphasis on relapse prevention
- Goal: Gaining a life worth living

The Three Fundamentals of Dialectical Behavior Therapy

A*.* Cognitive Behavioral Therapy

Learning new behaviors -- which can be anything a person thinks, feels or does -- is a crucial part of DBT. There are four main strategies that are used to change behavior: skills training, exposure therapy, cognitive therapy, and contingency management.

B. Validation

For patients with borderline personality disorder, the process of cognitive behavioral therapy can cause a great deal of distress. The push for change feels to them as if it invalidates the emotional pain they are feeling. Linehan and her team found that by offering validation along with the push for change, patients were more likely to cooperate and less

likely to suffer distress at the idea of change. The therapist validates that the person's actions "make sense" within the context of his personal experiences without necessarily agreeing that they are the best approach to solving the problem.

C. Dialectics

Dialectics makes three basic assumptions: (1) all things are interconnected (2) change is constant and inevitable and (3) opposites can be integrated to form a closer approximation of the truth. In DBT, the patient and therapist are working to resolve the seeming contradiction between self-acceptance and change in order to bring about positive changes in the patient.

DBT calls on the patient to accept reality while maintaining a strong and conscious commitment to change. DBT has also been modified so that it can be used with other difficulties such as eating disorders, substance use, self-harm and anger management. DBT targets the issues that cause distress and teaches skills to deal with them without having to resort to self-defeating behaviors. It does so in a framework that helps us understand that we are doing the best we can even though we need to learn ways that work better.

DBT is a practical evidence based practice with proven techniques aimed at the treatment of multi-problem adolescents at highest risk for suicidal behavior and self-injury. Using this method affords a step by step process of understanding and assessing severe emotional dysregulation in teens and implementing individual, family, and group-based interventions.(dbtselfhelp, 2009)

4. Aggression Replacement Training

A fundamental underpinning of Aggression Replacement Training is the idea that in every act of every child or adolescent aggression, whether it is in school, home or in the community has multiple causes. These causes are both internal and external. Further, there is ample evidence to support the belief that chronically aggressive youth possess a series of interlocking and compounding serious emotional challenges. These youth generally lack characteristically the many personal, interpersonal and social-cognitive skills that collectively constitute effective prosocial behavior. (*Gibbs, et, al, (1998)*

Aggression Replacement Training is a cognitive behavioral intervention program to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents. Developed by Arnold P. Goldstein and Barry Glick, Aggression Replacement Training has been implemented in schools and juvenile delinquency programs across the United States and throughout the world. The program consists of 10 weeks (30 sessions) of intervention training, and is divided into three components—social skills training, anger-control training, and training in moral reasoning. Clients attend a one-hour session in each of these components each week. Incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition and reinforce the lessons in the curriculum. Aggression Replacement

Training now has 25 years of service delivery in over 45 States, 6 Canadian Provinces, and several foreign countries.

The program was first developed for aggressive and violent adolescents aged 12 to 17 who were incarcerated in juvenile institutions. Aggression Replacement Training has been adapted for children in schools and mental health settings and for adults. Aggression Replacement Training can be taught to children and adolescents from all socioeconomic backgrounds in rural, urban, and suburban communities. In addition to being implemented in schools, Aggression Replacement Training has been used in juvenile delinquency programs and in mental health settings to reduce aggressive and antisocial behavior and promote anger management and social competence.

The Aggression Replacement Training program is a multi-modal intervention consisting of three components: social skills training, anger control training, and training in moral reasoning. Research has shown that students who develop skills in these areas are far less likely to engage in a wide range of aggressive and high-risk behaviors. Lessons in this program are intended to address the behavioral, affective, and cognitive components of aggressive and violent behavior. Detailed descriptions of the three components are provided below:

Social Skills Training: Social skills training teaches youth what to do in threatening or stressful situations. Aggression Replacement Training structured Learning is based upon a social learning process and activities include modeling, role-playing, and performance feedback.

Anger Control Training**:** As Aggression Replacement Training of their homework, Aggression Replacement Training participants relate examples of anger-arousing experiences from situations that had occurred during the previous week. The group facilitator uses a structured reporting checklist (hassle log) to reinforce the skills from the lesson.

Training in Moral Reasoning: This component of Aggression Replacement Training aims to raise Aggression Replacement Training participants' awareness of others' points of view (perspective taking) and teaches youth to view their world in a more fair and equitable way. (*Aggression Replacement Training-ART, (2007).*

Aggression Replacement Training embraces the viewpoint that the aggressive behavior is primarily learned behavior. Central to its purpose are the ideas that aggressive youth often do not posses the prosocial skills necessary to navigate through a non aggressive satisfying, effective lifestyle. Therefore the youth must be afforded the opportunity to learn the specific social skill set alternatives to antisocial behavior. Aggressive Replacement Training is a viable option for many youth where other means of interventions may have not been successful in behavior change. (*Gibbs, et, al., (1998)*

Tips for Working with Aggressive Teens

Notice signs of aggression. Learn to identify clues that a teen is potentially violent. Know how to defend yourself and how to restrain a client if necessary.

Offer alternatives**.** Aggressive teens may not know what to do with their feelings. Expose them to positive ways to expend energy, like exercising, drawing and painting, running, playing sports—even crying.

Practice problem solving**.** Most adolescents get angry for good reasons, but express their anger inappropriately. Teach them how to resolve conflicts through honest discussion and compromise.

Quiet time**.** Encourage young people to take time for themselves, away from noise and activity. Explain that this calming, quiet time is a gift to themselves.

Shut off the TV. Studies have linked television with violence and hyperactivity. It's not just the violent content of TV shows; it's the barrage of stimulation that makes it hard for kids to focus.

Touch appropriately. Many adolescents and adults use touch only as a means of control or showing aggression. By touching our adolescent clients appropriately (e.g., pats on the back, handshakes), we help them learn a better way to use their bodies. Do not touch a teen who is angry, however.

Explain the consequences of violence. When they are relaxed, explain to teens that as adults, violent behavior can hurt their chances of finding a job, alienate friends, or lead to jail. Make sure teens understand that you are simply describing reality, not trying to manipulate them with guilt or fear.

Role model. By remaining calm, speaking in a respectful and rational manner, and never condoning violence, even jokingly, you can exemplify the behavior we expect from adolescents.

Set clear standards of behavior. Make certain your clients know that anger is natural and should be expressed, but that violence is unacceptable under any circumstances.

Travel safely. Transporting an angry, agitated teens can lead to accidents. Always warn drivers if a child they are transporting is upset. If he or she starts to act out while you are on the road, stop the vehicle and give them time to cool off. *(Children's Services Practice Notes, (1998)*

5. Transition to Independence (TIP)

The mission of the Transition to Independence Process (TIP) system is to assist young people with emotional and/or behavioral difficulties (EBD) in making a successful transition to adulthood with all young persons achieving, within their potential, their goals in the transition domains of education, employment, living situation, and community life.

The TIP system was developed to engage youth and young adults in their own futures planning process, provide them with developmentally-appropriate services and supports, and involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and

successful achievement of their goals related to each of the transition domains -- employment, career-building education, living situation, personal-effectiveness and quality of life, and community-life functioning.

The TIP system is operationalized through seven guidelines and their associated elements that drive the practice level activities and provide a framework for the program and community system to support these functions.

A. TIP System Guidelines*:*

1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
2. Tailor services and supports to be accessible, coordinated, developmentally appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.
3. Acknowledge and develop personal choice and social responsibility with young people.
4. Ensure a safety net of support by involving a young person's parents, family members, and other informal and formal key players.
5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

To ensure the continuity of planning, services, and supports, the TIP system is implemented with the assistance of transition facilitators who work with the young people, their parents, family members, and other informal, formal, and community supports. The term "transition facilitator" is used to emphasize the function of facilitating the young person's future, not directing it. Different sites and service systems use similar terms such as transition specialist, resource coordinator, mentor, transition coach, TIP facilitator, service coordinator, or life coach.

The TIP system promotes independence. However, the concept of "interdependence" is central to working effectively with young people. This concept nests the focus of independent functioning (e.g., budgeting money, maintaining a job) within the framework of young people learning that there is a healthy, reciprocal role of supporting others and receiving support from others (i.e., social support network for emotional, spiritual, and physical support).

The concept of self-determination is one that the fields of education and psychology have defined in various ways. In order to operationalize this concept as much as possible, it can be defined as the ability to: 1) set goals that are likely to improve one's quality of life, 2) formulate alternative strategies, 3) choose among the strategies to find the most viable ones for achieving each goal, 4) implement the selected strategies, and 5) evaluate one's

progress in achieving the goals. Some of the personal skills associated with self-determination are: choice clarification, decision-making, goal setting, creativity, delayed gratification, self-advocacy, assertiveness, self-monitoring, self-evaluation, and self-reinforcement. (Florida Department of Education, 2005),

6. Supported Education

Individuals with psychiatric disabilities increasingly recognize that education can play a significant role in enhancing their recovery and reintegration process. To support them in reclaiming the valued role of the "student", the practice of supported education has evolved. Supported education prepares people with psychiatric disabilities to achieve educational goals in a college campus setting. Built on a psychosocial rehabilitation model, supported education addresses problems related to achieving educational success, such as managing stress, improving academic skills, problem solving, self-confidence, and career development. Its aim is to help students overcome the obstacles that prevent them from successfully completing their higher education. Supported education involves the provision of ongoing supports to assist people with psychiatric disabilities to take advantage of skill, career, education and interpersonal development opportunities within a normalizing academic environment.

Prior to the 1990 passage of the Americans with Disabilities Act, equal access and freedom from discrimination were rarities for people with psychiatric disabilities on college campuses. Supported education programs have been developed over the past decade to assist people with psychiatric disabilities in achieving their educational goals.

A. Supported Education has the following goals:

1. Provide access to a normalizing environment within which individuals with psychiatric disabilities can experience a wide range of people and social situations that allows for an alternate means of self-definition, from patient to student.
2. Provide access to the cultural and recreational resources available in educational settings.
3. Provide opportunities to strengthen basic competencies necessary to succeed in school and competitive employment.
4. Provide opportunities to explore individual interests relating to career development and vocational choice.
5. Provide opportunities to earn degrees, certificates, or vocational training that will lead to employment and careers.

Supported education allows individuals to transform their perceived identities from the stigmatized, role of psychiatric patient to the valued and culturally acceptable role of college student. Benefits of supported education include:

- Participants create for themselves a new identity - student!
- Participants experience a new and normalizing environment on college campuses.

- Students develop and participate in the structure afforded by a meaningful program.
- Students receive supports needed to focus on their educational goals.
- Most importantly, supported education students feel a renewed sense of hope for their futures.

Supported Education programs use group or individual-based services, to increase the access to, retention in, and completion of post-secondary education of adults who've had difficulties in higher education because of psychiatric disabilities. Karen Unger 1993 (2) identified four supported education prototypes - classroom, on-site, mobile support, and individual. Typically taking place on a college campus, Supported Education programs emphasize integration into a normalizing environment, access to campus resources, skill-building and skill-practice of educational competencies, opportunities to identify and explore vocational interests, support in mastering the educational environment, and peer support from others pursuing education.

B. Supported Education Underlying Philosophy

1. Students take control - of their disability, of their environment, and of their future.
2. Choice is fundamental. Students identify and explore their career interests and, in return, receive support in acquiring the skills and resources to meet career goals.
3. Many supports are necessary for learning. Students are encouraged to maintain relationships with the supported education staff, special student services on campus, CMH case managers, peers, families, and residential providers.
4. Students are involved in the implementation of the program. Students can serve as staff, peer mentors, tutors, and/or as board members.
5. Supported education programs incorporate empowerment strategies.

C. Supported Education Underlying Core Values

1. Flexibility: Services are evaluated on an ongoing basis
2. Dignity: Services are provided In a manner and In an environment that protects privacy, enhances personal dignity and respects cultural diversity.
3. Coordination: The resources are brought together to work for the benefit of the students.
4. Individualization: Services are tailored to meet the unique and changing needs of each student. Services build on the individual strengths of participants.
5. Self-determination: Students set their own goals and participate fully.
6. Active involvement: Students participate in all aspects of the program from planning to implementation to evaluation.
7. Strengths: Services are built on the unique strengths of individual students.

8. Hope: Participants are treated as developing persons, capable of growth and change.
9. Advocacy: Participants are given supports to advocate on their own behalf.

(Rehabilitation through Supported Education, 2005)

7. Assertive Community Treatment (ACT)

The Assertive Community Treatment (ACT) model delivers comprehensive services to individuals with serious mental illness whose needs have not been met through traditional service delivery. ACT is a team-based approach to the provision of treatment, rehabilitation and support services. The ACT model of treatment is built around a self contained multi-disciplinary team that serves as the fixed point of responsibility for all the client care for a group of clients. The ACT approach is normally used with clients who suffer from severe and persistent mental illness such as psychosis.

ACT team members collaborate on assessments, treatment plans, and day-to-day interventions and they share responsibility for ensuring that consumers receive services that support recovery. The treatment team provides all client services with a highly integrated approach to care. A key aspect of the ACT model is the reduced (e.g. 1:10) caseload size and availability of services in a variety of settings (community, school, home). The team reviews each consumer's status daily so that the nature and intensity of services can be adjusted quickly as needs change. The goal of ACT is to help the client stay out of the hospital setting and to develop skills for living in the community so that their mental illness is not the driving force in their lives. The services delivered are customized to the individual needs of the consumer. The core of the program is an interdisciplinary team who provide integrated services directly to people in the communities where problems occur—not in offices or clinics. Services can also be delivered in the evening and on weekends along with the traditional service day. Additionally, the model provides crisis service availability 24 hours a day, seven days a week.

Services are provided in community settings because that's where a lot of people need help and support. Whether it's help getting up and getting through the day, finding a place to live, applying for food stamps, going back to school, or getting a job, team members can provide practical, side-by-side support to the consumer figure out how to handle things. They will help as much or as little as the consumer wants or needs.

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

Daily team meetings in which the team is briefly updated on each individual facilitate this team approach. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs.

Some mental health programs have a limit on how long people can receive their services. It might be 30 days, or 60 days, or even 90 days. But, with assertive community treatment, there's no limit on how long you can receive services. That means that the assertive community treatment team is there for you as long as you need or want the support. An assertive community treatment team never discharges someone because they're "too difficult" or don't make "progress."

A. Assertive Community Treatment Goals:

1. Individualized, comprehensive and flexible treatment, support and rehabilitation services
2. Team members are direct providers of services
3. Majority of contacts with consumers are in community settings
4. Team is the fixed point of responsibility for services
5. Services are provided on a time–unlimited basis
6. It's important to follow the ACT model precisely as variations can limit or even nullify consumer benefits. Researchers have found that ACT, when done properly, surpasses alternative approaches such as brokered care or clinical case management programs in regard to consumers' independence, satisfaction, and quality of life.
7. In working with their teammates, practitioners are expected to:
8. Communicate their professional assessment of people's needs and suggest treatment strategies based upon their professional knowledge
9. Teach team mates as much as possible about their area of expertise
10. Ask other team members questions and learn as much as possible about their areas of expertise
11. Pitch in and help when needed, even if it means doing something that draws on their life experience rather than professional expertise (for example, helping someone move furniture into a new apartment)
12. Be innovative and creative
13. Focus on problem solving
14. In working with people who receive services from the team, team members are expected to:
15. Communicate hope and optimism
16. Treat people with dignity and respect
17. Actively involve consumers in decisions about their treatment and services

18. Help people attain the goals they set
19. Focus on people's abilities
20. Advocate for people's rights
21. Provide practical, hands-on, side-by-side support
22. Become familiar and comfortable with different cultures
23. Work with people's natural support systems

It takes pragmatism, initiative, "street smarts," and a "can do" attitude to be a successful member of an assertive community treatment team. One of the things that make assertive community treatment somewhat different is that it has been extensively tested, not just in university research settings, as is sometimes the case with mental health research, but in real world settings. Studies that have compared ACT to case management services consistently show that individuals who receive ACT services are less likely to be hospitalized and more likely to have stable housing than individuals who receive case management services in the traditional model. (SAMSHA 2005)

8. <u>Illness Management and Recovery Program</u>

The Illness Management and Recovery Program emphasizes helping people to establish and pursue personal goals and to implement action strategies in their everyday lives. This program model includes a wide range of health, lifestyle, self-assessment and treatment behaviors by the individual with mental illness. The information and skills taught in the program include learning how to get their needs met in the mental health system, reduction of relapse, building social support, and effective strategies for recovery.

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

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

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

The treatment is often with the assistance and support of others so they are able to take care of themselves, manage symptoms, and learn new ways to cope with their illness. Self-management includes psychoeducation, behavioral tailoring, and recognition of triggers, coping strategies, social skills training and cognitive behavioral treatment interventions. With the permission of the person who has experienced psychiatric symptoms, family members and other supporters may be asked to read the educational handouts, attend some sessions, and help the person develop and implement plans for coping with symptoms, reducing relapses, and pursuing recovery goals.

The content of the sessions focus on the following nine topic areas:

1. Recovery strategies
2. Practical facts about schizophrenia, bipolar disorder and major depression
3. The stress-vulnerability model and treatment strategies
4. Building social support
5. Using medication effectively
6. Reducing relapses
7. Coping with stress
8. Coping with problems and symptoms
9. Getting your needs met in the mental health system

This program pulls together the main components of effective illness management programs and provides a comprehensive, structured, step-by-step approach. It provides materials that have a recovery orientation and are user friendly both for practitioners and for persons who have experienced psychiatric symptoms. The program also heavily emphasizes helping people put knowledge into practice in their every day life. (SAMSHA 2005)

9. Integrated Dual Diagnosis Treatment

Integrated Dual Diagnosis Treatment is for people who have co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach encourages recovery gains by offering both mental health and substance abuse services at the same time and in the same setting to the client. Integrated dual disorders treatments also blend mental health and substance abuse treatments. For example, substance abuse treatments focus more on motivating people with two severe disorders to pursue abstinence, and mental health treatments are modified in light of the consumer's vulnerability to psychoactive substances.

More than half the adults with serious mental illness in public mental health systems are further impaired by substance abuse or a dependence on alcohol or drugs. These people are at high risk for negative outcomes, including hospitalization, overdose, violence,

legal problems, homelessness, victimization, HIV infection, and hepatitis. Co-occurring treatments combine or integrate key interventions for the mental health and substance abuse treatment goals in a coordinated fashion. For the individual with co-occurring treatment the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems is removed from the equation. The goals of recovery and treatment are more complex given that the goal for the individual with a Co-occurring diagnosis is to recover from two serious illnesses.

Integrated dual disorders treatment differs from traditional approaches in several ways. The most important is integration of mental health and substance abuse treatments.

One practitioner or one team in one agency provides both mental health and substance abuse treatments so that the consumer does not get lost, excluded, or confused going back and forth between two different programs.

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

At the outset of the program, consumers work with clinicians to form an individualized treatment plan for both disorders. There is also a motivational component in which clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. (Medline Plus, 2005)

Other features:

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

Implementation of a major program change like this requires that one person oversee planning, implementation, training, internal and external coordination, record keeping, and other sustaining activities. Mental health practitioners and clinicians often have not been trained to assess and treat substance abuse and mental health disorders. Implementing an integrated dual disorders treatment program requires training staff to acquire new skills; it does not mean that additional staff must be hired.

There are four basic skills that all clinicians need:

- Knowledge regarding substances of abuse and how they affect mental illness,
- Substance abuse assessment skills,
- Motivational interviewing skills, and
- Substance abuse counseling skills.

Research shows that treating the substance use disorder and mental illness together - as described in the Co-occurring Disorders model - helps to aid recovery. In this model, clinicians learn about the interactions of alcohol and drugs with mental illness. One core team provides integrated services to consumers at different stages of treatment. (SAMSHA, 2005)

10. Seeking Safety

Seeking Safety is a therapy-based program aimed to simultaneously treat post-traumatic stress disorder and substance use disorders in adolescent, youth, and young adult females. It was begun in 1992, under grant funding from the National Institute on Drug Abuse. It was developed by Lisa M. Najavits, PhD at Harvard Medical School/McLean Hospital.

Seeking Safety can be conducted in group and individual session formats for women, men or combined genders in a variety of settings (e.g., outpatient, inpatient, residential) and for both substance abuse and dependence.

A. Key Principles of Seeking Safety

1. Safety is the overarching goal (helping clients attain safety in their relationships, thinking, behavior and emotions)
2. It is an integrated treatment - working on both PTSD and substance abuse at the same time
3. There is a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
4. The four content areas are: cognitive, behavioral, interpersonal, case management
5. Attention is paid to clinician processes (helping clinicians work on counter-transference, self-care and other issues

Treatment consists of up to 25, 50-minute therapy sessions, either one-on-one or group-based, conducted over a three-month period. The program has five key components including:

1. Emphasizing safety as a priority

2. Integrating treatment of both post traumatic stress and substance use disorders
3. Focusing on regaining ideals that have been lost due to the disorders
4. Using four content areas, including cognitive, behavioral, interpersonal, and case management
5. Focusing attention on the clinician processes.

Seeking Safety consists of 25 topics that can be conducted in any order:

Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, , Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding). Life Choices and Termination. For a brief description of all topics.

Seeking Safety is a good choice model for TAY because of it's multi-modal application and the flexibility with family members or individualized treatment. Further, the program is designed to address multiple trauma issues at one for each individual. This is unique for our high risk and our most troubled youth. (childtrends, 2009)

11. Supported Employment (SE)

People with mental illness have strengths, talents, and abilities that are often overlooked—including the motivation to work. Research and opinion surveys have shown that the majority of adults with a serious mental illness want to work. And, they can do so effectively with the Supported Employment (SE) model. Mental Health Supported Employment programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through placement at the job site.

Primarily, this model focuses on helping consumers find competitive jobs they want in their community—jobs that are open to anyone and provide equal compensation. The SE model stresses the importance of letting consumers choose their work and support options based on their preferences, strengths, and experiences. In the Supported Employment model, vocational services are integrated with treatment. The SE team is assertive in engagement and retention of clients in treatment by using face-to-face community visits as a mean of contact rather than phone or e-mail. The employment specialists work with the case manager, therapist, psychiatrist, family and others on the treatment team when appropriate to promote the goals of the clients. What's more, nobody is excluded from a successful Supported Employment program, and there are no pre-vocational training requirements for participants. SE services are also frequently coordinated with Vocational Rehabilitation benefits.

A. Supported employment is based on six principles:

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

Currently, some of the elements of supported employment have more supporting evidence than others. The following components are predictive of better employment outcomes:

►Focus on competitive employment

►Rapid job searches

►Jobs tailored to individuals

►Time-unlimited follow-along supports

►Integration of supported employment and mental health services

►Zero exclusion criteria (that is, no one is screened out because they are not ready)

Research has suggested that even people who are assumed unlikely to succeed in employment can improve their employment outcomes with the help of supported employment. When an agency develops a culture of work and encourages people to consider employment options, the number of people who go to work increases. Giving people the choice to decide whether or not to participate in supported employment is consistent with the recovery philosophy. Many consumers in agencies with supported employment programs identify themselves as wanting to work in competitive jobs. (Substance Abuse and Mental Health Services Administration (SAMSHA), (2005).

12. Motivational Interviewing (MI)

One of the challenges associated with the TAY phase of development is making decisions about important aspects of living. Some of these decisions involve lifestyle pursuits regarding health choices, such as diet, exercise, social and recreational activities. Since these involvements have often been moderated by adults during childhood and adolescent years, the new found freedom of relative independence in the areas pertaining to pleasure can be enticing. Consequently, it may be tantalizing for TAY to overindulge in drugs and alcohol, video games and/or junk food. While too much Play-station or Crispy Creams can have some degree of a debilitating effect on a youth's health or social life, substance abuse can have both acute and chronic dangers inherent in intoxication and addiction. Lifestyle patterns established in early adulthood could also become life long engrained ways of self-care and socializing. Consequently, it can be of tremendous benefit for TAY to learn early on to make healthy decisions regarding substance use.

As indicated in Chapter VI (Co-Occurring Disorders), 21.7% of TAY surveyed indicated they experienced an alcohol or other drug dependence or abuse disorder. Moreover, 13.2 of these TAY surveyed met criteria for a serious mental disorder (United States Household Survey on Drug Abuse, 2002). Suggestions for treating these co-occurring disorders consisted of involving significant social supports of TAY, ensuring their basic needs are met, providing individualized treatment that recognizes TAY strengths, and involving family members in the treatment process whenever possible.

Traditional approaches to drug treatment counseling have often included confrontation. Therapists who use this style tend to argue that the client has the problem and needs to change. The client may also be given direct advice without encouragement to make their own choices. The therapist tends to do most of the talking and behave in a more punitive or coercive style with the client. (Rollnick and Miller, 1995). This style can hamper treatment by imposing an acceptance of reality the client cannot see or admit. The client is also presumed to lack knowledge or skills that are necessary for change to occur. Finally, the therapist acts as an authority figure who tells the client what he or she must do. (David Mee-Lee, MD, 2006).

TAY is often unresponsive to such confrontational style of therapy. First, authoritarian styles are often seen as parental and critical to TAY and often serve as a negative reminder of parenting styles that they are rebelling against or trying to individuate from as part of their own development. Secondly, TAY may not initially recognize their substance abuse difficulties because of the recent emergence of the problem or due to wide spread use among their same age peer group. Also, TAY may experience reluctance or ambivalence regarding drug or alcohol cessation due to the pleasure of positive experiences associated with use and abuse, such as anxiety reduction, peer affiliation, and/or recreational pursuits.

Stephan Rollnick, PhD, and William Miller, Ph.D. developed Motivational Interviewing (MI) as an alternative approach to the more confrontational style of drug and alcohol counseling. They describe MI as a "directive client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence." (Rollnick and Miller, 2002). This approach can be seen as both non-judgmental and non-

confrontational. In contrast to more authoritarian styles of drug counseling, MI motivation to change is elicited from the client rather than imposed by the therapist.

Miller and Rollnick (2002) have highlighted several additional key points that they believe espouse the spirit of MI. For example, they emphasize that it is the clients task not the counselor's, to articulate and resolve their ambivalence. In addition, direct persuasion is viewed as an ineffective method for resolving ambivalence. Rather, the counselor helps the client to explore the costs and benefits of a particular behavior (e. overindulgence) and encourages the client to decide between two courses of action regarding the behavior (e.g., indulgence or restraint).

MI is also described as a quiet and eliciting style of therapy. It is based on a few basic principles. First, the counselor *expresses empathy* by sharing with the client their understanding of the clients' perspective. The next step is to *develop discrepancy* between the clients' present behavior and the goals the client wants to achieve. In other words, explore to what extent the clients' current behavior is working for him or her. In addition, they recommend that therapist attempt to *roll with resistance***.** That is, client reluctance to change is viewed as natural rather than pathological. In this same vein, therapists are encouraged to *avoid argumentation***.** Finally, therapists can *support self-efficacy* in their clients by indicating their belief in the possibility of successful change.

According to Miller and Rollnick (2002), the fundamental approach of MI consists of collaboration, evocation and autonomy. Collaboration involves developing a partnership with the client that honors their perspective and experience. Evocation involves drawing out the resources and motivation that are within the client. Autonomy implies that the client has the right and capacity for self-direction as well as making their own informed choices.

MI has been adapted to include Motivational Enhancement Therapy (MET). This adaptation involves a time-limited approach that provides clients with normative-based feedback and explores client motivation to change in light of this feedback. The outcomes for MET have been positive in the reduction of alcohol problems. (Miller & Rollnick, 2002). Overall, MI has shown to be an effective treatment method in over 80 randomized clinical control trails across a range of behaviors and target populations. It has shown to be helpful in reducing substance abuse, promoting medical adherence and promoting positive health behaviors. (Yahne et al, 1998, Rubak et al, 2005).

MI is beneficial in facilitating client change toward a healthier life-style as well as a sense of mastery in their ability to make important decisions and take actions that will help them attain their goals. It is ideally suited to TAY for several reasons. The collaborative style is more developmentally consistent with the needs of TAY as opposed to more authoritarian approaches. The emphasis on an empathic relationship is often crucial to TAY. Finally, the highlight on the capacity of TAY to make their own decisions with the facilitation of a counselor empowers them to apply this same sense of capability to other key areas of their life, and hopefully, to develop a healthy life-style.

C. EVIDENCE BASED/PROMISING PRACTICE-FAMILY BASED TREATMENT

Virtually all evidence-based approaches include intensive family involvement. Good examples of family evidence-based practices include the "Wraparound", the "Multisystemic Therapy", Treatment Foster Care and Functional Family Therapy

1. Multisystemic Therapy (MST)

Multi-Systemic Therapy is an intensive family and community based treatment that addresses the multiple determinants of serious antisocial behavior. This approach views individuals within a complex network of interconnected systems that encompass individual, family, and extra familial factors. Interventions may be necessary in any one or a combination of systems.

MST is used for the treatment of emotional and behavioral difficulties in children and adolescents. According to Henggeler, Schoenwald, Rowland and Cunningham, MST uses Evidence Based Interventions but is not considered an Evidence Based Practice. However, given that MST borrows from Evidence Based treatment models, we mention this model as strong consideration for use with the TAY population. These models include Cognitive-Behavioral Therapy (CBT), behavioral therapy, and selected pharmacological treatment measurements.

MST uses these interventions within a programmatic context and treatment philosophy that contrasts with the ways in which evidence based interventions are usually delivered. The MST model is designed to incorporate the caregiver in the interventions with the youth. For example, if the youth responds to CBT interventions then the therapist will teach the caregiver how to deliver some of the interventions of CBT. In this way, MST supports the family's broader social ecology in change of behavior of the TAY client with the assistance of the caregiver. These changes are more likely to maintain favorable outcomes for the youth based on the delivery of the intervention. The MST model views the caregiver as the key in achieving long-term outcomes, emphasize accountability of the provider for engaging in families and achieving outcomes, and include intensive and ongoing quality assurance systems. These features are not characteristic of the above-mentioned EBPs.

The underlying philosophy of the MST model is that treatment cannot be effective if it is not delivered. Transitional Age Youth who experience significant emotional and behavioral problems and their families have many legitimate reasons for losing hope in traditional system interventions. MST specifically aims to overcome barriers to services access as an important step toward first engaging the family in treatment and eventually achieving treatment goals. Thus, the home-based MST model of service delivery provides a mechanism for the delivery of services with high ecological validity. For example, treatment is delivered where the problems generally occur: in the home, at school, and in other community settings. MST therapists provide services in the evening and weekend hours as well as the daytime traditional service providers are available. In addition, MST staff provides 24-hour crisis coverage seven days a week. Also, MST therapists have low caseloads of approximately four to six families each. These low caseloads allow the therapist the time they need to provide more intensive services and case management to

these challenging youth and families. One of the disadvantages of this approach consists of the limited resources providers often experience regarding 24/7 capacity and reduced caseloads.

The home based delivery also serves to provide the therapist more useful and complete assessment data when evaluating the family and planning their treatment goals. Having the ability to observe the family in their own environment increases the validity of the assessment information that increases the probability of more effective intervention and treatment planning.

The primary goals of MST are to:

- Reduce youth criminal activity
- Reduce antisocial behavior, including substance abuse
- Achieve these outcomes at a cost savings by decreasing incarceration and out-of- home placement rates

The primary benefits to MST youth:

- Were significantly less likely to use substances
- Had fewer arrests for all types of offenses
- Spent less time in out-of-home placements
- Engaged in less aggression with peers
- Were less likely to be involved in criminal activity

MST therapists focus on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). This family-therapist collaboration allows the family to take the lead in setting treatment goals while the therapist helps them to accomplish their goals.

Once engaged, the parents or guardians collaborate with the therapist on the best strategies to set and enforce curfews and rules; decrease the adolescent's involvement with deviant peers and promote friendships with prosocial peers; improve the adolescent's academic and/or vocational performance; and cope with any criminal subculture that may exist in the neighborhood.

Based on the philosophy that the most effective and ethical route to help youth is through helping their families, MST views parents or guardians as valuable resources, even when they have serious and multiple needs of their own. A "multisystemic" approach, however, views these youth as involved in a network of interconnected systems that encompass individual, family, and extra-familial (e.g., peer, school, neighborhood) factors, and recognizes that it is often necessary to intervene in more than one of these systems.

MST addresses these factors in an individualized, comprehensive, and integrated manner. (Multisystemic Therapy – MST, 2005)

2. Family Psychoeducation

Family Psychoeducation is designed for a single- or multi-family group format. Through Family Psychoeducation, practitioners work in partnership with families and consumers to support recovery. Specifically, practitioners educate families about the illness and help them develop coping skills for related problems. The term "family" in this case refers to anyone committed to the care and support of someone with mental illness. Through relationship building, education, collaboration, problem solving, and an atmosphere of hope and cooperation, the family and supporters can acquire more knowledge and skills about mental illness and the support of the family member.

Family Psychoeducation is offered as part of an overall clinical treatment plan for individuals with mental, emotional and behavioral challenges. These programs may be multi family focused or single family focused depending on the needs of family with respect to the cultural comfort level. This model is designed to achieve the best possible outcomes using family psychoeducation through active involvement of the family members in treatment and management of the services. Psychoeducation programs include the provision of emotional support, education, and resources during periods of crisis and non-crisis, and teaching problem solving skills. This approach will provide support for the family in their efforts to aid in the recovery of their loved ones thereby alleviating the suffering of the whole family. Licensed mental health practitioners—including social workers, psychiatric nurses, psychiatrists, psychologists, occupational therapists, and case managers—can learn to work within this model effectively.

Consumers, family members, and clinicians develop bonds and build their knowledge base through introductory sessions, educational workshops, and problem-solving sessions all devoted to recovery goals and sharing information. Clinicians stand to gain an enhanced understanding of how illness affects family dynamics and how to shift perspectives from being a practitioner to a partner in recovery.

Extensive research demonstrates that implementing family psychoeducation in routine mental health settings dramatically improves the lives of people with severe mental illness. There is abundant evidence for the effectiveness of family psychoeducation in working with consumers who experience schizophrenic disorders. Also, there is increasing research support for its use with mood disorders, OCD, borderline personality disorders, and even for consumers who lack family support altogether. Families and consumers with the most severe psychiatric disorders will experience the greatest benefit from the family psychoeducational model. The American Psychiatric Association cites Family Psychoeducation, when used in conjunction with medication, as one of the most effective ways to further the recovery process for schizophrenia. Recent studies also show promising results for people with bipolar disorder, major depression, and other serious mental illnesses.

Evidence also shows that for consumers whose families participate in family psychoeducation programs, relapse rates and re-hospitalization decrease significantly

within the first year after hospitalization when compared to consumers who only use medication with or without psychotherapy. With a family psychoeducation program in place there is evidence of savings in all areas that traditionally accompany relapse, including hospital costs and the need for police intervention and crisis intervention. Employment rates for consumers usually double; in combination with supported employment, they can quadruple.

The benefits of family psychoeducation programs to consumers and families are supported by demonstrated outcomes in research. These benefits have occurred across many cultural and racial groups, throughout the United States and in several international studies and programs. Some of the benefits are:

- Helps build a support network for recovery
- Provides hope
- Reduces relapse and hospitalization
- Improves symptom management
- Reduces medication dosages
- Improves social skills and community participation
- Increases employment, earnings and career options
- Strengthens family ties
- Reduces family conflicts

How successful the family psychoeducation program is depends in part on how closely the evidence-based model is adhered to. With Family psychoeducation as the evidence-based model of practice the practitioners view and interaction with the family is key to the families' success and thus the success of the program. If the practitioner implies or view the family at fault for their challenges, the participants may be drifting back in to old ways of implementing services. (Encyclopedia of Mental Disorders, 2005)

3. <u>Wraparound Program</u>

The Wraparound philosophy and approach focuses on strength-based, individualized care. Combined with a unique organizational structure, Wraparound delivers a comprehensive and flexible array of services to youth and their families. Its primary focus is to serve children and adolescents who have serious emotional disorders and who are identified by the Child Welfare or Juvenile Justice System as being at immediate risk of residential or correctional placement or psychiatric hospitalization.

Wraparound is a unique type of program that is designed to provide comprehensive, individualized and cost effective care to children with complex mental health and emotional needs. Wraparound is designed to reduce the use of institutional-based care such as residential treatment centers and inpatient psychiatric hospitals while providing more services in the community and in the child's home. The federal government also stressed more family inclusion in treatment programs along with collaboration between child welfare education, juvenile justice and mental health in the delivery of services.

Essential to the design and delivery of services and supports to children with severe emotional and mental health needs that are individualized, strength-based and family focused, Wraparound Milwaukee employs care coordinators are responsible for convening Child and Family Teams from which a wraparound plan of care is developed for each child and his/her family. Care Coordinators meet the child and family, conduct a strengths-based inventory, convene the Child & Family Team, and develop the care or treatment plan based on child/family needs, goals and formal and informal resources available or needed to support the family.

Care coordinators facilitate the delivery of services and other supports to families using a strength-based, highly individualized Wraparound approach. The care coordinators utilize life domains to look at family needs and create safety plans for each child to ensure there are structured supports and supervision to ensure child and community safety. Care Coordinators help develop the Care Plan to guide the delivery of services and treatment. They also are responsible to help the family identify and obtain formal services in the community with the Wraparound model to help meet mental health, social and other support needs. Care Coordinators, typically possess bachelor degrees, and work with caseloads of 1:8 or 1:9 families. Roles and responsibilities of care coordinators are defined in writing to minimize instances where they overlap with some of those duties of child welfare and probation workers.

In summary, the wraparound process helps families rediscover hope. Active crisis and safety planning minimize uncertainty and fear. Through wraparound, families develop an effective support network, increase their sense of competence, acquire new skills for managing the special needs of their child, and have access to the supportive resources they need to build brighter futures for themselves. (Research and Training Center on Family Support and Children's Mental Health, 2005)

4. Functional Family Therapy

Founded by Dr. Alexander in 1972, Functional Family Therapy, FFT, is an empirically grounded, well-documented and highly successful family intervention for at-risk youth. Dr. Alexander has demonstrated positive program outcomes in FFT across a wide range of youth and communities Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 10 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. Often these families tend to have limited resources, histories of failure, a range of diagnoses and multi-system exposure. *(Alexander, (2007-2010)*

One of FFT's hallmarks is its ability to fit an array of service delivery settings where at-risk adolescents are served. The FFT model has been successfully replicated across the continuum of juvenile justice, mental health settings, child welfare systems, from prevention and diversion type programs to aftercare and parole, as well as traditional drug and alcohol and school-based programs. FFT is a short-term, high quality intervention program with an average of 12 sessions over a 3-4 month period. Services are conducted in clinic, community based and home settings.

FFT is a strength-based model. At its core is a focus and assessment of those risk and protective factors that impact the adolescent and his or her environment, with specific attention paid both interfamilial and extra familial factors, and how they present within and influence the therapeutic process. *(DCHS, King County, (2009)*

FFT has a clinical model, built on an integrated theoretical foundation, and systematic research evidence to demonstrate its efficacy for reducing serious criminal behavior in youth. As a true family therapy, FFT targets the family relational system as the entry point and primary target for systematic and individualized treatment. The comprehensive FFT intervention and service delivery system includes:

1. A clinical core consisting of a integrated set of guiding theoretical principles,
2. A systematic clinical intervention program that relies upon phase-based change mechanisms,
3. Well-developed multi-domain clinical assessment and intervention techniques,
4. FFT has a systematic training a supervision system to train therapists with a systematic quality improvement system.

A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity so often characteristic of these families. Other goals include helping family members adopt positive solutions to family problems, and developing positive behavior change and parenting strategies.

The program is conducted by family therapists working with each individual family in a clinical setting, which is standard for most family therapy programs; more recent programs with multi problem families involve in-home treatment. The model includes four phases:

(1) Introduction/ Impression; The goals of this phase involve enhancing perception of responsiveness and credibility; demonstrating a desire to listen, help, respect, and "match;" and addressing cultural competence.

(2) Motivation(Therapy) Phase; The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy, and changing the meaning of family relationships to emphasize possible hopeful experience.

(3) Behavior Change Phase; Behavior Change goals consist of skill building, changing habitual problematic interactions and other coping patterns. Skills such as structuring, teaching, organizing, and understanding behavioral assessment are required.

(4) Generalization (more multisystem focused) Phase. The primary goals in the Generalization phase are extending positive family functioning; planning for relapse prevention and incorporating community systems.

Each phase includes assessment, specific techniques of intervention, and therapist goals and qualities. The intervention involves a strong cognitive/attributional component which is integrated into systemic skill-training in family communication, parenting skills, and conflict management skills. *(Alexander, (2007-2010)*

For over three decades, Functional Family Therapy (FFT) has applied efficacious, comprehensive model, driven, empirically tested principles, and a wealth of experience to the treatment of at-risk and delinquent, youth with successful outcomes in a variety of contexts to treat a range of these high-risk youth and their families. *(OJJDP, (2000).*

5. Therapeutic Behavioral Services (TBS)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federally mandated benefit under Medicaid (Called Medi-Cal in California). EPSDT has been a part of Medicaid since its inception. EPSDT provides comprehensive health, vision and dental care and also provides mental health care for eligible persons under 21 years of age with serious emotional disturbances (SED). In July 1999, following the preliminary injunction in the Emily Q. vs. Belshé lawsuit, county Mental Health Plans (MHPs) also became responsible for providing or arranging for Therapeutic Behavioral Services (TBS) as an EPSDT supplemental specialty mental health service.

TBS allows for the provision of intensive one-to-one services for children/youth with SED who are experiencing a stressful transition or life crisis. TBS is not a stand- alone service and may only be provided to support other EPSDT specialty mental health services. TBS may be an effective part of the treatment plan when additional short-term support is needed to prevent placement in a group home of Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs. TBS may also be provided to enable a transition from any of those levels to a lower level of residential care.

TBS is a short-term, strength-based, behavioral-focused service, which works in collaboration with a child, the child's caregivers and the primary mental health provider to address behaviors that jeopardize the child's current placement. All steps in the TBS process are done in collaboration with the child and, when appropriate, the family team or child's caregivers. The process includes:

- Assessment
- Plan Development
- Implementation
- Transition
- Graduation

TBS begins by looking at a child's behaviors and the risk of high-level placement or need for assistance transitioning to a lower level of care. TBS develops replacement behaviors for the child to use as alternatives to the targeted behaviors. Interventions and strategies focus on improved self-management, self-awareness, and communication skills as well as positive reinforcement of desirable behaviors. Strategies may include the

development of a behavioral plan, such as a step-by-step process in which caregivers follow a guideline to manage specific behaviors as they occur and/or an incentive plan where the child is rewarded for choosing positive replacement behaviors.

The client referral process for TBS varies county-to-county. The qualifying eligibility criterion for each child or youth is as follows:

1. Must have full-scope Medi-Cal and be less than 21 years of age.
2. Must meet medical necessity criteria (or have a qualifying mental illness diagnosis and an impairment in an important area of life functioning).
3. Must be receiving other EPSDT specialty mental health services.
4. Must meet the need criteria:
    - It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of therapeutic behavioral services that:
    - The child/youth will need to be placed in a higher level of residential care, including acute care because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in current facility; OR
    - The child/youth needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms are expected and therapeutic behavioral services are needed to stabilize the child in the new environment. The provider must document the basis for the expectation that the behavior or symptoms will change.
5. Must be a member of a certified class by meeting one of the following criteria:
    - Currently living in a group home facility, RCL 12 or above and/or locked treatment facility which is not an Institution for Mental Diseases (IMD).
    - Has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the past 24 months.
    - Is being considered for placement in a group home facility, RCL 12 or above, and/or a locked treatment facility which is not an IMD.
    - Has previously received TBS services

A child is graduated from TBS once the frequency, duration, and intensity of the targeted behaviors have been reduced, the child has met their targeted goals and interventions and strategies have been successfully transitioned to the child's caregivers. (CIMH, 2005)

6. Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) is an Evidence Based Practice (EBP) that has its roots in the work of Milton Erickson and has been developed over the past 30 years on the West Coast by Bateson and others at the Mental Research Institute at Stanford University and in the East at the Family Therapy Institute in Washington DC by Jay Haley, Cloe' Madanes and others. Jose Szapocznik Ph.D. at the University of Miami with considerable success has conducted most recently controlled studies in the practice. According to Jay Haley, "Therapy is strategic if the therapist identifies solvable problems, sets goals, designs interventions to achieve those goals, and examines and takes responsibility for the effectiveness of the outcome". The goal of BSFT is to improve the youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.

Therapy is tailored to target the particular problem interactions and behaviors in each client family. Therapists seek to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for new, more functional interactions to emerge. A typical session lasts 60 to 90 minutes. The average length of treatment is approximately 12-15 sessions over three months. For more severe cases, such as substance abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in the office or home/community settings. BSFT has been rigorously evaluated in a number of studies with experimental designs. The approaches have been found to be effective in improving youth behavior, reducing recidivism among youthful offenders, and in improving family relationships

So what is the advantage of a relational clinician using this method with TAY? Since the focus of treatment is on a specific presenting problem, and the discussion is centered on how to achieve change rather than focusing on the past and establishing pathology, TAY are more receptive to this brief model that approaches problems from a system's perspective. BSFT is strength based respectful method of assisting a family to resolve an issue in the clinic that a family has already attempted to solve without success at home. At the heart of the therapy is an attempt to fully understand the sequence of events that precede the specific behavior that the family wants to change. By knowing this, the clinician is in a favorable position to suggest a directive that may be done at home to interrupt the sequence and modify the homeostasis. Sessions generally include all family members living in the home, and every member may have an assignment to induce change. From the perspective of the TAY, their expressed concerns are equally important as any other family member's, and the directive may include information the TAY has contributed. The clinician keeps the focus on the presenting problem, and when homework has been given, there is always a processing of the outcome so that the family and clinician can come to a better understanding of the strengths and resources of the family.

Because family matters involving TAY can be highly charged, the clinician may not have the power to be able to give a directive that is straight forward that can result in quick change. In such circumstances, the clinician may need to create a paradoxical intervention so that humor is introduced in such a manner that change happens in an incremental way,

at least establishing the fact that change is possible. When families have no hope that change can ever happen, motivation to attend family sessions becomes weakened. The clinician always assumes the success of the therapy is due to the dedication and persistence of the family, and often the TAY can make a contribution to the solution that does alter the course of family dynamics in a fundamental manner. In closing, because BSFT is not so interested in the emotional or cognitive states of the family members, but more interested in action and change, this can compliment the mindset of the TAY. That there is a beginning of therapy with certain goals laid out, and an end when the goals are met, this can be appealing to a youth as they realize that therapy is not an endless assault against nebulous problems and charged emotional states of frustrated parents. (Helping America's Youth, The white House (2005)

D. <u>Myths & Facts of Mental Illness</u>:

Myth:
People with psychiatric disabilities can't meet the demands of college…

Fact:
With support and reasonable accommodations, people who choose college can be successful in school.

Myth:
People with psychiatric disabilities are disruptive in an academic setting…

Fact:
People with psychiatric disabilities are no more disruptive than other students.

Myth:
People with psychiatric disabilities aren't interested in pursuing higher education…

Fact:
When offered the opportunity to experience college, many students with psychiatric disabilities respond positively!

Myth:
People with psychiatric disabilities can't take the stress of college…

Fact:
Recovery helps people with psychiatric disabilities to adapt to a level of stress of their own choosing; having a meaningful choice can actually reduce stress.

(Reasonable Accommodations for People with Psychiatric Disabilities: An On-line Resource for Employers and Educators, 2005)

E. <u>CONCLUSION</u>

Primum non nocere - first do no harm - is not an idealistic adage. It serves as the lowest threshold to which adequate performance is compared. Once public safety and victim rights have been accounted for, it is reasonable to apply this minimal standard to the mental health system that intervenes on behalf of the highest risk, and oftentimes most highly misdiagnosed and misunderstood youth. For the majority of the TAY population the amount of time, thought, and expertise required to implement the principles outlined in this

paper may exceed current capacity for immediate change on an individual basis or system wide. Albeit optimistic, change must be implemented to a meaningful degree with our TAY population throughout the State.

The developmental principles outlined in this chapter can serve as a rationale for intense cross-disciplinary training, cooperation, and integrated treatment planning far beyond what currently exists in some systems. New models based on evidence are needed that specifically target the transitional age youth and pay particular attention to multicultural (including lesbian, gay, bisexual, transgender and questioning) youth and communities. Also, it is essential that the departments of probation, mental health, social service, rehabilitation, and education work synergistically to achieve the same treatment goals for youth. All participants in the client's community must appreciate the value of working towards fostering positive youth development and realize that some current practices are more helpful than outmoded approaches, especially when applied in a coordinated fashion.

In spite of very significant advances in understanding transitional age youth, the assessment and treatment of psychological trauma, neurobiology, and social learning psychology, there is a dearth of evidence on which practices conclusively show their effectiveness with this population. We know this is not an insolvable problem. At the very least, decision-makers are more educated about practices and interventions which have a developmental rationale or evidence base and therefore have a reasonable chance of being successful. This naturally leads to the elimination of ineffectual practices, which also frequently represent unacceptable risks to our transition age youth, their development and socialization. (Arredondo, 2003). At the very best; however, providers and administrators support further research on behalf of diverse TAY populations and exploration of promising practices from diverse communities themselves.

F. REFERENCES

Aggression Replacement Training-ART, (2007). Retrieved from the World Wide Wed: http://www.promoteprevent.org/publications/ebi-factsheets/aggression-replacement-training

Alexander, Dr. James F., Functional Family Therapy, Inc., (2007-2010,) Retrieved from the World Wide Web: http://www.fftinc.com/about_model.html

Arredondo, M.D. David E. (2003), Child Development, Children's Mental Health and the Juvenile Justice System: Principles for Effective Decision-Making, Stanford Law and Policy Review, Vol. 14.1, 13-28. Retrieved from the World Wide Web: http://www.childrensprogram.org/publications.htm

California Institute for Mental Health (CIMH) (2005), Evidence Based Practices for Youth. Retrieved from the World Wide Web: http://www.cimh.org/Initiatives/EvidenceBasedPractice

Children's Services Practice Notes, (July 1998, Vol. 3, No. 2) retrieved from the World Wide Web: http://www.practicenotes.org/vol3_no2/working_with_adolescents.htm

Department of Community and Human Services, King County Veteran and Community Evidence Based Services, January 26, 2009, Retrieved from the World Wide Web: http://www.kingcounty.gov/Socialservices/CommunityServices/Services/YouthandFamily/EvidenceBasedPractice.aspx

Dialectal Behavioral Therapy, About.com, a part of The New York Times Company, 2009, Retrieved from the World Wide Web, http://bpd.about.com/od/treatments/a/IntroDBT.htm

DBT, Life Skills For Emotional Health, 7/2009, Retrieved from the World Wide Web

http://www.dbtselfhelp.com/

DBT, Youth Care, Inc, 2006 | PO Box 909, Draper UT 84020, Retrieved from the World Wide Web, http://www.youthcare.com/therapeuticfocus.htmlEncyclopedia of Mental Disorders, 2005. Family Psychoeducation. Retrieved from the World Wide Web: http://www.minddisorders.com/Del-Fi/Family-psychoeducation.html

Evidence-Based Practices: Shaping Mental Health Services Toward Recovery, (2005), Substance Abuse and Mental Health Services Administration, Community Support Programs Branch. Retrieved from the World Wide Web: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/

Florida Department of Education, (2005), Transition to Independence Process. Retrieved from the World Wide Web: http://tip.fmhi.usf.edu/

Gibbs, John D., Glick, Barry, Goldstein, Arnold P., (1998), Aggression Replacement Training: A comprehensive intervention for Aggressive Youth, Champaign, Illinois, Research Press.

Helping America's Youth, The white House (2005). Brief Strategic Family Therapy. Retrieved from the World Wide Web: http://guide.helpingamericasyouth.gov/programdetail

Institute of Medicine Washington, DC, USA: National Academies Press; 2001, Committee on Quality of Health Care in America, Crossing the Quality Chasm: A New Health System for the 21st Century, Retrieved from the World Wide Web: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/ImprovementStories/MakingEvidenceBasedClinicalDecisions.htm

Institute of Medicine Washington, DC, USA: National Academies Press; 2001, Committee on Quality of Health Care in America Making Evidence-Based Clinical Decisions Retrieved from the World Wide Web: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/ImprovementStories/

Medline Plus: Dual Diagnosis; 2005, Retrieved from the World Wide Web: http://www.nlm.nih.gov/medlineplus/dualdiagnosis.html

Mental Health Links - Connecting Science to Service (2005), Substance Abuse and Mental Health Services Administration, Community Support Programs Branch. Retrieved from the World Wide Web: http://www.samhsa.gov/

Miller, W.R. & Rollinick, S. (2002). Motivational Interviewing (2nd Edition) New York: Guilford Press.

Multisystemic Therapy – MST, 2005. MST is a research-proven and cost-effective treatment for youth with serious behavioral problems. Retrieved from the World Wide Web: http://www.mstservices.com/

Office of Juvenile Justice Delinquency Prevention, Family Strengthening Series PDF, (2000) Retrieved From The World Wide Wed: http://www.ncjrs.gov/pdffiles1/ojjdp/December 2000

Rehabilitation through Supported Education, (2005). Retrieved from the World Wide Web: http://www.supportededucation.com/

Reasonable Accommodations for People with Psychiatric Disabilities, (2004): An On-line Resource for Employers and Educators: Retrieved from the World Wide Web: http://www.bu.edu/cpr/reasaccom/

Research and Training Center on Family Support and Children's Mental Health (rtc), (2005): The National Wraparound Initiative. Retrieved from the World Wide Web: http://www.rtc.pdx.edu/nwi/

Rubak S, Sandbaek A, Lauritzen T, Christianson B. Motivational Interviewing: A Systematic Review and Meta-Analysis. Br J Gen Pract. 2005 Apr;55 (513):305-12. Retrieved from the World Wide Web: http://www.ncbi.nlm.nih.gov/pubmed/15826439?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=2&log$=relatedarticles&logdbfrom=pubmed

Rupke, MD, Stuart J., David Blecke, M.DIV, MSW & Marjorie Renfrow, MD. Cognitive Therapy for Depression. American Family Physician. January 1 2006. Retrieved from the World Wide Web: http://www.aafp.org/afp/20060101/83.html

Seeking Safety, Child Trends Research, 4301 Connecticut Avenue, NW, Suite 350, Washington, DC 2008, Retrieved from the World Wide Web http://www.childtrends.org/Lifecourse/programs/seeking.htm

Seeking Safety: A model for Trauma and/or Substance Abuse, Najavits LM (2007). Retrieved from the World Wide Web, http://www.seekingsafety.org/

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), The National Child Traumatic Stress Network www.NCTSN.org