

APPENDIX K:

Evidence Based Practices

Introduction

Although the term “evidence based practice” has been used with increasing frequency over the past decade, it is still a relatively new term in health care and disabilities services. The work group put forth much effort to review various definitions of EBP to clarify the meaning of this term.

A summary of the various definitions and conceptions of the term “evidenced based practice” includes:

- **Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Sackett et al, 2000; Institute of Medicine, 2001).**
- Interventions for which there is consistent scientific evidence showing that they improve client outcomes (Drake, RE, et al, *Psychiatric Services*, 2001).
- An intervention with a body of evidence (i.e., rigorous research studies with specific target populations and client outcomes), specific implementation criteria (e.g., treatment manual), and a track record showing that the practice can be implemented in different setting (Bond G., et al, *Psychiatric Services*, 2001).
- Evidenced-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, *Policy Statement on EBP*, 2007).
- Evidenced-based medicine involves evaluating rigorously the effectiveness of healthcare interventions, disseminating the results evaluation and using those findings to influence clinical practice (Appleby J., Walshe K., and Ham C., 1995).
- Evidenced-based medicine is a set of strategies derived from developments in information technology and clinical epidemiology designed to assist the clinician in keeping up to date with the best available evidence (Geddes, 2000).
- It (EBP) recognizes that health care is individualized and ever changing and involves uncertainties and probabilities... Ultimately evidence-based practice is the formalization of the care process that the best clinicians have practiced for generations (McKibbon KA., 1998).

It is important to realize the varying definitions can be very different in terms of implementation and actual clinical practice. There are also differences between systems level evidenced- based practices and individualized client specific practices. Thus, the work group feels it is useful to think in terms of promoting the utilization of evidence-based models at **both** the systems level, as well as the specific intervention level. The definitions outlined in the third and fourth bullets above are the most commonly accepted definitions for EBP's within the mental health services field.

Parameters for assessment, choice and prioritization

In an effort to provide structure to the review of potential EBP's, each EBP was evaluated according to the following parameters:

- **Clarity of Construct:** To what extent is there clear agreement on what this means? Is there a manual to follow? Is it a circumscribed, teachable practice that can be replicated across sites?
- **Impact:** How much of an effect will an initiative in this area is likely to have? How many people will it be likely to affect?
- **Need:** How critical is the need for this service/intervention or initiative at this time?
- **Evidence-Base:** To what extent has the practice been demonstrated to yield good outcomes in rigorous studies across multiple sites?
- **Diversity:** Will this initiative impact diverse populations across the state, e.g., across culture, age groups, socio-economic groups?
- **Feasibility:** What is the likelihood that the initiative can actually succeed if undertaken?
- **Opportunity:** To what extent does this initiative make sense at this time- in terms of dovetailing with other initiatives?
- **Affordability:** What are realistic estimates of short-term (i.e., start up) and long-term costs?

Summary of Recommendations

In compliance with the legislative request – recommendations are provided below for the implementation of 2 evidence-based practices (EBPs) per year over the next 3 years for adults with serious mental illness and children and adolescents with serious emotional disturbances (i.e., a total of 6 practices over 3 years). However, there is universal concern among the workgroup that anything near full implementation of this many practices might overwhelm the capabilities of the system. Strategies to address this concern fall into two general areas, both of which may be applicable:

- 1) reduce the number of EBP's/year, e.g., to one/year for each population
- 2) clarify what is meant by "implementation", emphasizing that implementation doesn't have to be statewide. Rather, it may take the form of demonstration or pilot projects.

The recommended EBP's for adults and children are delineated here:

EBPs for Adults with Serious Mental Illness

Year 1:

A. Integrated Treatment for Co-occurring Disorders

The EBP workgroup is fully supportive of the overall "Comprehensive, Continuous, Integrated System of Care Model" as explicated by Minkoff. One specific implementation model is clearly laid out in the "[Integrated Dual Diagnosis Toolkit](#)" by SAMHSA. The workgroup supports expanded implementation of this model.

Critical components of the model include:

Integrated services: Clinicians provide services for both mental illness and substance use at the same time.

Knowledge about alcohol and drug use, as well as mental illnesses: Clinicians know the effects of alcohol and drugs and their interactions with mental illness.

Assessment: Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.

Stage-wise treatment: People go through a process over time to recover and different services are helpful at different stages of recovery.

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

Ongoing workforce development in core competencies in each of these areas must be pursued.

[Fidelity assessment](#) for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Peer Support

The EBP workgroup recommends the expansion of peer support services.

Although the evidence-basis for the effectiveness of peer support not been as strongly established in rigorous research studies as other recommended EBP's for adults, it is growing and there is increasing consensus and enthusiasm for the model, especially as pursued via the "[Georgia Model](#)" of peer support. This model revolves around "Certified Peer Specialists" (CPS). The workgroup recommends that the job [responsibilities and activities of the CPS](#) be built upon that which is in use in Georgia – and detailed in the appendix.

Peer support specialists should play an increased role in crisis intervention services, (e.g., in emergency room settings).

The MHDS should work with IME to ensure providers are appropriately reimbursed for peer support services.

The division must review and revise accreditation standards to describe the role, training, and quality assurance requirements of the CPS position.

Year 2:

A. Supported Employment

The EBP workgroup concluded that employment is a critical piece of recovery, and supported employment for adults with SMI is an evidence-based model that is being under-utilized in Iowa. With the introduction of the Medicaid Habilitation Option, and the CMS-funded Money Follows the Person Initiative/ Consumer Choice Option grant, it is felt that this is a good time to pursue this.

Supported employment revisions under the MR and BI Medicaid waivers need to be made consistent with or incorporated into the Habilitative services. The Habilitative services rules need to be reviewed and revised so as to be optimally consistently with the evidence-based practice model as described in the SAMSHA [Supportive Employment toolkit](#).

The Workgroup recommends that MHDS and IME ensure that providers are being appropriately reimbursed for supported employment services, and the MHDS must expand collaboration with Division of Vocational Rehabilitation.

Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA Supported Employment toolkit

Critical components and core principles of this supported employment model include:

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

[Fidelity assessment](#) for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Illness Management and Recovery (including Cognitive Behavioral Therapy)

"Illness management and Recovery" (IMR) refers to a set of evidence based principles and strategies that have been found to enhance recovery-oriented outcomes in adults with serious mental illness. The core components of IMR include:

- Psychoeducation, with the goal of improving consumer knowledge about serious mental illnesses
- Behavioral Tailoring, with the goal of helping people make informed choices regarding specific treatment recommendations including medications
- Relapse Prevention, with the goal of reducing symptoms, relapses and rehospitalization
- Coping Skills Training, with the goal of reducing the distress and functional impairment associated with persistent symptoms

Specifically, the IMR curriculum consists of nine modules, delivered in group or individual formats, typically taking six to nine months to complete. The modules include: recovery strategies, practical facts about mental illness, the stress-vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, getting your needs met in the mental health system.

Broadly, Cognitive Behavioral Therapy (CBT) is the underlying model, which unifies these components. Core competencies in CBT should therefore be an expectation across the mental health workforce.

Year 3:

A. Assertive Community Treatment (ACT)

Iowa currently has 5 ACT teams serving ~ 250 clients. It is estimated that the number that would qualify for and benefit from ACT in Iowa is ~ 2000 (based on an expected need of 2.2% of mental

health users, or 0.06% of adult population as per [Cuddeback et al.](#) It is estimated that ~ 15 ACT teams would be required for statewide access to ACT in Iowa. The workgroup recommended the implementation of one new team per year over the next 10 years.

The two major barriers to full statewide implementation involve funding and workforce issues. With an appropriate reimbursement strategy, ACT teams should pay for themselves within two years of start-up. Start-up costs are estimated at 500K for year 1 and 250K for year 2. Medicaid dollars are typically the primary source of payment for ACT. Payment for ACT services should be incorporated into Iowa's state Medicaid plan as a required rather than optional service.

As the availability of psychiatrists is a potentially rate limiting factor, accreditation standards that allow for nurse practitioners and/or physician's assistants to fill the psychiatric role should be pursued.

A key to the success of this "roll out" would be adequate training and support, e.g., in the form of an ACT TA center. Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA [Assertive Community Treatment](#) toolkit.

B. Family Psychoeducation

Family psychoeducation is an evidence-based program that can reduce relapse rates and facilitate recovery of persons who have mental illness. Psychoeducation is delivered by health care professionals, generally takes place over several months, and is linked to the treatment being received by the family member who has a mental illness. The main goals of working with families are to improve the quality of life for the person who has mental illness through collaborative treatment and management; and to reduce the stress and burden of family members while supporting them in their efforts to aid in the recovery of their loved one. Family psychoeducation has been shown to be useful in schizophrenia. The evidence base for other adult psychiatric disorders has been less well established.

The main barrier to family psychoeducation is typically concerns (real or perceived) about whether this activity meets typical standards for reimbursement. As is the case with parent training for conduct disorders, the evidence-based practice requires services not to the identified client – but rather to the supporters of that client. This can present a problem with respect to reimbursement. It is critical that barriers to funding for family psychoeducation be addressed, so that traditional third party reimbursement, e.g., from Medicaid, can be used to finance it.

It is recommended that training in core competencies for family psychoeducation in Iowa follow the model as laid out in the Family [Psychoeducation toolkit](#) from SAMHSA.

EBPs for Children and Adolescents

Year 1

A. School-based Mental Health Services

Research has yielded important advances in the development of effective treatment for children and adolescents who have mental health disorders. Early identification and treatment is critical as early identification of a mental health disorder and access to treatment prevents the loss of critical development years, can minimize the severity of a child's disability, has a greater effect in stabilizing a child's illness and contributes to long term positive outcomes of youth.

At the same time, the overwhelming majority of children with mental health disorders are often unidentified and youth do not receive needed treatment. The reason for this is largely because the symptoms of mental health disorders in youth are often not recognized as related to a mental

health disorder. Adults who are in regular ongoing contact with youth such as teachers, coaches, clergy, and others who work directly with youth do not receive training or other education regarding the prevalence, incidence, identification of risk factors, or other signs related to recognizing mental health needs in youth. Youth who are most in need are often difficult to engage in traditional treatment settings but often respond well to services when provided in more typical environments such as their home school.

As a result there is need to enhance the capacity of mental health professionals to identify and treat youth with mental health disorders in the school setting and for educational staff to receive education and training regarding meeting the mental health needs of youth in the school setting.

Although, there are several models for school based mental health services, the model that is the best fit to address current gaps between mental health services and schools in Iowa is to “house” mental health professionals within the educational setting for the purpose of:

- Early identification, screening, and assessment of mental health needs in youth.
- Linking youth and their families to appropriate mental health services supports and treatment, which includes services needed to help the child succeed in school and services needed beyond the educational setting.
- Facilitating timely access to services when more formal mental health services are needed.
- Providing education, consultation, and support to parents of targeted youth regarding youth’s mental health needs (both within and outside of school).
- Providing education, consultation, and training to educational staff regarding mental health needs of youth.
- Educating youth in the most appropriate, least restrictive educational setting.

The school based mental health service initiative will concentrate on:

- Improved collaboration and coordination at the state agency level between DHS-MHDD, the Department of Education, and the Area Educational Agencies (AEAs) with the goal of state level efforts extending to local school districts, AEA’s, special education services, Early Access, mental health service providers, and others involved in school based mental health services.
- Early identification, Screening and Assessment: A formal process for the early identification of mental health needs in youth, screening/assessment services, and coordination/referral to more formal mental health services when indicated.
- Coordination between home, school and active engagement of parents of youth.
- Mental Health education, training, consultation, and other support to educational staff about identifying mental health needs in youth and supporting youth with mental health needs in the classroom.
- School Based Mental Health Workforce Development needs: Training in core clinical competencies of specific evidence-based interventions for priority disorders needs to be available in a practical manner. This should focus on:
 - Parent Support, Education, and Training (e.g., Parent Child Interaction Therapy)
 - Cognitive Behavioral and Interpersonal Therapy approaches (e.g. Interpersonal Therapy – IPT for adolescents)
 - Early identification and intervention (e.g., ABCD II, Positive Behavioral Supports, etc.)
 - Co—occurring disorders

B. Intensive Case Management with Wraparound

Intensive Case Management is being recommended as a step towards the implementation of the System of Care Model. Intensive case management is a model of case management, which combines the typical coordination/brokerage of service functions with the provision of intensive direct services to the child/ youth and the child/youth's family. Intensive case management services for youth and families typically follow a Wraparound Model of service delivery. This model uses the approach of "one child at a time" individualized service planning to identify what the child and family's unique strengths and needs are.

Wraparound uses a team approach, includes other "key" people and/or agencies involved with the child and family in the service planning process and is typically coordinated by a case manager. The wraparound model is strengths based, family driven, community focused, outcomes driven, and is dedicated to keeping children and youth in the least restrictive environment appropriate to the youth's needs. The case manager convenes the Wraparound Team, facilitates the Wraparound process, coordinates across all services and service providers determined through the Wraparound process, and otherwise ensures that the most appropriate, least restrictive services are provided in the most efficient manner.

Year 2:

A. Parent Support, Education, and Training Services (e.g., Parent Child interaction therapy, Incredible Years, parent to parent support services, etc.)

Parent Support services are services provided by trained parent educators/advocates to work with parents who have children with serious emotional disturbance. Parent Support services include education and supportive services to parents, to otherwise help parents be active participants in their child's care. Parent support services typically follow a peer-to-peer model where parents of youth with serious emotional disturbance are trained to provide the support and educational services to other parents of youth with serious emotional disturbance. Parent Support and education services can be provided individually or in a group setting.

Parent Training Services are provided to parents who have youth with SED and are typically delivered in a more formal context, often in a group setting typically following a standardized curriculum.

Two examples of Parent Support, Education, and Training are:

1. Parent Child Interaction Therapy (PCIT): PCIT is an empirically supported treatment for youth with conduct disorders, which places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. With PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's pro-social behavior and decreasing negative behavior. This treatment focuses on two basic interactions: a). Child Directed Interaction (CDI) which is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; and b). Parent Directed Interaction (PDI) which resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.
2. The Incredible Years: This model is geared towards younger children with disruptive disorders (ages 4 – 8). It is focused on strengthening parenting competencies (monitoring, positive discipline, confidence) and fostering parental involvement in their

child's school experiences in order to promote a child's academic and social competencies and reduce conduct problems.

As there are several models of Parent Support, Education and Training, which focus on different targeted populations and age groups, it is recommended that flexibility be allowed for choice among the many options.

B. In-Home and Community Based Services and Supports

In home and community based services and supports are another critical component of a System of Care Model. These services are typically provided under the supervision and/or coordination of a child's therapist and are a critical part of the child's treatment team. Providers in home and community based services may be a bachelors or para professional level staff that have standardized training in the specific service they are providing. These services are individualized based on the unique needs of the child and family and can be provided in any community location where children and families spend their time: in the family home, at school, or in any other community location. In home and community based services may include respite care, peer support, parent support, attendant care services, behavioral health aides, community psychiatric support and treatment, in-home therapy, etc.

Year 3

A. Family Functional Therapy (FFT):

Functional Family Therapy is a family-based intervention program for youth ages 11 – 18 who have demonstrated dysfunctional and maladaptive behaviors such as delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, or depression. It provides 8 – 30 sessions of direct service time for the referred youth and their families. The program can be delivered in a variety of settings including home, school, clinical and juvenile facilities.

While there are some programs in Iowa that are implementing this EBP, it is recognized as an expensive, difficult to develop practice. However, there appears to be evidence that the approach is cost-effective (across service systems) for appropriately identified clients and families. The EBP group recommends that FFT be pursued further in terms of supporting the funding of FFT in pilot sites as well as developing statewide training for the service in select locations.

B. Integrated Dual Diagnosis Treatment of Co-occurring Mental Health and Substance Abuse Disorders in Children and Adolescents

The evidence base on the effectiveness of integrated MH/SA treatment has not been well established for children and adolescents in the research literature. However, the EBP workgroup believes that the basic principles recommended by co-occurring experts as they apply to adults would likely benefit adolescents as well, and some might very well be generalized to children. Certainly, youth with mental health disorders and/or their parents sometimes also have substance abuse disorders and can maximize benefits from services when service providers are cross trained and have competencies in co-occurring disorders. Therefore it is recommended that

- mental health and substance abuse service providers are cross trained in co-occurring disorders
- The adult model of IDDT is further examined as a service approach that can be implemented with adolescents.