

# **Mental Health:** Moving Toward Best Practices

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## Iowa Mental Health Forum

*Addressing the Mental  
Health Needs of Iowans*

**Iowa's Mental Health System:  
Assessing Awareness, Identifying Needs, and Promoting Solutions**

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**Prepared by**

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## **Introduction**

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Addressing the difficulties facing Iowa's mental health system can appear daunting given the variety of mental health needs and problems. Therefore, it can be helpful to focus on successes in providing quality mental health care both nationally and here in Iowa.

There are a number of evidence-based and promising models of mental health care available. The following section is not intended to be an exhaustive list of these possibilities. Rather, the purpose of this section is to highlight a handful of these programs in order to demonstrate some of the approaches available to meet specific mental health needs. It is hoped that these descriptions will help provide a focus to the discussion of changes in Iowa's mental health care system by providing a vision of the types of improvements that are possible.

The evidence-based and promising models described were selected by a panel of individuals involved in Iowa's mental health system. The panel was selected by contacting individuals who were considered to be knowledgeable about mental health services in Iowa and about national trends in the provision of mental health services. An effort was made to include individuals with a variety of perspectives. Specifically, the committee included members with expertise in different mental health specialties (e.g. children, elderly, chronically mentally ill), different vantage points of the mental health system (e.g. consumers, family members of consumers, and providers), and different training backgrounds (e.g. nursing, psychiatry, and psychology). Nevertheless, it was not possible to represent all the viewpoints of individuals affected by Iowa's current mental health care system.

Models were selected for inclusion in this publication by asking members of the panel to write brief descriptions of what they considered to be the most promising models of mental health service delivery in their fields. This list of models was then narrowed down by selecting only those models that had been subjected to rigorous scientific study and could meet criteria for "clarity of construct" and "evidence-based" practice.

Clarity of construct refers to the specificity of the particular model. That is, in research on this approach is there a specific, well-described model that is consistent across research studies? Clarity of construct is important as it allows us to better evaluate the cumulative research regarding a model and provides a specific outline of how to implement the model.

Evidence-based practices are models that have been extensively researched and demonstrated to be effective. For a program to be rated as having a strong or very strong evidence-base, it must have demonstrated positive outcomes both in carefully controlled research and in "real-world" settings.

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Finally, a chart was developed summarizing the models to serve as a quick reference to the types of models available. The chart and ratings were developed by the panel to reflect important variables to consider when evaluating models of mental health care. For each model the chart first summarizes the clarity of the construct and the evidence-base. The chart then considers national availability of the model, whether the model has been mandated or recommended at the federal level, the availability of the model in Iowa, and possible barriers to implementing the model in Iowa.

We did not attempt to provide an exhaustive list of all possible models of mental health care. Rather, we hope the model programs summarized in this section will promote debate and discussion of some of the promising approaches available. Most importantly, we hope to provide ideas of how our current mental health system can be better tailored to meet the mental health needs of Iowans.

# Programs of Assertive Community Treatment (PACT)

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## 1. Overview of model - What is PACT?

PACT is an integrated service-delivery system that provides needed treatment, support, and rehabilitation services for persons with serious mental illness. As opposed to traditional office based practice, patients receive care in their home and in the community. Team members represent various disciplines including psychiatry, nursing, social work, substance abuse, and vocational rehabilitation. Goals of treatment are to reduce psychiatric symptoms, prevent relapse of symptoms, promote independent living in the community, achieve desired social and occupational roles, and decrease the family burden of providing care. Treatment is comprehensive and individualized, and services are available 24 hours per day.

## 2. Needs of the population the model is designed to address

Persons with severe mental illness such as schizophrenia have difficulty organizing their thoughts and separating reality from fantasy, which often results in odd beliefs and bizarre behaviors. Many suffer from apathy and profound inertia, and as a result are unable to maintain structure in their everyday lives. This precludes meaningful relationships, employment, and oftentimes the ability to meet daily survival needs such as food, clothing, and shelter.

Traditional outpatient treatment directs patients to various services that they then must pursue on their own. Persons with serious mental illness have not fared well under this model. Conservative estimates report one third to one half of the nation's homeless suffer from a severe mental illness (1). Compared to the general population, persons with serious mental illness have ten times the suicide rate (2), ten times the HIV rate (3), and are at least three times more likely to have drug or alcohol abuse problems (4). Those with drug and alcohol problems are eight times more likely to commit violent acts (5). Additionally, these individuals are typically high utilizers of costly inpatient services.

Individuals with severe mental illness have needs in the following areas: medication support (ordering and administering medications, evaluating side effects, and efficacy of medications), housing assistance, entitlement acquisition, financial planning, health promotion, activities of daily living support, family education, substance abuse counseling, health promotion, social skills training, and occupational rehabilitation.

### **3. Clarity of the construct**

PACT programs are highly structured in terms of their goals, staffing patterns, types of interventions, recommended patient to staff ratios, types of patients included, and overall structure. The model is sufficiently clear to allow for methods of measuring fidelity to the theoretical model, and consequences of deviating from the model.

### **4. Empirical support for effectiveness of this model**

The PACT model has been extensively studied and found to be effective. Over 25 randomized controlled trials (9) have been published. Together, these studies indicate the following with a high degree of consensus: PACT reduces psychiatric hospitalizations (10), increases housing stability (10), decreases substance use (11), and is cost effective for patients who are high utilizers of inpatient hospitalization (12). Studies that examined satisfaction showed patients and their families prefer PACT care to alternative forms of treatment (13).

### **5. Availability of the model nationally**

Currently, 35 states have either PACT demonstration or PACT adaptation projects. Six states (DE, ID, MI, RI, TX, WI) have statewide PACT availability (6).

### **6. Mandated or recommended by governmental or other agencies**

PACT growth has escalated in recent years secondary to several factors. In 1999, the Surgeon General (7) and the federal Health Care Financing Administration (HCFA) (8) endorsed PACT. The National Alliance for the Mentally Ill has undertaken a major initiative to have PACT available across the United States by the year 2002, and has been lobbying at state and national levels to this end.

### **7. Availability of the model in Iowa**

There are currently three PACT programs in Iowa:

- The University of Iowa Health Care, ("IMPACT"), Iowa City, started 1996
- Abbe Center, Cedar Rapids, started 1998
- Eyerly Ball Mental Health Center, Des Moines, started 1998

### **8. Barriers to PACT implementation in Iowa**

Barriers to growth of PACT in Iowa include under funding, apathy of decision-makers, and lack of trained clinicians in the model.

Iowa is widely considered to be under funded to do PACT (6). Under funding has led to PACT teams that are not fully compliant with recommended PACT standards. Numbers of staff members are below recommendations, which in turn affects hours of operation, call schedules, and representation of all disciplines on the team. All

potential funding streams are not on board in Iowa. Each of the 99 counties in Iowa decides how to spend their mental health dollar, and individual counties have not been uniformly willing to fund PACT care.

Lack of clinicians trained in the model has limited PACT growth in Iowa. Within existing PACT teams, selecting and retaining qualified team members has been problematic. Continuous on-site leadership is required to help teams maintain PACT standards and prevent regressing to traditional individual case management, which can lead to burn out among staff. Availability of psychiatrist time is another difficulty. Iowa has maldistribution of psychiatrists across the state. Most psychiatrists are found in four counties, with 50/99 counties lacking a psychiatrist. Additionally, many psychiatrists are retiring from active practice and are not being replaced.

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# Supported Employment

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## **1. Overview of model - What is Supported Employment?**

Supported employment is a well defined and well-studied evidence based approach to helping people with serious mental illness participate as much as possible in the competitive job market. Supported employment programs assist individuals with disabilities find and keep community jobs paying at least minimum wage. These are preexisting jobs open to all applicants. Clients are placed in jobs consistent with their interests and capabilities. Supported employment programs do not require extensive pre-vocational readiness assessment. They focus on assistance with rapid job acquisition by assisting clients with the application and interview process and provide ongoing support once the client obtains a job. Supported employment programs are closely integrated with the client's mental health treatment team (1).

## **2. Needs of the population the model is designed to address**

Sixty to 70% of people with severe mental illness indicate that they would like to work in community based, paid jobs yet 85% of them do not. Less than 25% of persons with severe and persistent mental illness receive any form of employment assistance (2). The best employment outcomes for this population have been achieved by providing assertive professional assistance with every stage of the process involved in finding and keeping a job and closely integrating this assistance with the client's health care team.

## **3. Clarity of the construct**

The supported employment model has been used in the psychiatric rehabilitation literature in a fairly consistent way since its initial appearance in the psychiatric rehabilitation literature in the mid-1980s (3). The essential components of supported employment programs have been clearly defined (1), and include:

- A commitment to competitive employment as a reachable goal for persons with serious mental illness (committing resources to helping people with mental illness maintain paid employment instead of committing resources to day treatment or sheltered employment)
- Use of a rapid job search approach rather than lengthy preemployment assessment and training
- Attention to job placements according to client preference, strength, and experience
- Maintenance of supports for an indefinite period of time
- Integration with the client's mental health team

#### **4. Empirical support for effectiveness of this model**

Supported employment for persons with serious and persistent mental illness is an evidence-based practice. Findings from eight randomized controlled trials and three quasi-experimental studies demonstrate significant improvement in vocational outcomes with this model. Annual cost per person for supported employment is similar to the cost of traditional, less effective, vocational services. Bond and colleagues conclude in an extensive review of the literature on this subject that the evidence on supported employment is clear and consistent in its demonstration of improved employment outcomes (1). They also note that many vocational programs that are not effective continue to be funded and practiced.

#### **5. Availability of the model nationally**

Currently, only a small minority of persons with serious mental illness is receiving assistance in finding and keeping a job. However, supported employment programs are found in a variety of service agencies including mental health centers, rehabilitation programs, and clubhouses. Integrated, multi-service programs like PACT and clubhouse can offer immediate, practical help in initiating a job search anytime a consumer becomes interested. Informal, spontaneous assistance can bypass fears that may accompany application to specialized supported employment programs. Model programs of assertive community treatment (PACT), and supported employment models exist (e.g., Fountain House in New York City and Thresholds in Chicago) around the country.

#### **6. Mandated or recommended by governmental or other agencies**

Supportive employment programs have been strongly recommended as an evidence-based practice by academicians (1), but thus far, we are unaware of any specific governmental agencies that are mandating it. It has been suggested (1) that the provision of ongoing DVRS (Division of Vocational and Rehabilitative Services) be made contingent upon use of this model, but thus far this has not become policy.

#### **7. Availability of the model in Iowa**

The extent of use of the supported employment model in Iowa will be difficult to assess as long as there is no central oversight of adherence to the model's primary premises. The essential components of the model least often seen are the integration with the health care team and the ongoing provision of support services for an indefinite period of time once the job is attained.

#### **8. Barriers to supported employment implementation in Iowa**

Barriers exist on several levels including (1) governmental, (2) program administrators and clinicians, and (3) families and clients.

**Governmental:** The federal-state vocational rehabilitation system has been the primary funding source for employment services and this funding is sufficient to serve only a small portion of those in need of vocational services. Furthermore, available funds are not currently being used to fund supported employment.

**Program administrators and clinicians:** As noted above, funding for vocational services is limited. In addition to financial factors, leadership for innovations, even when they are evidenced based, is difficult. Administrators may not have access to information on evidence based practices, they may not value or believe that the outcomes are possible in their setting, and there may be no incentive to change their existing services. Administrators and clinicians trained in an earlier era may hold the opinion that work is not a reasonable goal for persons with schizophrenia and that work may, in fact, produce unmanageable levels of stress. Neither of these widely held opinions are borne out with evidence.

**Families and clients:** Sometimes clients are discouraged from seeking employment by families who are fearful that the stress of employment will outweigh the benefits. Some clients fear automatic loss of eligibility for Social Security and Medicaid benefits with any employment.

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# **School-Based Clinical Mental Health Services for Children and Families**

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## **1. Overview of model - What is School-Based Clinical Mental Health Services for Children and Families?**

Because schools are one institution that all communities must provide, they are an ideal setting for providing mental health services to children and families. Children receive substantial portions of their daily care in schools, especially as school days are now expanded to include before-and after-school programs, day care, and two meals per day for many working families. The need to provide community-based care and the difficulty in bringing children and adolescents to clinics to receive it are well known.

The model of school-based mental health care described here is one in which services are offered within the school environment, often as part of school-based general health clinics. Mental health professionals such as counselors, social workers, psychologists, nurses, or physicians see students for evaluation and treatment and consult with parents and teachers. These programs are funded through multiple sources including community school districts and mental health centers, Medicaid, private insurance, and grants.

The term “school-based mental health services” may also refer to specific programs delivered in schools as part of general curricula to help children avoid the onset of or problems associated with social, emotional, or behavioral disorders. These programs target children or adolescents in specific grades, range in duration from weeks to years, and the most effective of them typically have parent, peer, and teacher components.

## **2. Needs of the population the model is designed to address**

According to the Surgeon General’s 1999 report on mental illness, 22% of America’s nine to 17-year old children have diagnosable mental illness, 11% have one or more illnesses significant enough to cause impaired functioning at home, school, or with their peers, and 5% have extreme functional impairment (1). Only 16% of children receive any mental health services, and 70% to 80% of those who receive them at all do so within the school setting. That figure includes the curriculum-based programs mentioned above. For the overwhelming majority of children, the school system is their only source of mental health services. (2).

Providing ongoing therapy to students with diagnosed mental illness is the least common function of school-based mental health clinics. More typically, they provide evaluations and crisis services and refer patients to community resources for longer-

term care. Reaching many more children are the classroom, or school-wide programs ranging from pre-school developmental and other preventive programs, through those targeted for specific problems such as aggression, depression, or suicide prevention. These are also referred to in the literature as school-based mental health programs. Universal programs delivered without reference to individuals' problems eliminate the effects of labeling of students and target specific outcomes such as violence prevention, social and cognitive skill building, substance abuse, and teen pregnancy.

### **3. Clarity of the construct**

The term "school-based mental health" is used here to describe the provision of clinical services similar to those provided elsewhere in communities but located in school facilities. The construct is not a single, clearly defined one, and program designs vary widely depending on community needs, resources, the qualifications of the available service providers, and funding mechanisms which vary widely from place to place.

### **4. Empirical support for effectiveness of this model**

An example of a clinical mental health program studied with a sound research design is Vanderbilt University's School Counseling project (3). Mental health counselors worked with students in inner-city Nashville elementary schools, which they ran as mental health satellites to their university center. The interventions included individual counseling and classroom consultations with teachers. For a control group, college students were trained to spend equal amounts of one-on-one time with students but in friendly tutorial sessions without counseling content. Significant and substantial ratings were found for both groups of students: for the counseling group, change rate in ratings by parents, teachers, peers and self was twice as large. In addition, behavior referrals throughout the school were significantly reduced for all students. A second comparison group was with children who received individual counseling in a mental health clinic; despite rides and other incentives to families for bringing their children to the clinics, researchers could not maintain an adequate number of subjects to complete the comparison.

This difficulty in getting children into regular treatment in clinic settings is a major advantage of making clinical mental health care available in school settings. Not only is it more convenient to students and family, it is a natural setting that reduces the stigma and anxiety that may be associated with receiving mental health care. The empirical support for this model is less likely to be derived from typical outcome measures on individuals or groups of children than on numbers of children reached by such programs, particularly in target areas where resources are scarce. The school receives benefit as well in reduced disciplinary, absenteeism, and dropout problems. For instance, Henry County, Iowa schools reported a 40% reduction in behavioral problems as a result of having school-based mental health services, a meaningful outcome for a school-based intervention.

Iowa's state-funded School-Based Youth Services Program, currently in its sunset year, has had a \$20,000 evaluation component annually where its impact on school behavior, drop-outs, grade point averages, parent perceptions, and other success indicators has been gathered and summarized. Their evaluation tools and outcomes have recently been published by Corwin Press (4).

Rones and Hoagwood (5) reviewed 47 studies of school-based mental health programs, both curriculum based and clinical programs, that met their inclusion criteria and noted that "Results suggest that there are a strong group of school-based mental health programs that have evidence of impact across a range of emotional and behavioral problems" (5, p. 223). In their review, they identified the importance of school-based programs being well-implemented and noted examples of undesirable behaviors actually increasing when program fidelity was lacking. Multifaceted programs targeting the ecology of the child, including teachers, peers, and parents are more likely to be successful, as are those targeted toward changing specific skills associated with the intervention rather than those seeking general enrichment of children's experience. The inclusion of multiple approaches and modalities is associated with program success, for instance, including the teaching of empathy skills, self-control skills, and academic tutoring to high-risk children.

## **5. Availability of the model nationally**

School-based mental health clinics have been established in many cities throughout the country including Los Angeles, California; Albuquerque, New Mexico; Baltimore, Maryland; and New London/Groton, Connecticut. Some have included mental health services in school-based general health clinics. Where that has been the case, mental health services have been those most in demand or ranked equal with or just below reproductive services where those are offered.

The State of Connecticut has 51 school-based health clinics operating across the state, the sixth largest number in the nation. Started in 1985 and funded by the State Department of Public Health, they have been considered "ancillary providers" by Medicaid since 1997 and are reimbursed on a fee-for-service basis. Their services include parent-child counseling, victimization counseling, home-based family preservation and reunification services, a young parents program for teen mothers and their infants, and diagnostic and evaluation services. After evaluation and five therapy visits, students are referred to community providers for longer-term care. Lack of providers is a problem noted by clinicians in this system.

Among the largest and oldest city-wide system is Baltimore's, which has a close working relationship with its independent local mental health authority, the Baltimore Mental Health Systems (BMHS), which oversees all the city's mental health providers. It

provides mental health and substance abuse services in 80 schools. Medicaid funding is used, but the school board provides a large portion of the funding.

## **6. Mandated or recommended by governmental or other agencies**

In regards to mandated clinical mental health services in schools, they appear largely to be a function of a governing body's having a central mental health authority such as exists in the State of Connecticut and in the cities of Los Angeles and Baltimore where schools have long been primary centers for delivering mental health care to children and youth.

## **7. Availability of the model in Iowa**

In 1990, the Iowa Legislature funded the School-Based Youth Services Program. Initially funded for four school districts, these cooperative programs were originally designed to reduce school dropout rates in secondary schools only. The programs were required to include primary health and mental health providers, human services, drug prevention, workforce development, and juvenile court workers in their school-based programs and were encouraged also to include other community resources such as recreation. With one year of the program remaining, 28 school districts currently participate in this program as it has been expanded to include the full kindergarten through high school age range. They include districts as large as Des Moines and Waterloo and as small as Nevada where they have augmented Iowa funding with substantial federal grants. Most communities anticipate continuation of their programs after this year with the help of modified allowable growth whereby they can increase their local tax base by 5% of the K-12 allotment per student as approved by the State Board of Education to provide coordinated multiple services.

Nevada, as an example, brings a play therapist from the Richland Center in Ames to their elementary school two days a week and is using grant money to expand that program to after-school and summertime hours as well. A mental health worker from the McFarland Clinic in Ames is available weekly in the middle school, and a McFarland counselor is available for self-referral by students from the high-school where greater emphasis is placed on career development, Boys & Girls Club activities, and recreation than on direct mental health services. A family resource center that serves the full community including parents, youth, and seniors is central to their project. The most recently added example in Iowa of a School-Based Youth Services Program is the Winfield-Mt. Union Community School District in Henry County. This is just one part of a countywide partnership between Henry County Schools, the Real World Community Mental Health Center, and Henry County serving all four school districts in that county. Licensed psychologists and social workers in each school building screen students for mental health problems, provide initial counseling sessions, and assist them with referrals to community providers for ongoing treatment.

## **8. Barriers to school-based clinical mental health services implementation in Iowa**

The barriers to providing school-based clinical mental health services mentioned most frequently are getting buy-in from public and private providers who may feel their interests are threatened, concerns over confidentiality and liability, concerns related to stigmatizing students or families who access services, and funding difficulties. Territorial issues over what schools should and should not involve themselves in or be held responsible for and how closely social service and educational service agencies should intermingle exist in some places. States, cities, and school districts that have successfully started school-based mental health services stress the importance of community education and gaining commitment from all parties involved as first steps in their establishment.

The barriers to schools offering curriculum-based mental health programs in Iowa are few, and many or most Iowa schools offer a variety of programs that would fit under this broad definition in health classes or at-risk programs. The Department of Education has invested in a sequence of two major initiatives to improve schools' ability to address the social, emotional, and behavioral needs of all students in Iowa schools, first the Iowa Behavioral Initiative, which was subsequently developed into Success4. Currently, statewide training is underway to encourage school planners to include social, emotional, and behavioral goals in their mandated Comprehensive School Improvement Plans.

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# Family Psychoeducation

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## **1. Overview of model - What is Family Psychoeducation?**

Family psychoeducation is an evidence-based program that can reduce relapse rates and facilitate recovery of persons who have mental illness (1). 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 (1).

## **2. Needs of the population the model is designed to address**

The impact of mental illness on other members of the family is devastating and has been consistently documented. Many families become the primary caregivers for their psychiatrically disabled family member and must assume roles for which they are unprepared and untrained. Studies suggest 30 to 65 percent of adults with serious mental illness either live with their families or receive primary care from their families (2,3). People with mental illness often require a wide range of services including mental health, physical health, vocational, residential, and social, and, not always are satisfactory, appropriate services available.

The development of this program and the needs of the families are not to imply that families are to be responsible for the care of their mentally ill relative. This responsibility should remain with the mental health system.

## **3. Clarity of the construct**

Even though existing models of family intervention may differ from one another, there is consensus by leaders in the field on the essential components of an evidence-based program. Evidence-based models include 15 principles as part of the core elements health care professionals use when working with families who have a family member with mental illness. Core elements of the program include provision of emotional support, education, clinical guidance, resources during periods of crisis, and problem-solving skills (1).

## **4. Empirical support for effectiveness of this model**

Family psychoeducation is an evidence-based practice. Family psychoeducation has a solid research base and a substantial body of literature is available regarding this intervention. Based on an extensive review of research studies documenting the most effective practices from the last several years, this model demonstrates the benefits of

support and education for families, and has been proven to alleviate family burden and contribute to reductions in the relapse rate of consumers whose families have received psychoeducation (1).

## **5. Availability of the model nationally**

The availability of evidence-based family psychoeducation is limited (1). There are some states that acknowledge the importance of educational programs for families and are beginning to provide limited funding for family education programs (4). However, most of these programs are family-to-family self-help programs that have been developed by advocacy organizations and are delivered by volunteer-family members. These programs are independent from treatment for either the family or the ill relative; and are free standing rather than part of a comprehensive program (5). The most widely used program of this kind is the National Alliance for the Mentally Ill (NAMI) Family-to-Family Program (6).

## **6. Mandated or recommended by governmental or other agencies**

Family psychoeducation is a recommended treatment intervention included among best practice standards. This intervention is included in: The Schizophrenia Patient Outcomes Research Team (PORT), a major five year study funded by the National Institute of Mental Health and the Agency for Health Care Policy and Research (7); the American Psychiatric Association Practice Guidelines for the Treatment of Schizophrenia (8); the expert consensus guideline series (9); and other best practice standards from various disciplines that have recommended the participation of families in education and support programs, as well as emphasized the importance of including family members in the treatment and rehabilitation of their family members who are mentally ill (1).

## **7. Availability of the model in Iowa**

There are no family psychoeducation programs in Iowa that include the essential components. Most programs that are defined as family psychoeducation by their sponsors are brief in duration, usually one day or less, and do not provide continuing family support and clinical guidance, and linkage to the treatment being received by the family member who has a mental illness.

## **8. Barriers to family psychoeducation implementation in Iowa**

System and program barriers, including policies, attitudes, feasibility, and knowledge prevent the implementation of this evidence-based model program. The required resources, including health care professionals, time, funding, and reimbursement have not been available or provided.

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# Mental Health Courts

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## **1. Overview of model - What are Mental Health Courts?**

Mental Health Courts are a new phenomenon that have developed only within the past five years [1,2]. They are based on other specialized “problem-solving” courts, such as drug courts or domestic violence courts, which have become increasingly common around the country over the past decade [3]. They are predicated on the notion of “therapeutic jurisprudence”, i.e., the idea that the workings of courts, judges, lawyers, and the criminal justice process can have either therapeutic or anti-therapeutic effects on those accused and/or convicted of crimes [4,5,6]. The basic idea is to identify defendants with serious mental illnesses, put them on the same court docket, and have a multidisciplinary team involved in the entire process who are familiar with, and sophisticated about issues of mental health and the mental health services system within the jurisdiction [7]. The primary goals include the diversion of appropriate mentally ill offenders from the criminal justice to the mental health systems, and the ability to direct, encourage, and potentially enforce appropriate mental health treatment for those individuals.

## **2. Needs of the population the model is designed to address**

The mental health court initiative is primarily directed at diverting people who have clearly established histories of serious and persistent mental illness from the corrections to the mental health systems. Most of the courts require a clear indication that the mental illness was an important contributing factor in the crime for which the person is being charged. All but one of the existing courts limits eligibility to those accused of misdemeanors. (The San Bernardino, California court is also open to those charged with low-level felonies). Criteria for what constitutes a “serious mental illness” varies to some extent across the courts, but typically include both developmental disabilities (e.g., mental retardation) as well as other specified psychiatric diagnoses. Misdemeanants with serious mental illness are thought to be over-represented in the criminal justice system, and tend to have longer jail and prison stays than non-mentally ill offenders charged with similar crimes [8]. Mental Health Courts are aimed at identifying such offenders early on in the process, and diverting them to more appropriate treatment settings.

## **3. Clarity of the construct**

Although each of the existing Mental Health Courts have some common features, it has recently been pointed out that they also have important differences in mission, scope and operations [7]. Thus, the current construct remains somewhat unclear, and probably reflects a variety of practices and goals. Specific criteria for Mental Health Courts have recently been proposed [7], and include:

- All persons with mental illness identified for referral to community-based services on initial booking are handled on a single court docket.
- A courtroom team approach is used to arrive at recommended treatment and supervision plans with a person specifically designated as a “boundary spanner” to ensure actual linkage.
- Assurance of existing appropriate treatment slots is necessary before the judge rules.
- Appropriate monitoring occurs under court aegis with possible criminal sanctions for non-compliance, such as reinstatement, continued charges or sentences.

#### **4. Empirical support for effectiveness of this model**

In light of the relative newness of this model, there has not yet been adequate time or resources to carry out methodologically sound research studies on their effectiveness. Anecdotal reports from each of the pioneering Mental Health Courts have been consistently encouraging, but data to back up these claims remain very limited. Currently, at least two of the mental health courts are involved in naturalistic follow-ups to look at various indices of effectiveness [1].

#### **5. Availability of the model nationally**

Currently there are at least five Mental Health Courts in operation nationally:

- |                              |                            |
|------------------------------|----------------------------|
| ▪ Marion County, Indiana     | Established 1980, 1996*    |
| ▪ Broward County, Florida    | Established June, 1997     |
| ▪ Anchorage, Alaska          | Established July, 1998     |
| ▪ King County, Washington    | Established February, 1999 |
| ▪ San Bernardino, California | Established February, 1999 |

\*Note: The Marion County, Indiana court was the country’s first Mental Health Court in name and identifiable form – initially established in 1980, it ran until 1992. It was then revived and remodeled in 1996 as the PAIR Mental Health Diversion Project.

#### **6. Mandated or recommended by governmental or other agencies**

Federal legislation was passed by Congress in the fall of 2000 to fund the establishment of approximately 100 mental health courts around the country. This legislation was signed into law by President Clinton in the final weeks of his administration (November 13, 2000). However, thus far no federal monies have been appropriated.

#### **7. Availability of the model in Iowa**

A mental health court is in the formative stage in Woodbury County. This is part of a larger project, known as Project Compass, which includes case management for offenders in the Woodbury County Jail who appear to have significant mental health

and/or substance abuse problems. The overall effort was initiated by a core group in Woodbury County, consisting of the county's CPC, sheriff, police chief, board of supervisors, mental health center director and Judge Patrick McCormick. Funding for the Mental Health Court was anticipated to come at least partly from the federal legislation described above. Despite the lack of funding, thus far, the court is planning to move forward. More information on this effort can be obtained by calling Project Compass at 712-293-1705.

## **8. Barriers in Iowa**

- The judicial system in Iowa has traditionally been reluctant to specialize.
- As Iowa is a rural state with limited population centers, a single Mental Health Court may not be practical.
- Iowa lacks any real secure psychiatric facilities outside of a prison setting.

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# Medication Algorithms for the Treatment of Severe Mental Illness

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## 1. Overview of model - What are Medication Algorithms for the treatment of severe mental illnesses?

Medication treatment of severe mental illness has been both advanced and complicated by the introduction of numerous therapeutic agents over the past decade [1]. Practice guidelines based on research evidence have been developed to help clinicians make complex decisions. Evidence-based clinical practice guidelines rely on thorough and ongoing literature reviews to evaluate the efficacy, safety, tolerability, spectrum of action, indications, and contraindications for available treatment options. These guidelines are the foundation for developing more specific, clinician-friendly, recommended treatment sequences (treatment algorithms). Treatment algorithms recommend more specific treatment sequences and are often accompanied by tactical recommendations (at what dose, over what period of time, at what therapeutic blood levels?) for particular strategies (e.g., specific medications for specified diagnoses or clinical presentations).

Medication algorithms are commonly used in the treatment of cancer, asthma, arthritis, diabetes, and other chronic general medical disorders. On the other hand, they are relatively new to psychiatry because diverse medication choices and the tools by which to measure outcomes (and therefore to consistently apply the algorithms in routine practice) are both only recently available.

The most well developed and well-researched medication algorithm project in psychiatry is the Texas Medication Algorithm Project (TMAP), started in 1996. This project was designed to develop, implement and evaluate not just a set of medication algorithms, but an algorithm-driven treatment philosophy for major adult psychiatric disorders treated in the Texas public mental health sector [2]. The ultimate goal of TMAP is to improve the quality of care and achieve the best possible patient outcomes for each dollar of resource expended. TMAP is a treatment philosophy for the medication management portion of care, consisting of: evidence-based, consensually agreed upon medication treatment algorithms [3], clinical and technical support necessary to allow the clinician to implement the algorithm [4] [5], patient and family education programs that allow the patient to be an active partner in care [6], and uniform documentation of care provided and resulting patient outcomes [7].

## 2. Needs of the population the model is designed to address

For patients with severe and persistent mental illnesses (SPMI), medication treatment guidelines, or algorithms, may bring appropriate uniformity to treatment at predictable costs, thereby improving the quality of care. Treatment guidelines may also provide a

benchmark against which to monitor care and to evaluate treatment programs. Whether these benefits accrue, and at what cost (or cost savings) to the treatment system, or to society, is unknown because these potential benefits have never been formally evaluated in SPMI patients. Treatment algorithms, such as TMAP are designed to allow for such evaluation on an ongoing basis.

In the TMAP project, algorithms have been developed for patients with schizophrenia, bipolar disorder, and major depressive disorder. A broader set of treatment algorithms have been developed for a variety of other psychiatric disorders, but as of yet, these do not include the methods for implementation, as in the case of the TMAP.

### **3. Clarity of the construct**

The construct of medication algorithms is quite clear throughout the medical literature. However, as noted above, the model employed by the TMAP project goes far beyond the use of medication algorithms alone, to include several other components aimed at optimizing the success in implementing the algorithms (e.g., patient and family education, technical assistance to clinicians, common documentation, and outcome measures).

### **4. Empirical support for effectiveness of this model**

The effectiveness of medications for the treatment of severe mental illness is firmly established. However, the treatment algorithm model is a relatively new area in psychiatry. Thus far, a limited amount of research suggests that when appropriately applied, treatment algorithms such as those employed by TMAP result in higher quality of care and greater efficiency of resources [1]. Much more work needs to be done to establish the effectiveness of these models in “real world” settings.

### **5. Availability of the model nationally**

A variety of professional organizations have issued treatment guidelines in several forms including: 1) recommendations, 2) comprehensive treatment options, 3) medication algorithms, and 4) expert consensus. It is the implementation and enforcement of such guidelines that is the key element of the model described herein. Thus far, Texas is leading the way in terms of applying the full model.

Other states and agencies are beginning to follow this trend. For example, the Ohio Medication Algorithm Project (OMAP) was modeled after the Texas experience. It is designed to improve the quality of care for persons with serious mental disorders in Southwestern Ohio by creating a uniform clinical environment based on existing expert consensus guidelines. The program utilizes a pharmacological treatment algorithm for

schizophrenia that addresses the use of anti-psychotic medication and other treatments. Input from clinicians, consultants and consumers shaped the algorithm.

## **6. Mandated or recommended by governmental or other agencies**

The Texas Department of Mental Health and Mental Retardation has been a core partner in the development of TMAP and has mandated its public sector agencies, administrators, and clinicians to participate.

## **7. Availability of the model in Iowa**

No efforts to employ the model have been tried thus far in Iowa.

## **8. Barriers in Iowa**

The implementation of such as system requires a strong central mental health authority. Iowa has one of the most decentralized mental health service system in the nation. The implementation of such a program must be tied to funding and/or accreditation. Even in those settings in which a central mental health authority has any real means of controlling practice, it is difficult to change clinician behavior.

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## **Relevant Websites**

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2. <http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPover.html>
3. <http://www.mhmr.state.tx.us/centraloffice/medicaldirector/sczman.pdf>

# **The Starting Early Starting Smart (SESS) Model of Early Intervention**

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## **What do we mean by early intervention?**

The terms early intervention, prevention, and infant mental health are used to describe a variety of different strategies to enhance the emotional and behavioral functioning of infants and young children in order to prevent the development of mental illness. Some of these early intervention approaches target all infants and toddlers in a community, others target young children who are at risk of developing problems, and others target young children you are already exhibiting symptoms of mental illness. Many of these programs focus on the ability to form secure attachments as lack of a secure attachment relationship in infancy has been associated with later behavior problems and some types of mental illness (1). A meta-analysis of 12 early intervention programs found the majority of attachment-based interventions were effective in improving mother-child interactions and increasing rates of secure attachment (2). In general, short-term preventive interventions that were conducted prior to the development of serious difficulties in mother-infant interactions were more effective than longer more intensive programs targeting infants and toddlers that had already developed serious problems (2).

Three recent reviews (3,4,5) describe a variety of innovative early intervention approaches that are currently being used in other communities to address the mental health needs of young children. Approaches vary from broad, comprehensive models such as the Vermont Children's Upstream Project (CUPS) that uses a statewide approach to address the mental health needs of young children (3) to specific, focused models that address the needs of a particular at-risk population such as the Prevention and Evaluation of Early Neglect and Trauma (PREVENT) program designed to intervene with young children involved in juvenile court in Miami-Dade county, Florida due to abuse or neglect (5). A number of communities in Iowa are also involved in early intervention efforts, often through the local Area Education Agencies.

Due to the variety of early intervention efforts currently being used, the construct of early intervention is so broad that it is not possible to evaluate fidelity to the model or to reliably assess outcomes. Therefore, for this publication, we chose to describe one particular early intervention approach. The SESS approach was selected for this publication as it is specific enough to provide a relatively clear construct yet broad enough to be applicable to a number of different communities.

## **1. Overview of model - What is the SESS Model of Early Intervention?**

The goal of the SESS model is to deliver integrated behavioral health services (prevention and treatment services targeting substance abuse and mental health issues) within settings where families with young children are already taking their children for child care or primary health care (4). The SESS model strives to increase access to comprehensive services for young children and their families in order to improve mental health and developmental outcomes for young children (4).

The SESS model provides mental health and substance abuse prevention and treatment, parenting education and support, consultation to childcare or primary care staff, and care coordination in settings frequented by parents of young children. In order to accomplish this, the model includes screening and assessment, identification of appropriate services, and referral. In order to improve access to services, the SESS program locates behavioral health services for children in the early childhood setting and utilizes “facilitated referrals” to help their families access needed behavioral health services. In a facilitated referral approach, a family advocate helps the family identify appropriate services, communicates with the referral agency, follows up to ensure services are received, and helps the family overcome any barriers to accessing service.

## **2. Needs of the population the model is designed to address**

The model is designed to address the behavioral health needs of young children and their families. In recent years, there has been an increase in the prescription of psychotropic medications for behavior problems in young children (5) despite the lack of efficacy data for the use of psychotropic medications in young children (6). In a recent survey of Iowa daycare settings, the largest identified need was for training related to working with children who have behavioral problems. Thus, there is clearly a need for effective mental health interventions for this age group.

“Young children whose emotional and behavioral development is of concern are a heterogeneous group. They are children in families where poverty has taken a great toll on parents or other relative caregivers, leaving them with little energy or skills to nurture and stimulate their children. They are children struggling to negotiate transitions among multiple caregivers. Some are young children who show the scars stemming from serious family problems, such as depression, substance abuse, domestic discord, or violence.” (3)

The foster care placement of young children is often associated with substance abuse and mental health problems (7). Young children are more likely than older children to be placed in foster care and spend a larger proportion of their life in the foster care system (7).

### **3. Clarity of the construct**

The Starting Early Starting Smart model is a broad conceptual framework with mild to moderate clarity of construct. The model specifies common intervention components: mental health and substance abuse prevention and treatment services, parenting education and support, and care coordination and family advocacy. The model also specifies that interventions be relationship-oriented, strength-based, and involve a multidisciplinary team effort. The model is designed to be adapted to local needs and resources. Specific staffing patterns or educational background of staff members is not specified and the types of interventions offered are likely to differ between settings.

### **4. Empirical support for effectiveness of this model**

Empirical data is now being collected from the current 11 sites to evaluate the efficacy and cost-effectiveness of this specific early intervention approach. However, other than this, the empirical support for this particular approach remains very limited. In its absence, it has been noted that...“practice wisdom, although not yet rigorous evaluation, suggests that more intensive family and child-focused interventions explicitly designed to repair damaged relationships can help young children exposed to multiple risk factors” (3). In general, programs targeting children’s mental health suffer from lack of empirical research demonstrating the effectiveness of the treatments in actual practice settings (as opposed to evidence of efficacy in controlled research) (10).

### **5. Availability of the model nationally**

The model is currently being used in 11 sites (child care settings or primary care clinics) in 10 states.

### **6. Mandated or recommended by governmental or other agencies**

While we are not aware of any governmental agencies that are mandating the SESS model, SAMSHA and the Casey Foundation are investing substantial resources in the further evaluation of cost and outcomes and dissemination of this particular early intervention model. The recent surgeon general’s report on mental health (10) notes that “preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development.”

### **7. Availability of the model in Iowa**

This model is not currently available in Iowa. The Iowa Consortium for Mental Health has sought funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to offer this model in two daycares in Johnson County.

## **8. Barriers to implementation of the SESS model of intervention in Iowa**

The primary barrier to implementation is funding. Traditionally, funders have been reluctant to invest in prevention programs or to fund services that provide consultation to caregivers. However, this barrier has been overcome in other communities through direct city and state funding (3,4,5) or changes in regulations regarding reimbursement for mental health services (5). As noted in one recent publication, “states are also in a position to carry out assessments of how Medicaid dollars could better be used for a broad range of early childhood mental health strategies, including consultation, as well as to review state mental health regulations regarding young children and families” (3).

Another possible barrier is the attitudes of families towards the program. However, the SESS model specifically addresses this possible barrier by involving families in the development and implementation of the program at each site.

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# **Integrated Mental Health and Substance Abuse Treatment**

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## **1. Overview of model - What is integrated mental health and substance abuse treatment?**

Integrated mental health and substance abuse treatment programs recognize that both diagnoses are primary and need to be addressed concurrently in treatment. An integrated service system provides coordinated and simultaneous mental health and substance abuse treatment in the same setting by dually trained clinicians or a cross-trained treatment team. Integrated treatment is a more coherent system that reduces barriers to access and treatment, combines appropriate interventions, and eliminates conflicting messages. The goal of integrated interventions is that the individual learns to manage the illnesses so that they can pursue meaningful life goals, and achieve a higher functional status and improved quality of life (1,2).

## **2. Needs of the population the model is designed to address**

The co-occurrence of substance abuse and severe mental illness is common. According to the National Institute of Mental Health Epidemiologic Catchment Area (ECA) Study, at least 50% of the 1.5 to 2 million Americans with severe mental illness abuse illicit drugs or alcohol (3). When compared to persons who have one disorder, these individuals with co-occurring illnesses have higher rates of homelessness, hospitalization, relapse, violence, incarceration, and serious infections such as HIV and hepatitis (2). It is particularly difficult for individuals with “dual diagnosis” to assess services in two different and separate systems of care.

## **3. Clarity of the construct**

Even though integrated mental health and substance abuse treatment models vary, models with demonstrated positive outcomes include several common service features that are considered evidence-based practices (1). These include: interventions that are appropriate to the stage of the illness the individual is experiencing, assertive outreach, motivational interventions, counseling, social support interventions, long-term perspective, comprehensiveness, and cultural sensitivity and competence (1).

## **4. Empirical support for effectiveness of this model**

Despite the encouraging findings regarding the effectiveness of integrated treatment programs for individuals with co-occurring disorders, there remains some disagreement regarding the model's effectiveness. However, there is agreement that further studies are urgently needed. Some reviewers conclude there is either only limited (4) or no clear empirical evidence (5) that supports the model of integrated treatment resulting in better

outcomes. Other studies report that comprehensive, integrated dual diagnosis programs that include evidence-based components are generally more effective than programs without these components (6,7), and are more effective than non-integrated programs (1). Findings from recent studies reported that comprehensive integrated programs resulted in reductions of substance abuse and hospitalizations, as well as improvements in other outcomes (7).

## **5. Availability of the model nationally**

While most states have policies and/or regulations in place that govern services provided to individuals with co-occurring disorders (8), the degree to which states have incorporated an integrated system with evidence-based components appears to be limited (1).

## **6. Mandated or recommended by governmental or other agencies**

We are not aware of any state governments or agencies that have recommended or mandated an evidence-based comprehensive, integrated treatment model.

## **7. Availability of the model in Iowa**

An integrated model program that includes evidence-based components is not available in Iowa. There are at least three community mental health centers in Iowa that are licensed to provide substance abuse services, however, treatment is not fully integrated in these programs.

## **8. Barriers to integrated mental health and substance abuse treatment implementation in Iowa**

State and county policies relating to regulations, funding, and organizational structure intensify the difficulty of integrating mental health and substance abuse treatment. Among the barriers to implementation are: 1) separate service delivery systems; 2) financing limitations; 3) different treatment philosophies, and 4) inadequate training of providers.

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# Elderly Outreach Programs (EOP)

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## 1. Overview of model - What are Elderly Outreach Programs?

Elderly outreach program (EOP) models facilitate early identification, assessment, treatment, management, and referral of mentally ill older adults. The primary goals of EOP models are to: 1) provide needed mental health services sites that are both acceptable and accessible to the older person; 2) assure that medical, social, *and* mental health needs of often frail and isolated older adults are met; and 3) avert costly, premature and often unnecessary institutionalization. Although variations exist across the nation today, these programs typically combine four key components to assure successful service delivery to otherwise under and unserved mentally ill elderly.

First, EOP models build on local resources. These programs use both “traditional” (e.g., family members) and “non-traditional” referral sources (e.g., community gatekeepers, elderly case management workers/networks, onsite screenings) to identify older adults in need of mental health services. Use of community-wide mental health education and training to facilitate “non-traditional” referral sources is a second key component. Training encourages the mental health agency and the community to join as problem-solving partners who together must meet the often-complex medical, social service, and mental health needs of older adults.

Once identified as being potentially at-risk for mental health problems, the older adult is referred to a multidisciplinary team for evaluation. Team members often include geriatric psychiatric nurses, social workers, and psychiatrists, as well as ancillary professional and paraprofessional personnel as needed. One or more team members provide comprehensive assessment, diagnosis, treatment, and referral to other community services. Site of service is a third key component. All mental health services are provided in the person’s home, or at another community site that is emotionally acceptable and geographically accessible to the older person. Finally, collaborative, cooperative relationships with other community providers, often in the form of participation in the community’s elderly case management system, are critically important to the model’s overall success.

## 2. Needs of the population the model is designed to address

Older adults suffer from mental illness in equal or greater numbers than younger adults. The recent Surgeon General’s Report on Mental Health (1) notes that nearly 20% of individuals aged 55 years and older have specific mental disorders that are clearly not part of “normal” aging. “Unrecognized or untreated, depression, Alzheimer’s Disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal; in the U.S., the rate of suicide, which is

frequently a consequence of depression, is highest among older adults relative to all other age groups” (1).

Identification and management of mental illness among older adults is confounded by a long list of factors not common in younger people. Older adults experience an increased number of general medical conditions and age-related physiological changes that both precipitate, and interact with, mental disorders. These medical conditions often result in taking high numbers of prescription and nonprescription drugs, causing both medication side effects and interactions that may mimic psychiatric illness. Declining functional abilities, financial changes, loss of friends and family due to death or relocation and other losses and changes cluster in later life to create substantial psychosocial stress for older adults. These stressors both precipitate the development of, and interfere with recovery from, mental disorders.

Even though older adults regularly experience mental disorders that are highly treatable, they are unlikely to seek mental health services from either private or community mental health providers. A number of factors are believed to influence their low service use. Lack of, or misinformation about mental illness and its treatment often emerges in beliefs that illness symptoms are “punishment” or a “natural consequence of aging” (e.g., Who wouldn’t feel that way?). Others fear being labeled as “crazy” (e.g., stigmatized) and/or being “locked up” (e.g., institutionalized in state hospitals or even today’s nursing facilities), a common practice earlier in history. Older adults with dementia, especially those living alone, may not realize they need assistance. Regrettably, older adults most often come to the attention of mental health providers at the time of crisis, thus requiring more intensive, and hence more costly, forms of service (e.g., emergency services, hospitalization, long-term placement in nursing facilities). In sum, the mental health needs of often frail and vulnerable older adults cannot be separated from their physical, social, or economic needs. Innovative approaches that include coordination of mental health, medical, and social service providers, and which maximize best use of limited, and often unique community resources are needed.

### **3. Clarity of the construct**

The principles on which elderly outreach programs are built are quite clear, and include the four essential features described in section 1. These programs, by design, overcome common barriers that prevent older adults from receiving needed mental health care and thus reduce use of more costly long-term intervention (e.g., institutionalization). At the same time, the model is flexible and allows individual communities to maximize use of local resources. Given the model’s use in a wide variety of demonstration projects across the country over the last 15 years, meaningful evaluation protocols exist to accurately assess the models’ effectiveness in specific communities.

#### **4. Empirical support for effectiveness of this model**

Empirical support exists for both the clinical and cost-effectiveness of both rural and urban elderly outreach programs (3, 4, 5, 6, 7, 8, 9). Raschko's model, as one of the longest running elderly outreach program in the country, has perhaps been most extensively evaluated. Recent findings reported by the Washington Institute for Mental Illness Research and Training again supported use of the Gatekeeper model (e.g., nontraditional referral sources) as a means to effectively identify and treat older adults with mental health problems (4). A year-long investigation of outcomes, including level of social, physical, psychological, and economic isolation, physical health problems, services needed, and service utilization, supported the approach as an inexpensive and effective method that does not result in high service use and benefits communities by increasing collaboration among service providers.

Likewise, various demonstration projects, including both the Iowa and Virginia rural EOPs, have demonstrated effectiveness in identifying and treating individuals who are mentally ill and at-risk for institutionalization. The Iowa EOP, of specific interest here, employed rigorous independent evaluation that explored a) characteristics of clients served by the program, b) ability of the program to identify and deliver mental health care to elderly individuals in the community who are in need of services, c) effectiveness of services, and d) costs. The evaluation concluded that the program was effective in achieving its identified goals – to identify and treat mentally ill elderly in the community. Of interest, the cost-effectiveness data, although considered a preliminary finding due to the small sample size, indicated that the EOP provided mental health services at a lower cost than that reported by a group of local mental health providers (3).

#### **5. Availability of the model nationally**

The elderly outreach model of mental health service delivery first emerged in Spokane, Washington nearly 20 years ago. Recognizing that the mental health/illness needs of older adults were largely unmet in his community, Raskcho (2) developed, implemented, and evaluated a program to identify and treat previously unserved mentally ill elderly. This urban model, called the Gatekeeper Program, has served as a “gold standard” for service delivery and has been replicated in numerous other urban centers nationwide. The model was adapted in the Mental Health of the Rural Elderly Outreach Project and found to be an effective means of delivering mental health services to rural elderly as well (3). Over time, both replications and variations on the approach have emerged in communities throughout the country.

The essential features of the model – of using nontraditional referral sources, providing mental health services in sites that are both accessible and acceptable to older adults, building on formal and informal community resources, and collaborating with existing medical and social service delivery systems – have become the foundation of a wide variety of additional urban and rural programs. A brief literature search identified multiple

manuscripts recently published in the literature describing various programs throughout the U.S. and Canada, including but not limited to the following:

- Rabin's Psychogeriatric Assessment and Treatment in City Housing (PATCH) program in Baltimore;
- Gurian's geriatric outreach program at Massachusetts Mental Health Center;
- Abraham's rural elderly outreach project in Virginia;
- Atkinson's Senior Adult Growth and Enrichment (SAGE) project in North Carolina;
- Worley's rural psychiatric nursing outreach program in South Carolina;
- Bane's case management and rural mental health outreach model in Missouri;
- Hesson's private partnerships in care approach to geriatric mental health outreach in Niagra;
- Stollee's community development and geriatric mental health outreach in Ontario; and
- Community-based Gatekeeper Programs in locations all over the country, from Lincoln, Nebraska to Columbus, Indiana, Chicago, Illinois, Houston, Texas, Leesburg, Florida, and Cedar Rapids, Iowa to name only a few.

## **6. Mandated or recommended by governmental or other agencies**

At the current time, federal regulations or agencies have not specifically endorsed EOPs as a preferred model of care. Of note, however, the Surgeon General's Report on Mental Health emphasizes the need for community-based services but observes that the lack of a special administrative mental health body to represent the unique needs of older adults continues to result in largely fragmented service delivery and funding. The Report calls for mental health services for older adults that are comprehensive, integrated and multidisciplinary, including specialized geropsychiatric services, integrated medical care, dementia care, home and community-based long-term care, family support services, intensive case management, and psychosocial rehabilitation services (1).

## **7. Availability of the model in Iowa**

The Mental Health of the Rural Elderly Outreach Program (EOP) was a demonstration project that was funded by the National Institute of Mental Health, the Administration on Aging, and the Iowa Department of Human Services. The project was implemented and evaluated in two Iowa counties between 1986 and 1989. The model, which was adapted from Raschko's highly successful urban Gatekeeper Program, proved to be both clinically and cost effective. The EOP, which was funded by grants for three years, was maintained on a substantially smaller scale in Linn County after the demonstration project ended (e.g., The program could not be self-sustaining on a fee-for-service basis because in-home services by non-physician providers do not qualify for Medicare reimbursement.). In recent years, Linn County has allocated funds to support elderly outreach services that are provided countywide through the community mental health center (CMHC), and in cooperation with the county's case management and aging

services organizations. Similarly, the CMHC in Polk County adopted the elderly outreach model and provides in-home mental health services to individuals who live in Des Moines.

## **8. Barriers to implementation of elderly outreach programs in Iowa**

Implementation of the model does require 1) an adequate number of appropriately trained mental health professionals who are knowledgeable about, and sensitive to, the problems of aging; and 2) funding that does not rely on fee-for-service payment through insurance. Adequate funding to initiate and sustain the EOP model is both the key to its success and the primary deterrent to its use.

Barriers in Iowa are largely the same as in other parts of the country. The primary barrier to use of the EOP model in Iowa, as in other places throughout the country, is the need for dedicated and continuous funding to initiate and sustain the model of care. Most of the program costs consist of “non-reimbursable” activities such as community education, consultation, collaboration with other providers, “off-site” (e.g., in-home) services by non-physician mental health providers, and associated costs of time and travel to consumers to provide services. Although lack of mental health professionals who are knowledgeable about, and sensitive to, the problems and issues of aged persons is another predictable barrier in Iowa, this issue may be easily overcome via education, consultation, and networking with existing geriatric psychiatric professionals in our state.

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# Evidence-Based and Promising Models of Mental Health Care

Model	Clarity of Construct	Evidence-Based	Use in US	Mandated or Government Recommended	Use in Iowa	Barriers in Iowa
PACT (Programs for Assertive Community Treatment)	++++	++++	++	++++	+	Shortage and maldistribution of MH professionals, funding, training of staff
Supported Employment	++++	++++	+	+	?	Funding, oversight, family and patient concerns about loss of benefits
School-based Clinical Mental Health Services	++	+++	+++	++	+	Funding, decentralized distributed governance, community buy-in
Family Psychoeducation	++++	++++	+	++	+	Labor intensive, attitudinal, reimbursement
Mental Health Courts	+	+	+	++	+	Judicial resistance to specialty courts, lack of large population centers within jurisdictions, lack of funding
Medication Treatment Algorithms	++	+	+	+	+	Lack of centralized mental health authority, education, enforcement, funding
Early Childhood Interventions	++	+	+	+	+	Reimbursement, parental attitudes
Integrated Substance Abuse & MH Services	+	++	+	?	+	Reimbursement, credentiality
Elder Outreach Programs	+++	+++	++	+	+	Funding, training issues, shortage and maldistribution of MH professionals

**KEY:**

- ? = unable to assess
- + = minimal
- ++ = moderate
- +++ = strong
- ++++ = very strong / very widespread



# Iowa Consortium for Mental Health

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## University of Iowa College of Medicine

The Iowa Consortium for Mental Health was established in 1994 to enhance state-university collaboration for education, coordination of research, and transfer of knowledge among researchers, mental health services providers, public policy makers, consumers, and families in order to promote effective, efficient, and equitable mental health services in the community based programs in Iowa. The Consortium is primarily funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant to the state. Among the goals of the Consortium are ongoing identification and prioritization of mental health needs in the State of Iowa and optimizing the linkage of those needs to existing clinical, educational and academic resources. The organization is located on the University of Iowa Health Care campus and is directed by Michael Flaum, MD, psychiatrist and faculty member of the University of Iowa College of Medicine, Department of Psychiatry.

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