COLORADO WORK GROUP
FOR
EVIDENCE BASED MENTAL HEALTH PRACTICES

Final Report

Colorado Department of Human Services
Division of Mental health
January, 2004

COLORADO WORK GROUP FOR EVIDENCE-BASED MENTAL HEALTH PRACTICES

INITIAL REPORT

SEPTEMBER 2003

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I. BACKGROUND AND PURPOSE

National and regional trends in health care and economics are driving an increased focus on evidence-based practices (EBPs) in the US health care system. The movement's origins in Canada and the United Kingdom began years ago, but it has only recently gained momentum in the US. Various factors have heightened interest in EBPs, including the rapid expansion of scientific knowledge regarding the causes and treatments of medical disorders, the growing voice of consumer and advocacy sectors, the managed care reform movement, and concerns about the increasing costs of health care.

Despite the significant advances in knowledge about mental health treatment, both the recent Institute of Medicine report and the 2003 President's New Freedom Commission on Mental Health report found that this science often is not translated into available services. A 15-20 year lag typically occurs between the development of effective treatments and their widespread adoption in clinical practice. The National Association of State Mental Health Program Directors has made the identification and dissemination of evidence-based mental health practices a priority. The National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, and other federal agencies have increased their focus on mental health services research and implementation.

The Colorado Division of Mental Health (Department of Human Services, Office of Behavioral Health and Housing) has several initiatives aimed at promoting evidence-based mental health practices in Colorado. In July, 2002, its director, Tom Barrett, PhD, commissioned the Colorado Work Group for Evidence-Based Mental Health Practices, under co-chairs Alexis Giese, MD and Bridget Barron, PhD, with the following primary objectives:

- Develop priority recommendations for EBPs in Colorado's public mental health system;
- Identify dissemination and implementation factors that affect the availability of EBPs in Colorado's public mental health system;
- Provide resources and information regarding evidence-based mental health practices to Colorado stakeholders, including monitoring emerging promising practices and updating recommendations periodically.

Other objectives include expanded awareness and support for the value of scientific evidence as the basis of mental health practices, enhancement of emerging competence and activities regarding EBPs within mental health programs and agencies across Colorado, increased availability of EBPs in Colorado, and improved outcomes for consumers and their families.

II. METHODS[1]

A group comprised of key Colorado stakeholders, including representatives from Colorado Division of Mental Health, consumers, family members, advocates, Colorado Behavioral Healthcare Council, provider agencies, mental health professionals, and the Colorado Psychiatric Society was formed. Additional input was obtained from local, regional, and national contacts, literature review, and national conferences focusing on EBPs. Published guidelines, toolkits, EBP materials developed by other states, and additional resources were also considered.

The population of interest was defined as children/adolescents with serious emotional disturbance (SED) and adults with serious or serious and persistent mental illnesses (SMI/SPMI). This population was selected because it is targeted for services by Colorado's publicly funded mental health system and is generally considered "most in need" of services.

Evidence-based practices are those shown to be consistently effective in systematically conducted scientific research. The scientific evidence to evaluate a particular treatment or practice can vary regarding the number of studies conducted, the rigorousness of study design, the size of samples, the amount of detail about the services or intervention(s) being studied, and other factors. The cumulative strength of scientific evidence regarding a particular practice can be categorized using a variety of schemes. The Canadian Task Force on the Periodic Health Examination first described "levels" of scientific evidence, which were later revised in cooperation with the United States Preventive Services Task Force. This approach to categorizing the body of evidence regarding clinical practices can be condensed as follows:

A (best): randomized controlled trials (RCTs), usually multiple and replicated in more than one site; clearly defined homogeneous target populations and interventions (i.e. manualized treatments, identification of critical components); demonstration of significant benefits and reasonably low risks; systematic reviews and meta-analyses examining a large body of scientific evidence.

B (good): RCTs or large controlled or well designed open studies, replicated in several sites, demonstrating significant benefits, but with more heterogeneity with respect to target population, intervention, and/or study design.

C (moderate): Observational, naturalistic, or case-control pilot studies of reasonable size representing different sites but with generally consistent positive results; expert opinion.

Implementation of EBPs may sometimes make use of other processes designed to structure and/or improve clinical care. EBPs are sometimes incorporated into **clinical practice guidelines**, which are sets of clinical strategies designed to condense available information and efficiently assist clinical decision-making. Guidelines are usually based on available scientific evidence of variable strength, but often incorporate expert consensus and prevailing practice standards, which are not necessarily based on empiric data, as well. Moreover, the implementation of specific guidelines is seldom studied to determine their effectiveness when applied in clinical settings. **Algorithms**

[1] Relevant literature and supporting references are found in Appendix II.

are highly structured clinical practice guidelines that delineate a series of sequential steps in managing a particular clinical disorder or problem. **Toolkits** are educational materials and other resources developed to assist health care providers in adopting and sustaining a new clinical practice or process, such as an EBP or a clinical practice guideline.

The Colorado work group gave highest consideration to published scientific evidence, as above, but also sought and considered other sources of evidence, including:

- Consumer, family member, and advocate experience, values, and preferences;
- Cultural, regional, and clinical variables operative in Colorado;
- Experience of Colorado mental health providers/agencies; and
- Available clinical guidelines, algorithms, and toolkits.

The rationale for this approach included Colorado's commitment to consumer-centered care, sparse scientific research for some disorders and practices, the uniqueness of Colorado's geography, including frontier and rural settings that have not been well researched, awareness of high priority and/or underserved populations in Colorado, and the desire to promote practices likeliest to have the greatest overall impacts.

Based on published scientific evidence and the other sources of evidence, as above, the work group developed EBP recommendations for Colorado, as follows:
Top priority—strong scientific evidence, high volume, and/or high need area;
High priority—good to strong scientific evidence, high need area but with more targeted or limited population(s); and
Promising practices—important high need area but evidence to support specific interventions/models and or applicability may be more limited.

There are several limitations to the Colorado work group's findings and recommendations. The chief limitation is that the scientific database itself has large gaps in some areas. Another is that some practices, disorders, and populations are difficult to study, and many individual consumers do not fit readily into the homogeneous cohorts that are usually selected for research. Thus, there will always be individual consumers and clinical sub-populations for whom there is little scientific evidence to drive practice; however, it should not be construed that services should therefore not be provided.

The recommended EBPs for Colorado should be considered guidelines for program planning and development, rather than treatment directives for particular consumers. Service planning for individual consumers should incorporate their needs, preferences, values, goals, and strengths, as well as the assessment and clinical judgment of those providing services.

III. KEY FINDINGS OF THE COLORADO WORK GROUP[2]

Principles and Values for the Colorado Mental Health System

- **Consumers and families** are at the center of the treatment and recovery process, and their participation should drive service planning at all levels.
- Mental health **service planning** should be individualized, strength-based, culturally competent, family informed, coordinated with other resources and services, cost effective, and oriented to specific goals and measurable outcomes.
- **Consumer-driven**, family-driven, and peer-to-peer services are consistent with important values in the Colorado mental health system.
- The appropriate range of mental health services should be available, with an emphasis on providing services in the **home and community**.
- Adequate **inpatient resources** must be maintained for the relatively small number of consumers who require this level of care. Inpatient services may be an important resource for consumer and community safety.
- **Prevention and early detection/treatment** are important in decreasing the overall burden of mental illnesses.
- **Outcome assessments** for mental health services should include not only conventional measures (e.g., symptom levels, relapse rates, hospitalization), but also capture recovery, hopefulness, community integration, and quality of life. Outcome assessments should address the overall impacts of services on the system of care, the population being served, and the community as a whole.

Status of the Evidence for Mental Health Practices

- Much of the currently available scientific evidence on mental health treatment was **generated before the recovery movement** and other more recent developments, and thus is slanted toward conventional outcome measures such as psychiatric symptoms, relapse rates, service utilization patterns, etc, rather than global outcomes and recovery.
- **Guidelines and algorithms** are available for many clinical areas. However, implementation of these guidelines, including the impact on practices, consumer outcomes, provider and system outcomes, and costs, has usually not been subjected to rigorous study.
- The lack of knowledge about **how to accomplish practice change** is another major gap in the scientific database. There is little research on the effectiveness of various change strategies to move providers and systems to adopt and sustain new practices, once they have been established via research or demonstration projects.

[2] Relevant literature and supporting references are found in Appendix II.

Key Clinical Considerations

- **Primary care services** are often inadequate for consumers with mental illnesses, and coordination between mental health and other medical services is difficult. The need for mental health services in nursing home populations and other residential/long term care settings is especially great. Despite this clear need there are few evidence-based models for mental health service delivery integrating mental and physical health care.
- **Cultural factors** are an important consideration in planning and delivering mental health services. Many evidence-based mental health practices have not been systematically studied across cultural subgroups (e.g., ethnic minorities, immigrants, genders, age groups). Thus, implementing evidence-based practices in settings or populations that differ culturally from those in which they were studied may require culturally competent adaptation.
- Colorado has a unique and diverse **geography**, with communities ranging from highly urban to frontier, from plains to rugged mountains. There is little scientific study of how geographic setting affects mental health practices. Nevertheless, as with culture, adaptation of evidence-based mental health practices to Colorado's unique regions and communities will need to be addressed.
- **The role of trauma** may be an underestimated factor in the presentation, treatment, and recovery of many mental health consumers, not just those whose primary mental health diagnosis is posttraumatic stress disorder (PTSD). While the scientific basis for addressing trauma in treatment is best developed for PTSD, trauma may nonetheless be important in service planning for many consumers, including children.

Issues for Child/Adolescent/Family Mental Health Services

- The **scientific database** on mental health services for children/adolescents is even sparser than that for adults. Reasons for this include the problems conducting research with minor subjects, the previous lack of emphasis by NIMH and the FDA on research for children and adolescents, limitations in the diagnostic nomenclature as applied to children/adolescents, etc. Despite this historical lag, there has been a recent expansion in scientific data, and it is expected that the evidence base for child/adolescent/family mental health services will continue to grow quickly in the coming years.
- Despite the paucity of scientific studies on specific treatments, it is generally accepted that mental health services for **young children (0-5 years) and adolescents/young adults in transition (15-24 years)** are extremely important. This is due to the potential for prevention and early detection/treatment that these critical time periods offer and the high human, social, and economic costs of waiting to intervene.
- The use of **psychiatric medications** for children/adolescents is considered controversial by some individuals or groups on the basis of political, personal, or ideological issues. However, there is no scientific controversy regarding the safe and effective use of psychiatric medications in certain clinical situations for children/adolescents. As with all medications, the potential for overuse and inappropriate use exists. However, the recent national trend of increasing use of psychiatric medications for children/adolescents does not necessarily indicate a problem. It likely represents, in part, increasing availability of effective treatments and greater provider knowledge regarding these treatments. When used,

psychiatric medications are usually a component of a treatment plan that includes other services, such as psychotherapy or family counseling.

- Most EBPs are studied in discrete categorical populations grouped according to relatively circumscribed diagnostic or other clinical criteria. However, approximately 10-15% of child/adolescent consumers have more **complex cross-system needs** (e.g., child welfare, education, Juvenile Justice) that are best met by some form of intensive case management and possibly some specific categorical services within a coordinated system of care.

IV. EBPs FOR ADULTS: COLORADO RECOMMENDATIONS

<table>
<tr><th>Priority</th><th>Recommended practices</th></tr>
<tr><td>Top Priority</td><td>Assertive community treatment
Intensive comprehensive services in community settings. Effective for persons with severe mental illnesses. Clearly defined model with critical components that have been well studied.

Supported employment
Competitive work in integrated work settings via programs that facilitate job acquisition and provide ongoing support. Effective for a wide range of persons with mental illnesses across various community settings. Critical components of effective programs have been identified.

Integrated substance abuse/mental health services
Combines and integrates mental health and substance abuse interventions in a single setting. Effective for persons with co-occurring severe mental illnesses and substance use; critical components of effective programs have been identified.

Cognitive behavioral therapies
The Lieberman model for psychosocial & independent living skills training is effective for persons with SMI/SPMI, such as schizophrenia. Uses well established manualized modules in group settings, requires specialized training.
Individual cognitive behavioral therapy uses specific, goal-driven interventions with targeted timelines. Highly effective for depression, panic disorder, post-traumatic stress disorder, and related mood and anxiety disorders. Effective for depressive episodes occurring in the context of schizophrenia. Some specialized forms exist for specific disorders and may require additional training.
Dialectical behavior therapy is a cognitive behavioral treatment that provides skills training in group and individual settings. Effective for borderline personality and related disorders, suicidal behaviors, and impulsive behaviors. Well defined, manualized treatment with established critical components. Requires specialized training.
Psychiatric medication services
Guidelines promote treatment based on scientific evidence. Evidence-based processes, such as identification and tracking of target symptoms using rating scales and other outcome measures, are appropriate.

Electro-convulsive therapy</td></tr>
</table>

	Strong evidence supports use in severe and treatment-resistant depression, mania, treatment-resistant schizophrenia. While the number of consumers in this group is small, access to this treatment option may be critical for some. Provided in hospital settings, either inpatient or outpatient basis.
High Priority	**Family psychoeducation** A variety of models exists: effective programs provide a combination of education, problem solving, crisis intervention, and support. Often combined with individual psychoeducation. Reduces relapse rates and promotes recovery. **Group/milieu cognitive behavioral therapies for schizophrenia** • **Integrated psychotherapy for schizophrenia** is a group therapy cognitive model shown to increase social cognition and competence. • **Social learning programs** are behavioral milieu models studied primarily in inpatients with schizophrenia and related disorders.
Promising Practices	**Wellness recovery action plans** Consumer-driven model of developing an individual plan for wellness and recovery, including consumer action, accessing clinical services, community supports, and peer services. **Motivational interviewing** Interviewing technique directed at behavioral change, best established for substance abuse disorders, limited but promising data for co-occurring mental illnesses and substance abuse disorders. **Effective forensic services** Set of principles guiding management of offenders based on risk and need. May have relevance for offenders with mental disorders, but more data needed. **Integrated primary care/mental health services** Collaborative care management models are effective in promoting EBPs and improving outcomes for depression and anxiety disorders. Expansion and refinement of models for SMI/SPMI consumers are needed.

V. EBPs FOR CHILDREN/ADOLESCENTS: COLORADO RECOMMENDATIONS

<table>
<tr><th>Priority</th><th>Recommended practices</th></tr>
<tr><td>Top Priority</td><td>Cognitive behavioral therapies
Individual or family cognitive behavioral therapy uses specific, goal-driven interventions with targeted timelines. Effective for depression, panic disorder, post-traumatic stress disorder, conduct problems, and related mood and anxiety disorders. Specialized forms for specific disorders may require additional training.

Family based services
Individualized family treatment using cognitive behavioral, structural, or strategic models, usually focused/short-term. May incorporate additional services such as peer-peer support groups, in-home visits, and the development of informal resources.

School based services
School based services have a key role in early identification and prevention of behavioral and mental disorders and facilitating access to more intensive services. Specific services known to be effective in schools include:
Behavioral management for ADHD/conduct problems
Behavioral consultation
Therapeutic day treatment.
Psychiatric medication services
Guidelines promote treatment based on scientific evidence. Evidence-based processes (e.g., using rating scales to track target symptoms and other outcome measures) are appropriate.
Stimulant medication for ADHD in children and adolescents is an example of a strongly evidence-based medication practice.
Therapeutic foster care
Foster parents with specialized training host children with behavioral/emotional problems. Effective for children with severe and/or multiple mental disorders.</td></tr>
<tr><td>High Priority</td><td>Wraparound services
Targets consumers with multiple problems/systems, incorporates case management and use of both formal and informal supports.

Multisystemic therapy
Family and community based model that addresses multiple needs and contributors to delinquency and out-of-home placements. Intensive treatment over 3-6 months. Best evidence for adolescents with serious behavioral disturbances/juvenile justice contact. Evidence in mental health populations is less strong. Franchised product requiring intensive external supervision and fidelity to defined model.
Functional family therapy</td></tr>
</table>

	Behavioral systems family therapy for high-risk adolescents, using cognitive skill-building. Extensive evidence for reducing violence and criminal outcomes, some support for mental health populations. Franchised product requiring specialized training that maximizes fidelity to critical components. **Acute care and alternative services** • **Home-based crisis intervention** provides in-home crisis services for children at risk of hospitalization or placement. May include skill-building, referral/linkage, and respite care. Usually short-term. • **Inpatient services** may be needed if alternatives to hospitalization are not effective and/or safe. Provides stabilization of severe psychiatric symptoms, assessments, and development of follow-up services. Usually short-term.
Promising Practices	**Integrated substance abuse/mental health services** Combines and integrates mental health and substance abuse interventions in a single setting for consumers with co-occurring disorders. **Intensive case management** Clinically oriented case management model for children/adolescents with multiple co-occurring disorders and/or multi-system involvement, usually long-term. **Dialectical behavioral therapy** Cognitive behavioral treatment that provides skills training in group and individual settings. Promising evidence in adolescents with personality disorders, emotional dysregulation, and impulsive behaviors. **System of Care** Set of principles that emphasize a flexible child- and family-driven orientation to structuring and delivering services, as well as coordination of services across systems and utilization of informal resources. Not a clinical treatment per se, but a process that would potentially promote utilization and effectiveness of EBPs.

VI. IMPLEMENTATION ISSUES

Cultural Factors

It is widely accepted that cultural factors play an important role in mental health treatment. The supplement to the US Surgeon General's 1999 report noted that culture may affect family structure, coping styles, treatment-seeking behaviors, privacy norms, stigma, and other factors that can influence the presentation and treatment of mental disorders. Also, cultural factors may manifest in the culture of the clinician, the service delivery system, and society at large. Despite this awareness, very few systematic studies of defined mental health practices have examined their efficacy or effectiveness in cultural subgroups, nor have many studies determined the cultural adaptation(s) needed to achieve effectiveness in groups that differ from the one(s) for which the original research was conducted.

In order to implement EBPs across Colorado's diverse cultural subgroups, it is recommended that:

- Fidelity to practice parameters, especially identified critical components, should be the goal when implementing EBPs.
- Flexibility in adapting EBPs may be appropriate to implement successfully in areas or populations with unique cultural influences.
- Consultation with local/regional consumers, representatives from cultural groups, and experts may inform the adaptation and implementation process.
- Colorado's Cultural Competence Plan for Mental Health Services is a template for pursuing culturally appropriate services in a sequential fashion.
- Outcome assessment and quality improvement activities associated with EBP implementation in cultural subgroups are highly recommended in order to gauge effectiveness for the population in question and identify critical components, areas for further adaptation, etc.

Geographic Factors

Colorado's geography includes a wide variety of settings, population densities, industrial/commercial bases, and community configurations that contribute to its unique identity and diversity. Much of Colorado is comprised of frontier and rural counties and communities, while most EBPs have been studied primarily in urban-suburban settings. It is anticipated that implementation of EBPs in Colorado may require substantial adaptation in order to achieve effectiveness in some regions. An evidence-based process for EBP adaptation in geographic contexts that have not been well studied (similar to the above for cultural adaptation) may promote flexible implementation while preserving critical components.

Administrative and Fiscal Factors

Some evidence-based mental health practices and processes involve multiple systems and funding streams, representing a barrier to both implementation and outcomes assessment. This is particularly true in the areas of mental health/substance abuse and in child/adolescent services.

Capturing outcomes on a system-wide or statewide level is challenging but necessary. The difficulties relate to the lack of uniform outcome measures, the number of different systems and funding streams involved, and the tendency of existing measures to capture utilization, symptoms, relapses, etc, rather than recovery measures such as hopefulness and reintegration.

Decreased funding for mental health services for Colorado Medicaid and non-Medicaid eligible consumers heightens the importance of using treatments that have been shown to be effective. However, some EBPs would require additional or redirected funds in order to be implemented in Colorado. In general, both the administrative and training costs associated with EBPs tend to be somewhat higher than "treatment as usual," as they often call for more intensive provider training, more supervision in order to achieve and sustain fidelity to the model, and more resources needed for outcomes assessment. The costs associated with implementing EBPs are not limited to the start-up phase, but may be distributed longitudinally for ongoing training, supervision, etc. Despite this, many EBPs have been shown to be cost effective as they reduce inappropriate or ineffective care, decrease hospitalization, decrease over-utilization of general medical services, improve functional recovery, and decrease costs in other public systems such as criminal justice. Measuring the cost effectiveness of EBPs requires a longitudinal time frame and capturing the total costs to the systems that consumers are in contact with.

The work group's findings suggest an opportunity for Colorado's mental health system. Some of the high priority EBPs already exist in Colorado in limited areas, pilot programs, demonstration projects, etc. Examples include assertive community treatment and dialectical behavioral therapy. Expansion may be facilitated by collaboration, partnership and/or integrated funding, or consultation among provider groups or systems.

Successful implementation of EBPs will likely depend upon their being provided in the context of effective coordination and oversight within and among care systems. This may be especially important for integrating primary care/mental health services and for children/adolescents/families. Collaborative care management, disease management programs, System of Care, and other models exist for increasing access to and participation in evidence based treatments. Promotion of specific EBPs in Colorado will likely involved expansion and adaptation of care coordination models; these programs should be conceptualized and studied as part of the overall EBP expansion effort.

Successful implementation of EBPs may also depend on the availability of a well trained mental health work force. This issue has many facets, including the number and distribution of mental health professionals in Colorado, the high need for psychiatrists and others with specialized training in child/adolescent mental health, the presence of EBPs in graduate mental health educational programs, the need for mental health professionals with cultural and linguistic competencies, and ongoing training in EBPs for

those already in the work force.

VII. RECOMMENDATIONS

1. Primary recommendation: Evidence-based mental health practices should be *promoted and disseminated in Colorado* through a broad based effort including program planning and evaluation, policies and funding strategies, educational activities, resource acquisition, and advocacy/support.

In order to implement the primary recommendation, Colorado should not only incorporate evidence obtained from research studies and national demonstration projects, but be an active contributor in implementing, adapting, developing, and evaluating evidence-based mental health practices. This represents an expansion of current local, regional, and statewide activities in the areas of pilot and innovative program implementation, program evaluation, outcomes assessment, quality improvement activities, and consumer/family/advocate participation.

2. Implementation of EBPs for Colorado's priority population for mental health services should be a major focus; broad-based input and discussion should occur regarding how best to operationalize this with available resources.

3. Existing toolkits should be used as a starting point for EBP implementation, such as SAMHSA's recently released toolkits for adult services (illness management and recovery, medication management, assertive community treatment, family psychoeducation, supported employment, and integrated mental health/substance abuse treatment). Use of toolkits may facilitate outcomes assessment and the ability to compare Colorado programs to each other and to national prototypes.

4. Areas that are difficult to capture using traditional scientific evidence—prevention programs, systems change, integrated services across systems, recovery outcomes, etc. should be addressed in the process of promoting EBPs in Colorado. Exclusive focus on traditional categorical intervention services would likely result in limited dissemination unless the broader issues are also considered priorities.

5. A detailed, operationalized implementation plan, incorporating the recommended priorities and practices, should be developed.

6. An outcomes assessment based on the implementation plan should be conducted on a periodic basis to determine progress in EBPs and identify areas for further focus.

7. EBPs should be promoted for inclusion in curricula for Colorado higher education programs in mental health fields.

APPENDIX I
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Acknowledgements:

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APPENDIX II
REFERENCES AND RESOURCES

From Colorado Department of Human Services/Mental Health Services

Colorado Mental Health Services Cultural Competency Plan
The Colorado Cornerstone Initiative.
www.cdhs.state.co.us/ohr/mhs

Colorado Best Practice Guidelines for Atypical Antipsychotic Medications, 2001
By request

Books and Publications

Achieving the Promise: Transforming Mental Health Care in America. The President's New Freedom Commission on Mental Health, 2003.

Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine, National Academy of Sciences.

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