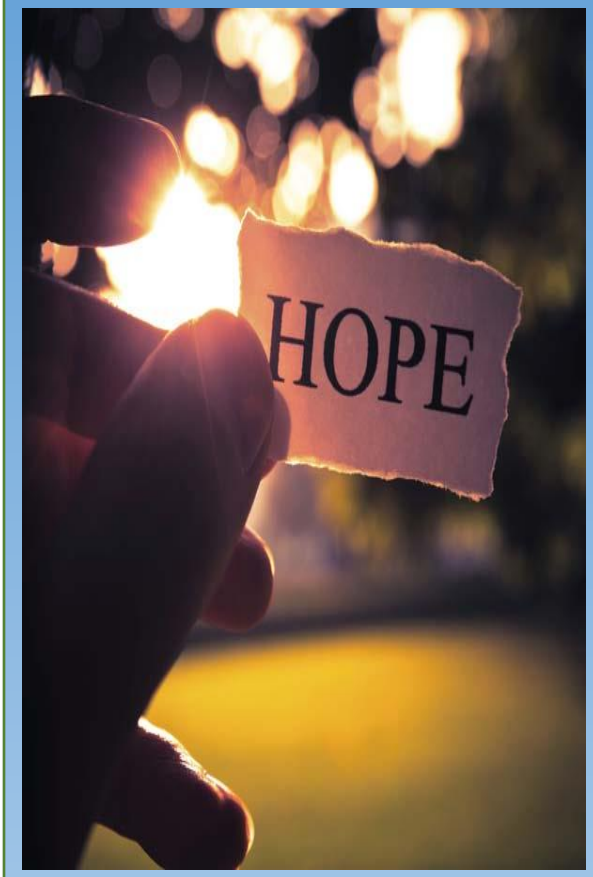

Mental Health Recovery Interventions Guide

2018

Office of State Mental Health Treatment Facilities

Policy and Program Section
Director, Wendy Scott

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Disclaimer

The Mental Health Recovery Interventions Guide (RIG) is not all-inclusive and the information may change without notification. Interventions may be added as empirically and methodologically sound evaluations are conducted and supported in the literature. The rankings of the interventions are subject to change. A ranking for a particular intervention may increase as new empirical research is conducted using either a more methodologically rigorous design, or the intervention demonstrated to be more effective than in previous analyses. The ranking of a particular intervention may decrease as new research demonstrates the intervention to be less effective than previously reported. Furthermore, an intervention may be eliminated entirely from the RIG in the event rigorous empirical research demonstrates the intervention to be iatrogenic or potentially harmful to the target population.

New versions of the RIG, as developed, will be posted on the Florida Department of Children and Families' (DCF) website. It is the sole responsibility of the reader to ensure utilization of the most up-to-date version. Additionally, it is the sole responsibility of the reader to obtain the required training, certification, education, and licensure (if applicable) to facilitate any intervention described within. DCF is not liable for any licensure or copyright infringements by any individual or agency engaging in unlawful actions in the facilitation of the interventions within.

Foreword

In 2018, a dedicated workgroup compiled a list of recovery interventions aimed at reducing symptoms of mental illness, promoting recovery and/or competency restoration, and preventing recidivism for individuals residing in one of the seven state mental health treatment facilities. These interventions were rank-ordered into the following three categories: Evidence-Based Practices, Promising Practices, and Practices with Demonstrated Effectiveness. The goal of the RIG is to serve as a tool to sustain and advance efforts by providing this inventory of examined practices by category, as defined by DCF.

The RIG is updated as new empirical research is available. The RIG will be updated with either new practices, new information for an intervention, or to move an intervention to a different category.

Persons desiring to submit material for review for potential inclusion in the Mental Health Recovery Interventions Guide are to follow the template format (page 8) and complete it with information for the proposed intervention. The completed form is to be submitted to the chairperson of the facility-specific research committee (or lead psychology coordinator for facilities without a research committee). The research committee chairperson will review the proposed intervention, check available sources, and provide a recommendation along with supporting research and documentation to the Director of Policy and Programs for State Mental Health Treatment Facilities (SMHTFs). A statewide committee, appointed by the Director of Policy and Programs, will review the recommendation, along with any research articles or citations included, and notify the Director of Policy and Programs of either approval or disapproval. The Director will notify the requesting facility of the outcome, and if approved, will revise the RIG, disseminate to the Mental Health Treatment Facilities and post on DCF's website.

Acknowledgements

DCF would like to acknowledge and commend the dedicated workgroup members who conducted research and had countless discussions regarding the criteria and how to categorize each intervention included in this guide. The RIG would not be possible without their dedication and hard work. The DCF workgroup members included:

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Wendy Scott – Director of Policy and Programs, State Mental Health Treatment Facilities
Julie Tindall – Chief of Nursing Services
Jackie Young – Senior Management Analyst Supervisor

DCF would like to acknowledge and thank the Florida Department of Juvenile Justice for sharing their Sourcebook of Delinquency Interventions, which inspired the creation and design of DCF's RIG.

DCF would also like to acknowledge the Substance Abuse and Mental Health Services Administration and the American Psychological Association's 2005 Policy Statement on Evidence-Based Practice in Psychology as helpful resources in developing its definition of "evidence-based practice."

Florida State Mental Health Treatment Facilities adhered to the following criteria provided in SAMHSA's 2009 "Identifying and Selecting Evidence-Based Interventions" guidance document in the process of identifying evidence-based practices for the populations our treatment facilities serve:

1. The intervention is included in a federal registry of evidence-based interventions, such as the National Registry of Evidence-based Programs and Practices (NREPP) OR
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal OR
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed. These guidelines require interventions to be:
    - Based on a theory of change that is documented in a clear logic or conceptual mode AND
    - Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals AND
    - Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects. AND

- Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

Recovery Interventions

The purpose of implementing an intervention is to reduce symptoms of mental illness, reintroduce individuals into the community by promoting recovery and/or restoring competency, and prevent recidivism for individuals in the mental health treatment facilities.

There are three levels at which we define recovery interventions. The level an intervention is placed within is dependent upon the empirical research conducted on that practice and the results of those analyses. The levels progress in terms of methodological rigor and effectiveness of the practice, with evidence-based practices requiring the highest level of rigor and the highest level of program success with results lasting at least one year from completion. The levels and their respective definitions are as follows:

Evidence-Based Practices: The integration of the best evidence from research on mental illness interventions with clinical expertise in the context of resident characteristics, culture, and preferences. The effectiveness of severe mental illness interventions is demonstrated by a substantial and supporting body of evidence drawn from a variety of research designs and methodologies. More specifically, evidence drawn from clinically relevant research on psychological and mental health treatment practices should be based on systematic reviews, reasonable effect sizes, and statistical and clinical significance while recognizing limitations in the existing literature.

Promising Practices: Manualized curricula that use interventions which have been evaluated and have a significant amount of empirical support for their use and efficacy among targeted populations consistent with the goals and objectives of the activity or program, but do not have enough data collected or rigorous research conducted with clinical populations to meet the criteria of an Evidence Based Practice. Programs utilizing Promising Practices are expected to demonstrate adherence to model fidelity in practice implementation, and to actively work toward building stronger evidence through ongoing evaluation.

Practices with Demonstrated Effectiveness: Practices based on general principles, strategies, and modalities reported in psychological or other social science research as being effective with adult, mentally ill or behavioral health disorder population. These interventions have empirical support for the principles, theoretical framework, or components of the intervention. The specific interventions have usually not been empirically evaluated using either random assignment or the use of control/comparison groups. For an intervention to be deemed a practice with demonstrated effectiveness, the empirical research must have shown that practices that contain similar components or similar principles have shown reductions of the program participants versus the comparison group(s) in at least one treatment need. These practices should be outlined in a format that ensures consistent delivery by a facilitator across multiple groups and/or there is evidence that replication by different implementation teams at different sites is possible.

Template

Name of Program and Acronym

Florida DCF Classification:	Level of empirical support for the program; based on the three definitions of evidence-based, promising, or practice with demonstrated effectiveness
Program Author	Program Person(s) who developed the intervention
Program Contact:	Web address for program information
Overview:	Brief synopsis of the program/curriculum
Recommended Group Size:	Recommended group size per session
Recommended Frequency and Length:	Recommended length of service, number of sessions, hours, and any specific requirements for delivery
Therapeutic Focus:	Diagnosis of focus, presenting problems or issues, discharge barriers, and treatment target
Proven Outcomes:	Demonstrated benefits of treatment
Population:	Targeted segment of DCF population
Treatment Setting:	Therapeutic settings in which this intervention has been successful
Modality:	How the program/curriculum is delivered
Facilitator Training & Certification:	Type of training and/or certification needed to facilitate the curriculum
Bibliography:	A reference list identifying the rigorous research conducted on the program. The reference list is not exhaustive, but is meant to provide information as to the types of analyses conducted on the program and results garnered.

Evidence-Based Practices

Acceptance and Commitment Therapy

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Steven C. Hayes, Ph.D., Kirk D. Strosahl, Ph.D., Kelly G. Wilson, and Ph.D.
Program Contact:	https://www.unr.edu/psychology/faculty/steven-hayes, https://www.mtnviewconsulting.com/ http://onelifellc.com/
Overview:	The use of acceptance and mindfulness strategies help clients to be fully present in the moment and to accept otherwise negative emotions. Commitment and behavior change strategies help clients to change or persist in behaviors more in line with their own values. Used together these strategies increase client's psychological flexibility.
Recommended Group Size:	Tailored to fit the needs and resources of the context and population
Recommended Frequency and Length:	Approximately 12 1-hour weekly sessions
Therapeutic Focus:	Depression and anxiety
Proven Outcomes:	A-Tjak, Davis, Morina, Powers, Smits and Emmelkamp (2015) conducted a meta-analysis of 39 randomized controlled trials on the efficacy of acceptance and commitment therapy (ACT), including 1,821 patients with mental disorders or somatic health problems. Their findings indicated that ACT is more effective than treatment as usual or placebo and that ACT may be as effective in treating anxiety disorders, depression, addiction, and somatic health problems as established psychological interventions such a cognitive behavioral therapy.
Population:	Adults experiencing symptoms of depression, anxiety, addiction, and somatic health problems
Treatment Setting:	Inpatient and outpatient
Modality:	Individual or group
Facilitator Training & Certification:	Licensed therapists or psychologists (or therapists supervised by a licensed therapist or psychologist) with education and training in Acceptance and Commitment Therapy
Bibliography:	A-Tjak J, G, L, Davis M, L, Morina N, Powers M, B, Smits J, A, J, Emmelkamp P, M, G, A Meta-Analysis of the Efficacy of Acceptance and Commitment Therapy for Clinically Relevant Mental and Physical Health Problems. Psychotherapy and Psychosomatics 2015; 84:30-36

Anger Management for Substance Abuse and Mental Health Clients

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration; Publication writer: Patrick M. Reilly, Ph.D.
Program Contact:	CSAT: 240-276-1660; Dr. Reilly: Patrickreillyphd@gmail.com
Overview:	The treatment model described in this Anger Management intervention is a combined Cognitive Behavioral Therapy (CBT) approach that employs relaxation, cognitive, and communication skills interventions. The purpose of the Anger Management group is to: (1) Learn to manager anger (2) Stop violence or the threat of violence (3) Develop self-control over thoughts and actions (4) Receive support and feedback from others.
Recommended Group Size:	The ideal number of participants in a group is 8, but groups can range from 5 to 10 members.
Recommended Frequency and Length:	Twelve, 90-minute weekly sessions
Therapeutic Focus:	Individuals who have a past history with poor management of anger and a lack of understanding how anger manifests; alcohol use or abuse problems, substance use or abuse problems, mental health
Proven Outcomes:	A meta-analysis (Beck, 1998) reviewed 50 studies involving 1,640 participants and found individuals receiving CBT for anger management had greater anger reduction outcomes than individuals who were untreated. Meta-analysis studies (Edmondson & Conger, 1996; Trafate, 1995) conclude that there are moderate anger reduction effects for CBT interventions, with average effect sizes ranging from 0.7 to 1.2 (Deffenbacher, 1999). In studies at the San Francisco Veterans Affairs Medical Center and San Francisco General Hospital using this treatment model, decreased substance use has also been found (Reilly, Shopshire, Clark, Campbell, Ouaou, & Llanes, 1996).
Population:	Adult male and female substance abuse and mental health clients (age 18 years and above). Recommended that participants be abstinent from drugs and alcohol for at least 2 weeks prior to joining the anger management group.
Treatment Setting:	Inpatient, Outpatient

Modality:

Individual, group therapy (recommended)

Facilitator Training & Certification:

Counselors and social workers should have training in cognitive behavioral therapy, group therapy, and substance abuse treatment (preferably, at the master's level or higher; doctoral-level psychologists have delivered the anger management treatment as well).

Bibliography:

Beck, R., and Fernandez, E. (1998). Cognitive behavioral therapy in the treatment of anger: A meta-analysis. Cognitive Therapy and Research, 22, 63-74.

Edmondson, C.B., and Conger, J.C. (1996). A review of treatment efficacy for individuals with anger problems: Conceptual, assessment, and methodological issues. Clinical Psychology Review, *10*, 251-275.

Reilly, P.M. & Shopshire, M.S. (2012). Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual. HHS Pub. No. (SMA) 13-4213. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Reilly, P.M.; Shopshire, M.S.; Clark, H.W.; Campbell, T.A.; Ouaou, R.H.; and Llanes, S. (1996). Substance use associated with decreased anger across a 12-week cognitive-behavioral anger management treatment. In: NIDA Research Monograph: Problems of Drug Dependence, Proceedings of the 58th Annual Scientific Meeting, College on Problems of Drug Dependence. Rockville, MD: National Institute on Drug Abuse.

Trafate, R.C. (1995). Evaluation of treatment strategies for adult anger disorders. In: Kassinove, H. (Ed.), Anger Disorders: Definition, Diagnosis, and Treatment (pp. 109-130). Washington, DC: Taylor and Francis.

Bipolar Management

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Ad Adjunctive Cognitive Behavioral Group Treatment Program for Bipolar Disorder. Second edition. Louella Lim, Laura Smith
Program Contact:	Centre for Clinical Interventions, Perth, Western Australia. www.cci.health.wa.gov.au
Overview:	The Centre for Clinical Interventions (CCI) Bipolar Program is an adjunctive psychosocial treatment program for people with bipolar disorder. The primary aim of the program is to help people improve their coping with bipolar disorder. The psychosocial training program addresses issues specifically related to the Bipolar Condition (mixed with depression and mania).
Recommended Group Size:	Six to eight participants
Recommended Frequency and Length:	The Lam Manual is designed for 12 to 18 individual weekly sessions, followed by 2 booster sessions over the next 6 months.
Therapeutic Focus:	Focuses on teaching individuals to monitor mood symptoms, recognize early signs of episodes, and be able to distinguish this condition from Major Depression or Dysthymia (Persistent Depressive Disorder). It provides strategies in managing episodes of mania and depression. •Increasing knowledge about the dynamics of Bipolar Depression •Distinguish between Bipolar, Major Depression, and Dysthymia •Increase the ability to manage depressive and manic episodes •Develop a personal plan for Bipolar management of symptoms
Proven Outcomes:	The CCI Bipolar Program is adjunctive psychosocial treatment program for people with bipolar disorder. It has been developed and tested at CCI over the last 7 years. The changes in the Second Edition of the manual reflect a continuous process of review and evaluation of the program, and materials.
Population:	Bipolar disorder
Treatment Setting:	Community Mental Health, Rehabilitation, hospital and private office practices Treatment Facility, and Substance Abuse Treatment Center
Modality:	Individual, group therapy (recommended)

Facilitator Training & Certification:

Experience in CBT and in working with people with Bipolar Disorder. CCI offers a series of clinically relevant workshops in evidence-based treatment. These workshops have a practical, skills-based focus and have been evaluated positively by past participants. The workshops are suitable for all mental health practitioners. Some of the workshops do require experience in using CBT, however, the CBT Foundation Course is suitable for mental health practitioners with no previous experience of CBT, and provides a good basis for completing the other workshops.

Bibliography:

Lam, D. H., Hayward, P., Watkins, E. R., Wright, K., & Sham, P. (2005). Relapse prevention in patients with bipolar disorder: Cognitive therapy outcome after 2 years. American Journal of Psychiatry, 162, 324-329.

Lam, D. H., McCrone, P., Wright, K., & Kerr. N. (2005). Cost-effectiveness of relapse-prevention cognitive therapy for bipolar disorder: 30-month study. British Journal of Psychiatry, 186, 400-506.

Lam, D. H., Watkins, E. R., Hayward, P., Bright, J., Wright, K., Kerr, N., et al. (2003). A randomized controlled study of cognitive therapy of relapse prevention for bipolar affective disorder: Outcome of the first year. Archives of General Psychiatry, 60, 145-152.

Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Kogan, J. N., Sachs, G. S., et al. (2007). Intensive psychosocial intervention enhances functioning in patients with bipolar depression: Results from a 9-month randomized controlled trial. American Journal of Psychiatry, 164, 1340-1347.

Patelis-Siotis, I., Young, T. L., Robb, J. C., Marriott, M., Bieling, P. J., Cox, L. C. et al. (2001). Group cognitive behavioral therapy for bipolar disorder: a feasibility and effectiveness study. Journal of Affective Disorders, 65, 145-153.

Scott, J., Paykel, E., Morriss, R., Bental, R., Kinderman, P., Johnson, T. et al. (2006). Cognitive behavioural therapy for severe and recurrent bipolar disorders: A randomised controlled trial. British Journal of Psychiatry, 188, 313-320.

Cognitive Behavioral Therapy for Schizophrenia (CBT for Schizophrenia)

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Informed by the following authors on CBT for Schizophrenia: Beck, J.S. (2011), Chadwick, P., Birchwood, M., & Trower, P. (1999), Kingdon, D.G., & Turkington, D. (1994), Morrison, A.P., Renton, K.C., French, P. & Bentall, R.P. (2008), and Smith, L., Nathan, P., Juniper, U., Kingep, P., & Lim, L. (2003).
Program Contact:	https://beckinstitute.org/ http://www.cci.health.wa.gov.au/docs/Psychosis%20Manual.pdf
Overview:	Founded on the general principles of cognitive behavioral therapy (CBT) and incorporates techniques and skills that address many of the positive symptoms (i.e., delusions, paranoia, hallucinations) associated with schizophrenia spectrum disorders. CBT is a well-established, empirically researched therapy that encourages individuals to understand the connection between their thoughts, feelings, and behaviors. Once this connection is made, group members are encouraged to gradually challenge their thinking patterns and behaviors using CBT interventions taught and demonstrated by the group facilitator. In addition to regular psychoeducation on schizophrenia, examples of group topics include distinguishing thoughts from emotions, understanding the connection between thoughts and emotions, identifying and labeling cognitive distortions, and introduction to though records. Examples of interventions taught to group members include how to conduct behavioral experiments, relaxation techniques, creating coping cards, and reality testing skills.
Recommended Group Size:	8-15
Recommended Frequency and Length:	Ongoing, five 1-hour sessions per week
Therapeutic Focus:	Individuals with schizophrenia spectrum disorder diagnoses with an interest in understanding and coping with their symptoms
Proven Outcomes:	Dickerson (2004) reviewed 17 recent clinical trial studies involving CBT for Schizophrenia. The studies involved four different groups, which are as follows: patients with recent onset psychosis, patients with persistent symptoms from community settings, patients with high symptom severity primarily in long term inpatient settings, and patients with specific comorbid diagnoses. Meta-analysis from formal effect-size analysis indicate effect sizes of from .65 to 1.25 lending support that CBT is an effective adjunctive

	treatment for some patients with schizophrenia. While the most robust findings were for outpatient populations, inpatient populations experienced improvement in self-esteem, lower total and positive symptoms, and greater improvement in their cognitive interpretation of auditory hallucinations and in the physical characteristics of the hallucinations.
Population:	18-25 (young adult), 26-55 (adult), 55+ (older adult), civil or forensic
Treatment Setting:	Inpatient and outpatient
Modality:	Group or individual therapy
Facilitator Training & Certification:	Licensed therapists or psychologists (or therapists supervised by a licensed therapist or psychologist) with education and training in cognitive behavioral therapy
Bibliography:	Update on cognitive behavioral psychotherapy for schizophrenia: Review of recent studies Dickerson F.B. (2004) Journal of Cognitive Psychotherapy, *18* (3), pp. 189-205.

Cognitive Behavior Therapy Group (CBT)

Florida DCF Classification: Evidence-Based Practice

Program Author: Program utilizes materials from various CBT sources and tailors information to patient's level of functioning. The theoretical orientation of A.T. Beck and Albert Ellis are the primary references.

Program Contact: South Florida State Hospital, Psychology Department
Dr. Sheila Schmitt 954-392-3120

Overview: Cognitive Behavioral Therapy (CBT) has demonstrated effectiveness for individuals with mental health problems. This intervention was adapted to a group setting while utilizing the same principles as the individual therapy intervention. The group aims to teach persons served how to interpret and evaluate situations, by identifying how thoughts and emotions impact their behavior. The ABC model is explained in order to facilitate understanding of the connection between emotions, thoughts and behaviors. Members are also taught coping skills and adaptive strategies to manage symptoms.

In cognitive therapy, clients learn to:

- Distinguish between thoughts and feelings.
- Become aware of the ways in which thoughts can influence feelings in ways that sometimes are not helpful.
- Learn about thoughts that seem to occur automatically, without even realizing how they may affect emotions.
- Evaluate critically whether these "automatic" thoughts and assumptions are accurate, or perhaps biased.
- Develop the skills to notice, interrupt, and correct these biased thoughts independently.

Recommended Group Size: 6 to 10 members

Recommended Frequency and Length: Weekly one hour sessions for 6-20 sessions

Therapeutic Focus: Mood disorders, such as depression, bipolar disorder, and substance use disorders

Proven Outcomes:

In 2012, Hoffman et al. identified 269 meta-analytic studies and reviewed of those a representative sample of 106 meta-analyses examining CBT for the following problems: substance use disorder, schizophrenia and other psychotic disorders, depression and dysthymia, bipolar disorder, anxiety disorders, somatoform disorders, eating disorders, insomnia, personality disorders, anger and aggression, criminal behaviors, general stress, distress due to general medical conditions, chronic pain and fatigue, distress related to pregnancy complications and female hormonal conditions. Additional meta-analytic reviews examined the efficacy of CBT for various problems in children and elderly adults. The strongest support exists for CBT of anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress. Eleven studies compared response rates between CBT and other treatments or control conditions. CBT showed higher response rates than the comparison conditions in 7 of these reviews and only one review reported that CBT had lower response rates than comparison treatments. In general, the evidence-base of CBT is very strong.

Population:

Adults

Treatment Setting:

Inpatient, outpatient, other community settings

Modality:

Individual, group therapy

Facilitator Training & Certification:

Workshops on CBT are offered by the Beck Institute
https://psychwire.com/beck/courses

Bibliography:

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. Cognitive Therapy and Research, 36(5), 427–440. http://doi.org/10.1007/s10608-012-9476-1

Dialectical Behavior Therapy (DBT)

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Marsha Linehan, Ph.D. ABPP
Program Contact:	https://behavioraltech.org/
Overview:	Dialectical Behavior Therapy (DBT) is a therapeutic methodology designed to treat persons with borderline personality disorder. DBT combines standard cognitive behavioral techniques for emotion regulation and reality-testing with concepts of mindful awareness, distress tolerance, and acceptance largely derived from Buddhist meditative practice. DBT is the first therapy that has been experimentally demonstrated to be effective for treating borderline personality disorder. Research indicates that DBT is also effective in treating individuals who represent varied symptoms and behaviors associated with spectrum mood disorders, including self-injury.
Recommended Group Size:	Six to eight persons per group
Recommended Frequency and Length:	Weekly individual sessions (approximately 1 hour) and a weekly group skills training session (approximately 1.5–2.5 hours. Phone coaching as needed.
Therapeutic Focus:	Suicide ideation, substance use disorders, eating disorders, depression, personality disorders, schizophrenia, Bipolar disorder
Proven Outcomes:	Linehan (n.d.) found 23.1% of DBT participants reported suicide attempts, compared with 46.7% of recipients of alternative expert treatment after 1 year of care during a randomized controlled trial ($p = .005$). Multiple evaluations, including randomized controlled trials and independent studies, have also confirmed that patients completing 1 year of DBT experienced less nonsuicidal self-injury than patients awaiting care or receiving alternative treatment ($p < .05$). DBT participants were also found to remain in treatment longer than patients receiving treatment as usual or alternative treatment ($p<0.002$). Safer (2001) also found DBT participants reported significantly less binging or purging behavior than patients awaiting treatment ($p < .05$).
Population:	18-25 (young adult), 26-55 (adult), 55+ (older adult)
Treatment Setting:	Inpatient, outpatient, other community settings
Modality:	Individual, group therapy

Facilitator Training & Certification:

DBT-Linehan Board of Certification certified clinicians who have received a graduate degree from a regionally accredited a mental health-related field and are licensed mental health practitioners. For more information on certification and eligibility, visit https://dbt-lbc.org/index.php?page=101120

Bibliography:

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (n.d.). Dialectical behavior therapy versus treatment-by-experts for suicidal individuals with borderline personality disorder: One-year treatment and one-year follow-up. Unpublished manuscript.

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry*, *158*, 632-634.

Dialectical Behavior Therapy – HOPE Group

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Marsha Linehan, Ph.D. ABPP
Program Contact:	https://behavioraltech.org/
Overview:	This group provides members with an opportunity to practice the core DBT skill of mindfulness in an experiential manner. This will be accomplished through structured and guided art therapy activities with attention on the present experience. Regular mindfulness practice may allow participants to decrease distress and suffering as well as increase emotion self-regulation and distress tolerance.
Recommended Group Size:	4 to 6 (with one therapist) or 6 to 8 (with two therapists)
Recommended Frequency and Length:	This is a weekly group skills training session (approximately 1.5–2.5 hours)
Therapeutic Focus:	Suicidal ideation, self-injurious ideation, substance use disorders, eating disorders, depression, personality disorders, schizophrenia, schizoaffective disorder, bipolar disorder
Proven Outcomes:	Linehan (n.d.) found 23.1% of DBT participants reported suicide attempts, compared with 46.7% of recipients of alternative expert treatment after 1 year of care during a randomized controlled trial ($p = .005$). Multiple evaluations, including randomized controlled trials and independent studies, have also confirmed that patients completing 1 year of DBT experienced less nonsuicidal self-injury than patients awaiting care or receiving alternative treatment ($p < .05$). DBT participants were also found to remain in treatment longer than patients receiving treatment as usual or alternative treatment ($p<0.002$). Safer (2001) also found DBT participants reported significantly less binging or purging behavior than patients awaiting treatment ($p < .05$) 18-25 (young adult), 26-55 (adult), 55+ (older adult).
Population:	Residents who are already involved in DBT and who need to learn skills to increase attention, regulate mood, decrease mood-based impulsive behaviors, particularly self-injury, instill and maintain a more positive and hopeful attitude about themselves and their future.
Treatment Setting:	Inpatient and outpatient

Modality: Group

Facilitator Training & Certification: At least a Master's Degree in a Therapy related field (i.e. clinical psychology, counseling psychology) and DBT-Linehan Board of Certification certified clinicians who have received a graduate degree from a regionally accredited a mental health-related field and are mental health practitioners. For more information on certification and eligibility, visit https://dbt-lbc.org/index.php?page=101120

Bibliography:

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness. Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (n.d.). Dialectical behavior therapy versus treatment-by-experts for suicidal individuals with borderline personality disorder: One-year treatment and one-year follow-up. Unpublished manuscript.

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. American Journal of Psychiatry, 158, 632-634.

Dialectical Behavior Therapy – Mindful Arts Group

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Marsha Linehan, Ph.D. ABPP
Program Contact:	https://behavioraltech.org/
Overview:	This group provides members with an opportunity to practice the core DBT skill of mindfulness in an experiential manner. This will be accomplished through structured and guided art therapy activities with attention on the present experience. Regular mindfulness practice may allow participants to decrease distress and suffering as well as increase emotion self-regulation and distress tolerance.
Recommended Group Size:	4 to 6 (with one therapist) or 6 to 8 (with two therapists)
Recommended Frequency and Length:	This is a weekly group skills training session (approximately 1.5–2.5 hours
Therapeutic Focus:	Suicidal ideation, self-injurious ideation, substance use disorders, eating disorders, depression, personality disorders, schizophrenia, schizoaffective disorder, bipolar disorder
Proven Outcomes:	Linehan (n.d.) found 23.1% of DBT participants reported suicide attempts, compared with 46.7% of recipients of alternative expert treatment after 1 year of care during a randomized controlled trial ($p = .005$). Multiple evaluations, including randomized controlled trials and independent studies, have also confirmed that patients completing 1 year of DBT experienced less nonsuicidal self-injury than patients awaiting care or receiving alternative treatment ($p < .05$). DBT participants were also found to remain in treatment longer than patients receiving treatment as usual or alternative treatment ($p<0.002$). Safer (2001) also found DBT participants reported significantly less binging or purging behavior than patients awaiting treatment ($p < .05$).
Population:	18-25 (young adult), 26-55 (adult), 55+ (older adult). Residents who show “moodiness” (emotional reactivity to daily stress) and show an interest in learning how to self-regulate using creative expression and meditative practices within a group setting and who already attend DBT group training
Treatment Setting:	Inpatient and Outpatient
Modality:	Group therapy

Facilitator Training & Certification:

Master's Degree in an Art related field (i.e. creative arts, art therapy) and DBT-Linehan Board of Certification certified clinicians who have received a graduate degree from a regionally accredited a mental health-related field and are mental health practitioners. For more information on certification and eligibility, visit https://dbt-lbc.org/index.php?page=101120

Bibliography:

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Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (n.d.). Dialectical behavior therapy versus treatment-by-experts for suicidal individuals with borderline personality disorder: One-year treatment and one-year follow-up. Unpublished manuscript.

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Family Psychoeducation Evidence-Based Practice (EBP) KIT

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Center for Mental Health Services (CMHS)
Program Contact:	CMHS: 1-877-SAMHSA-7 (1-877-726-4727) https://store.samhsa.gov/shin/content//SMA09-4423/BuildingYourProgram-FP.pdf
Overview:	Family Psychoeducation (FPE) is an approach for partnering with individuals and families to support recovery. The goal is that practitioners, individuals, and families work together to support recovery by learning problem-solving, communication, and coping skills.
Recommended Group Size:	Multifamily groups consist of five to eight individuals and their respective families
Recommended Frequency and Length:	Initial joining session for trained practitioners to meet with individuals and their respective families; (2nd phase) practitioners offer a 1-day educational workshop; (3rd phase) practitioners offer ongoing sessions for 9 months or more
Therapeutic Focus:	Mental illness, schizophrenic disorders, bipolar disorder, major depression, obsessive-compulsive disorder, borderline personality disorder
Proven Outcomes:	Family psychoeducation was found to be highly effective in reducing families' expressed emotion and improving patients relapse rates and outcomes (Penn et al., 1996; Penn et al., 2001). Penn et al. also found reductions of time spent in the hospital and improvements in housing stability (2001).
Population:	People with mental illness, schizophrenia and schizoaffective disorder (Penn et al., 2001), bipolar disorder (Miklowitz et al., 2000), major depression (Leff et al., 2000), obsessive compulsive disorder (Van Noppen et al., 1999), anorexia nervosa (Geist et al., 2000) and borderline personality disorder (Gunderson et al., 1997)
Treatment Setting:	Community mental health centers, hospital settings, outpatient clinics
Modality:	Multifamily or single-family groups
Facilitator Training & Certification:	*Training Frontline Staff* workbook of the Family Psychoeducation KIT
Bibliography:	Substance Abuse and Mental Health Services Administration. Family Psychoeducation: Building Your Program. HHS Pub. No. SMA-09-4422, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Fitness for Fun

Florida DCF Classification: Evidence-Based Practice

Program Author: Robert Paul Liberman, MD-Clinical Research Center for Schizophrenia & Psychiatric Rehabilitation. Cosponsored by Brentwood Division of the West Los Angeles Veterans Administration Medical Center, Camarillo State Hospital, UCLA Department of Psychiatry, McNeil Pharmaceutical.

Program Contact: Liberman Social and Independent Living Skills (SILS) curriculum contact: http://www.psychrehab.com/

Overview: Fitness for Fun is based on the Lieberman SILS Recreation for Leisure module. It is designed to introduce the individual to the principals of physical fitness in order to develop and foster an active, healthy lifestyle.
Skill areas of this module include:

- Identify benefits of activities
- Obtain information
- Find out what's needed for various activities
- Make a commitment, evaluate, maintain

Individuals will be exposed to numerous options that they can use to maintain physical fitness upon reentering the community. They will also be instructed on the purpose of healthy lifestyle choices through proper diet and stress management. The activities performed during this program will place emphasis on the opinion that exercise should be used for their fun and enjoyment.

Recommended Group Size: 4-10 participants recommended

Recommended Frequency and Length: Sessions are typically conducted 1-3 times per week. Sessions last 45-90 minutes.

Therapeutic Focus: Schizophrenia, bipolar disorder, depression

Proven Outcomes: The Social and Independent Living Skills (SILS) modules have been widely implemented throughout the US, translated into 23 languages, and implemented in more than 30 countries (Journal of Mental Health. There are more than 40 Type 1 or Type 2 studies and two meta-analyses that addresses improvements in social functioning, and reductions in relapse… (Benton & Schroeder, 1990; Corrigan, 1991). The structured curriculums have been validated in controlled clinical trial and field tested (Eckman, Liberman, Phipps & Blair, 1990; Eckman et al., 1992; Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992). Overall, there is excellent and well-replicated evidence for the efficacy of social skills training in the acquisition of the skills taught, with durability extending for at least 1 year.

Population:	Individuals with serious and persistent mental illness.
Treatment Setting:	Community Mental Health, Rehabilitation, Hospital, Private Office Practice, Treatment Facility, and Substance Abuse Treatment Center
Modality:	Group Therapy
Facilitator Training & Certification:	The modules are highly structured, permit practitioners with diverse educational and clinical backgrounds to implement them with equal ease and accuracy. No special training or qualifications are required to conduct a module.
Bibliography:	APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf UCLA Social and Independent Living Skills Modules. (n.d.). Retrieved from https://www.psychrehab.com/pdf/Prostectus.pdf

Illness Management and Recovery (IMR)

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Kim Mueser, Ph.D.; Susan Gingerich, M.S.W.
Program Contact:	Kim Mueser: kim.t.mueser@dartmouth.edu; Susan Gingerich: gingsusan@yahoo.com
Overview:	The Illness Management and Recovery (IMR) program teaches individuals how to manage their psychiatric disorder in collaboration with others in the context of setting and pursuing personally meaningful goals. The personally meaningful goals are identified by each individual at the beginning of the program and continually supported and followed up throughout the program. The goals of IMR are to: instill hope that change is possible; help people establish personally meaningful goals; teach information about mental illness and treatment options; develop skills for reducing relapses, dealing with stress, and coping with symptoms; provide information about where to obtain needed resources; and help people develop or enhance their natural supports for managing their illness and pursuing goals. Modules covered within the program include, but are not limited to, the stress-vulnerability model, building social support, effective medication use, and drug and alcohol use.
Recommended Group Size:	The IMR program can be provided in an individual or small group (up to 8 persons) format
Recommended Frequency and Length:	Individuals receive at least 3 to 10 months of weekly IMR individual or group sessions
Therapeutic Focus:	Schizophrenia, bipolar disorder, depression
Proven Outcomes:	In a randomized control trial group study of coping-oriented therapy versus supportive therapy in schizophrenia, Schaub et al., (2016) found IMR patients learned significantly more information about psychosis and had greater reductions in overall symptoms and depression/anxiety over the treatment and follow-up period than patients in supportive therapy. A meta-analysis of 40 randomized controlled studies (Mueser et al., 2002) also found IMR to improve people's knowledge of mental illness, helps people use medication as prescribed, reduce symptom relapses and rehospitalizations, and reduce the severity and distress of persistent symptoms.
Population:	People with mental illness, ages 18-65
Treatment Setting:	Inpatient and outpatient mental health settings

Modality:

Individual, group therapy

Facilitator Training & Certification:

The IMR leader may facilitate the initial training for IMR practitioners by using the training tools in the *Training Frontline Staff* workbook of the Illness Management and Recovery KIT

Bibliography:

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf

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Substance Abuse and Mental Health Services Administration. Illness Management and Recovery: Building Your Program. HHS Pub. No. SMA-09-4462, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Integrated Dual Disorders Treatment (IDDT) Recovery Life Skills Program

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Lindy Fox, MA, LADC, of the Dartmouth Psychiatric Research Center
Program Contact:	http://www.bhevolution.org/public/index.page
Overview:	IDDT is an evidence-based practice that improves quality of life for people with co-occurring severe mental illness and substance abuse disorders by combining substance abuse and mental health services. IDDDT is modifiable for the group members and their readiness for change, and can be easily designed for either a group that is ready for active treatment or a group who needs more motivational enhancement to work towards recovery. IDDT was developed and continues to be studied by researchers at the Dartmouth Psychiatric Research Center of Dartmouth Medical School in Lebanon, New Hampshire.
Recommended Group Size:	Optimal group size is 6-8 members. In groups with more than 10 members, individual members do not have enough time to process the materials and learn the necessary skills, even when additional sessions are included.
Recommended Frequency and Length:	18 sessions delivered in a 1-hour group session, or over two 1-hour sessions held consecutively. At the end of the 18 sessions, group members are given the opportunity to repeat the curriculum.
Therapeutic Focus:	People with dual, or co-occurring, disorders and substance use
Proven Outcomes:	Reduced substance abuse and psychiatric symptoms, hospitalization, and arrests. Improved functional status, quality of life, and housing status (Drake et al., 1998).
Population:	Individuals in active treatment or relapse prevention for co-occurring mental illness and substance abuse disorders. Most individuals in treatment are between 18 and 55.
Treatment Setting:	Inpatient, Outpatient, long-term residential (Brunette, M.F. et al., 2001)
Modality:	Group therapy
Facilitator Training & Certification:	*Training Frontline Staff* workbook of the Integrated Treatment for Co-Occurring Disorders KIT. Hazelden also offers training three-day, counselor implementation training https://www.hazelden.org/web/public/trainingcooccurring_disorders_program.page

Bibliography:

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Brunette, M.F., Drake, R.E., Woods, M., & Hartnett, T. (2001). A comparison of long-term and short-term residential treatment programs for dual diagnosis patients. *Psychiatric Services, 54(3)*, 526-528.

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin 24*,589–608.

Substance Abuse and Mental Health Services Administration. Integrated Treatment for Co-Occurring Disorders: Building Your Program. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Living in Balance (LIB): Moving from a Life of Addiction to a Life of Recovery

Florida DCF Classification: Evidence-Based Practice

Program Author: Jeffrey A. Hoffman, Ph.D.

Program Contact: Kaylene McElfresh (kmcelfresh@hazelden.org)
Jeffrey A. Hoffman (301-565-2142 ext. 1050)

Overview: LIB is a manual-based, comprehensive addiction treatment program that emphasizes relapse prevention. LIB can be delivered on an individual basis or in group settings with relaxation exercises, role-play exercises, discussions, and workbook exercises. The psychoeducational sessions cover topics such as drug education, relapse prevention, available self-help groups, and sexually transmitted diseases (STDs). The experientially based or interactive sessions are designed to enhance the individual's level of functioning in certain key life areas that are often neglected with prolonged drug use: physical, emotional, and social well-being, adult education opportunities, vocational development, daily living skills, spirituality/recovery, sexuality, and recreation/leisure. These sessions include a large amount of role-play with time to actively process personal issues and learn how to cope with everyday stressors.

Recommended Group Size: Recommended based on state and billing requirements

Recommended Frequency and Length: LIB consists of a series of 1.5- to 2-hour psychoeducational and experiential training sessions, for 12 core and 21 supplemental sessions.

Therapeutic Focus: Substance abuse

Proven Outcomes: In a 4-month, randomized clinical trial, individuals abusing cocaine were significantly more likely to remain in treatment longer ($p<0.001$) and less likely to drop out in the first week of therapy if they received LIB enhanced with individual psychotherapy or LIB enhanced with individual psychotherapy plus family therapy, relative to individuals in usual group therapy only (28%-34% vs. 56%; $p<0.005$). Individuals who were assigned to LIB or an LIB enhanced condition were more likely to remain in treatment (23.4 sessions attended, on average) relative to clients in the usual group therapy condition (16.5 sessions, on average) (Hoffman et al., 1994).

There were no significant differences in regular drug or alcohol use between LIB and usual group therapy, thus all treatment conditions

were collapsed and analyzed as one group from intake to the 12-month follow up. At the 12-month follow up interview, only 23% of the 178 individuals reported regular cocaine use (at least weekly), compared to 84% at the intake interview ($p<0.05$). Only 16% of individuals across conditions reported regular alcohol use in the past year, compared with 31% at intake ($p<0.01$) (Hoffman et al., 1996).

Population: Adults ages 26-55 years old, with issues relating to alcohol, crime/delinquency, drugs, treatment/recovery, and violence

Treatment Setting: Residential, hospital, community, counseling centers, outpatient, inpatient correctional facilities

Modality: Individual, group therapy

Facilitator Training & Certification: A two-day, on or off-site training is scheduled regionally on an as-needed basis, or can be scheduled and customized to fit the needs of any major program installation. For more information, see http://www.hazelden.org/web/public/traininglivinginbalance.page

Bibliography:

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Recovery-Oriented Cognitive Therapy (CT-R)

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Paul Grant, Ph.D.; Aaron T. Beck, M.D.
Program Contact:	pgrant@mail.med.upenn.edu; recovery@aaronbeckcenter.org
Overview:	Based on the cognitive model, Recovery-oriented Cognitive Therapy (CT-R) is an evidence-based treatment focused on engagement, achievement of goals, and elimination of obstacles for people diagnosed with schizophrenia. CT-R pairs with psychiatric practice to produce measurable progress, is readily teachable, and has been successfully implemented in many settings (hospital, residential, case management team, outpatient) for people with a range of needs. CT-R involves meeting people where they are, accessing their adaptive mode, developing aspirations and steps toward successfully achieving them, strengthening positive beliefs, weakening negative beliefs, and developing resiliency in regards to stress and challenges.
Recommended Group Size:	6 to 10 members
Recommended Frequency and Length:	Sessions are typically held weekly, for 50 minutes at a time, for eighteen months
Therapeutic Focus:	Schizophrenia and schizoaffective disorder
Proven Outcomes:	Clinical trial by Grant (2012) found CT-R and standard treatment (ST) combined to improve global functioning (d=0.56), reduce avolition-apathy (d=-.066), and improve positive symptoms (d=-0.46) compared to people who only received ST alone.
Population:	Adults age 18-65
Treatment Setting:	Outpatient, inpatient, civil and forensic state hospitals, residential treatment facilities
Modality:	Individual, group therapy, team-based approach
Facilitator Training & Certification:	The Beck Psychopathology Research Center of the University of Pennsylvania offers webinars, workshops, consultations, and other trainings. https://aaronbeckcenter.org/2017/07/07/recovery-oriented-cognitive-therapy-evidence-to-practice/
Bibliography:	Grant, P.M., Huh, G.A., Perivoliotis, D., Stolar, N.M., Beck, A.T. (2012). Randomized trial to evaluate the efficacy of cognitive therapy for low-functioning patients with schizophrenia. *Archives of General Psychiatry, 69*(2):121–127. doi:10.1001/archgenpsychiatry.2011.129

Seeking Safety

Florida DCF Classification: Evidence-Based Practice

Program Author: Lisa Najavits, Ph.D.

Program Contact: Email:director@treatment-innovations.org;
Website: https://www.treatmentinnovations.org/seeking-safety.html

Overview: Seeking Safety is an evidence-based, present-focused counseling model to help people attain safety from trauma and/or substance abuse. It is an extremely safe model as it directly addresses both trauma and addiction, but without requiring individuals to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of individuals and easy to implement. It has also been delivered successfully by peers in addition to professionals of all kinds and in all settings. It can be conducted over any number of sessions available although the more the better when possible.

Recommended Group Size: The size can vary based on program. Some run small groups of three to eight individuals; some run medium-sized groups (nine to fifteen individuals) and others run large groups (16 or more) (Najavits, 2009).

Recommended Frequency and Length: Choose session length and pacing to fit the setting. Typically, 25 sessions held weekly, twice weekly, or more. The length can be 1 hour to 1.5 hours.

Therapeutic Focus: Mental health treatment, trauma, PTSD, substance abuse

Proven Outcomes: A randomized control trial of 107 women found that compared with women in the usual care control condition, women who participated in Seeking Safety significantly reduced their substance use at the end of treatment ($p < .001$) and at the 6-month follow-up ($p < .05$) (Hien et al., 2004)., improvement in trauma-related symptoms, decrease in thought related to PTSD, increased treatment retention. Hien (2004) also found the Seeking Safety participants showed a significant improvement on measures of trauma symptoms compared with usual care participants at the end of treatment ($p < .01$), at the 6-month follow-up ($p < .05$), and at the 9-month follow-up ($p < .05$).

Population: 13-17 (adolescent), 18-25 (young adult), 26-55 (adult) females, males, and mixed-gender groups

Treatment Setting: Inpatient, outpatient, residential

Modality: Individual, group therapy

Facilitator Training & Certification:

Any clinician can conduct Seeking Safety; no specific degree or experience is required. Because the treatment focuses on stabilization rather than trauma processing, it does not exceed the training, licensure, or ethical limits of most clinicians. However, there are many ways to learn Seeking Safety. Training can occur by simply reading the workbook, through onsite training, the Seeking Safety video training series, phone consultation, or some combination of these. See www.seekingsafety.org (Training section) for various options.

Bibliography:

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf

Hien, D. A., Cohen, L. R., Miele, G. M., Litt, L. C., & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry*, *161*, 1426-1432.

Najavits, L.M. (2009) Seeking safety: An implementation guide*. In A. Rubin & DW Springer (Eds). The Clinician's Guide to Evidence-Based Practice*. Hoboken, NJ: John Wiley

Substance Abuse and Mental Health Services Administration. (n.d.). Seeking Safety. Retrieved from https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=139

Social Skills Training for Schizophrenia

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Bellack, A.S., Mueser, K.T., Gingerich, S., & Agresta, J. (2004)
Program Contact:	http://www.va.gov/visn5mirecc/
Overview:	Founded on research which indicates that social skills training is an evidence-based practice for improving social functioning in people with schizophrenia and other severe mental illnesses. Group members will systematically be taught more effective skills for interacting with others. Skills training will include, but not be limited to the following techniques: modeling, reinforcement, shaping, overlearning, and generalization.
Recommended Group Size:	4-10
Recommended Frequency and Length:	Ongoing, five 1-hour sessions per week
Therapeutic Focus:	Diagnosis of schizophrenia or thought disorder and impaired social functioning. This group will be particularly helpful for individuals who face issues of social anxiety related to schizophrenia spectrum disorders.
Proven Outcomes:	Kopelowicz, Liberman, and Zarate, (2006) cite over 50 studies that document the significant and substantial improvements in participants' knowledge and behaviors as the result of social skills training. These improvements are maintained for up to 2 years, the maximum duration measured. Overall outcome is improvement in social adjustment of individuals diagnosed with schizophrenia.
Population:	18-25 (young adult), 26-55 (adult), 55+ (older adult), civil and forensic
Treatment Setting:	Inpatient and outpatient
Modality:	Group Therapy
Facilitator Training & Certification:	Therapists with knowledge of behavior principles and schizophrenia who are warm, caring, and empathic
Bibliography:	APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf Kopelowicz, A., Liberman, R.P., Zarate, R. (2006) Recent advances in social skills training for schizophrenia. Schizophrenia Bulletin, 32, pS12-S23

Substance Abuse Management

Florida DCF Classification: Evidence-Based Practice

Program Author: Robert Paul Liberman, MD-Clinical Research Center for schizophrenia & Psychiatric Rehabilitation. Cosponsored by Brentwood Division of the West Los Angeles Veterans Administration Medical Center, Camarillo State Hospital, UCLA Department of Psychiatry, McNeil Pharmaceutical.

Program Contact: Liberman Social and Independent Living Skills (SILS) curriculum contact: http://www.psychrehab.com/

Overview: Constructed to teach persons abusing or dependent upon alcohol or drugs how to acquire the skills for relapse prevention and for living satisfying and sober lives, this module is suitable for all types of individuals who abuse alcohol and whose mental disorders are complicated by drug or alcohol abuse. The Trainer's Manual contains exercises and handouts for facilitating the developments of required skills by participants. Skill areas of this module include:

- Drug relapse prevention principles
- Avoid abuse and develop healthy pleasures
- Adapt refusal skills to actual environments

The module teaches participants how to identify and address the warning signs of relapse through exercises, handouts, videos, discussion, and implementation of problem solving skills areas.

Recommended Group Size: 4-10 participants recommended

Recommended Frequency and Length: Sessions are typically conducted 1-3 times per week. Sessions last 45-90 minutes.

Therapeutic Focus: The goal of the Substance Abuse Management Module is to teach people, dependent upon or abusing alcohol or drugs, how to acquire the skills for relapse prevention and for living satisfying and sober lives.

Proven Outcomes: The Social and Independent Living Skills (SILS) modules have been widely implemented throughout the US, translated into 23 languages, and implemented in more than 30 countries. There are more than 40 Type 1 or Type 2 studies and two meta-analyses that address improvements in social functioning and reductions in relapse (Benton & Schroeder, 1990; Corrigan, 1991). The structured curriculums have been validated in controlled clinical trial and field tested (Eckman, Liberman, Phipps & Blair, 1990; Eckman et al., 1992; Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992). Overall, there is excellent and well-replicated evidence for the efficacy of social skills training in the acquisition of the skills taught, with durability extending for at least 1 year.

Population:	This module is suitable for all types of individuals who abuse alcohol and drugs and is specifically organized to meet the needs of the dually diagnosed whose mental disorders are complicated by drug or alcohol abuse.
Treatment Setting:	Community Mental Health, Rehabilitation, Hospital and Private Office Practice Treatment Facilities, and Substance Abuse Treatment Centers.
Modality:	Group Settings
Facilitator Training & Certification:	The modules are highly structured, permitting practitioners with diverse educational and clinical backgrounds to implement them with equal ease and accuracy. No special training or qualifications are required to conduct a module.
Bibliography:	APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness. Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf UCLA Social and Independent Living Skills Modules. (n.d.). Retrieved from https://www.psychrehab.com/pdf/Prostectus.pdf

Supported Employment

Florida DCF Classification:	Evidence-Based Practice
Program Author:	Center for Mental Health Services (CMHS)
Program Contact:	CMHS: 1-877-SAMHSA-7 (1-877-726-4727) https://store.samhsa.gov/shin/content//SMA08-4365/BuildingYourProgram-SE.pdf
Overview:	Supported Employment (SE) is an approach to vocational rehabilitation for people with serious mental illnesses that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace. SE offers vocational rehabilitation services in a variety of settings, utilizing training and support modalities. SE also provides assistance such as job coaches, specialized training, job retention and individual supervision. SE helps consumers obtain competitive work in the community and provides the supports necessary to ensure success at the workplace. SE programs help consumers find jobs that pay competitive wages in integrated settings (i.e., with others who don't necessarily have a disability) in the community.
Recommended Group Size:	Providers manage caseloads of up to 25 individuals
Recommended Frequency and Length:	Weekly or biweekly. Individuals who receive SE services are never terminated unless they directly request it, despite their vocational success. Follow-along supports are provided for individuals on a time-unlimited basis.
Therapeutic Focus:	Research on SE focuses on individuals with serious mental illness. Diagnosis, symptoms, age, gender, disability status, prior hospitalization, and education have been examined, and none have proved to be strong or consistent predictors (Bond et al., 1995; Drake et al., 1997; Dra ketal., 1999). Notably, a co-occurring condition of substance use has not been found to predict employment outcomes either (Goldberg et al., 2001; Meisler et al., 1997; Sengupta et al., 1998).
Proven Outcomes:	A review of 17 studies involving employment programs consistently demonstrated that 58% of individuals who were in SE obtained competitive employment compared to 21% in traditional programs (Bond et al., 2001). Additional research found that individuals that succeed in finding competitive work may experience improvements in symptoms, self-esteem, and satisfaction with finances. The research on SE also suggests that individuals who participate in SE programs do not experience more severe symptoms or higher levels of distress, nor do they require more intensive psychiatric treatment such as emergency room visits or psychiatric hospitalizations (Bond et al., 2001).

Population:	Individuals who are living with mental illness and are seeking employment; young adults (18-25), adults (25-30+)
Treatment Setting:	Community mental health center, community rehabilitation programs, and psychiatric rehabilitation centers, inpatient and outpatient
Modality:	Supported employment in community settings
Facilitator Training & Certification:	*Training Frontline Staff* workbook of the Supported Employment KIT.
Bibliography:	APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf Substance Abuse and Mental Health Services Administration. Supported Employment: Building Your Program. DHHS Pub. No. SMA-08-4364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Symptom Management

Florida DCF Classification: Evidence-Based Practice

Program Author: Robert Paul Liberman, MD-Clinical Research Center for Schizophrenia & Psychiatric Rehabilitation. Cosponsored by Brentwood Division of the West Los Angeles Veterans Administration Medical Center, Camarillo State Hospital, UCLA Department of Psychiatry, McNeil Pharmaceutical.

Program Contact: Liberman Social and Independent Living Skills (SILS) curriculum contact: http://www.psychrehab.com/

Overview: Symptom Management teaches individuals the skills to monitor the "signs" that warn of an impending symptomatic relapse, and implement a predetermined "emergency" plan to prevent the relapse or minimize its effects. The intent is to help individuals live in the community at the highest level of functioning possible with a minimum of disruption due to inevitable variations in their symptoms. Skill areas of this course include:

- Identifying warning signs of relapse
- Managing warning signs
- Coping with persistent symptoms
- Avoiding alcohol and street drugs.

The Module is designed to make participants skillful observers of their own current treatments symptoms, and full collaborators in selecting, implementing, and evaluating the symptoms' medication and psychosocial treatment.

Recommended Group Size: 4-10 participants recommended

Recommended Frequency and Length: Sessions are typically conducted 1-3 times per week. Sessions last 45-90 minutes.

Therapeutic Focus: Schizophrenia, bipolar disorder, depression.

Proven Outcomes: The Social and Independent Living Skills (SILS) modules have been widely implemented throughout the US, translated into 23 languages, and implemented in more than 30 countries (Journal of Mental Health. There are more than 40 Type 1 or Type 2 studies and two meta-analyses that addresses improvements in social functioning, and reductions in relapse… (Benton & Schroeder, 1990; Corrigan, 1991). The structured curriculums have been validated in controlled clinical trial and field tested (Eckman, Liberman, Phipps & Blair, 1990; Eckman et al., 1992; Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992). Overall, there is excellent and well-replicated evidence for the efficacy of social skills training in the acquisition of the skills taught, with durability extending for at least 1 year.

Population:	Individuals with serious and persistent mental illness.
Treatment Setting:	Inpatient and outpatient mental health settings
Modality:	Group Therapy
Facilitator Training & Certification:	The modules are highly structured, permit practitioners with diverse educational and clinical backgrounds to implement them with equal ease and accuracy. No special training or qualifications are required to conduct a module.
Bibliography:	APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness.* Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf UCLA Social and Independent Living Skills Modules. (n.d.). Retrieved from https://www.psychrehab.com/pdf/Prostectus.pdf

Token Economy Programs

Florida DCF Classification:	Evidence-Based Practice
Program Author:	William D Spaulding, Ph.D. (key author among numerous behavioral psychologists)
Program Contact:	https://psychology.unl.edu/william-spaulding
Overview:	Token economy programs are generally used in long-term care setting such as long-stay inpatient units and residential care settings, but can be adapted for shorter stay and less intensive treatment programs as well. They are comprehensive behavioral programs, based on social learning principles, in which participants receive reinforcers (such as tokens or points) for performing clearly defined target behaviors. These reinforcers are provided immediately after a desired behavior and then exchanged at a later time for tangible goods or desired privileges. The focus of a token economy is on shaping and positively reinforcing desired behaviors and not on punishing undesirable behaviors.
Recommended Group Size:	Flexible to needs of setting
Recommended Frequency and Length:	Integrated into daily milieu
Therapeutic Focus:	The primary goals of a token economy program are to increase the presence of adaptive behaviors and reduce the frequency of maladaptive or inappropriate behaviors, with the ultimate goal of preparing each participant for greater independence and improved functioning.
Proven Outcomes:	Glynn (1990) reviewed landmark studies in the area of Token Economies. Research designs ranged from reversals and multiple baseline designs to random assignment with control and treatment conditions. Outcomes from these landmark studies included improvements in self-care, medication adherence, work skills, and treatment participation. Token economy programs appear to be most effective when implemented in the context of appropriate medication management, individualized treatment planning, and other evidence-based psychosocial treatments.
Population:	18-25 (young adult), 26-55 (adult), 55+ (older adult), civil or forensic
Treatment Setting:	Inpatient settings
Modality:	Selected units of a facility
Facilitator Training & Certification:	Token Economy programs must be overseen by a psychologist with specialized training and experience in behavior modification practices or a Board Certified Behavioral Analyst.
Bibliography:	Glynn, S. Token economy approaches for psychiatric patients: Progress and pitfalls over 25 years. Behavior Modification, 17:383-407, 1990.

Promising Practices

Double Trouble in Recovery (DTR)

Florida DCF Classification: Promising Practice

Program Author: Howard S. Vogel

Program Contact: www.hazelden.org

Overview: DTR is a mutual-aid, self-help program for adults who have been diagnosed with both a mental illness and a substance use disorder. In a mutual-aid program, people help each other address a common problem, usually in a group led by consumer facilitators rather than by professional treatment or service providers. DTR is adapted from the 12 Steps of Alcoholics Anonymous; however, DTR groups are structured with the intent of creating an environment in which people with an active addiction and psychiatric diagnosis can identify with other members and explore their dual recovery needs.

Recommended Group Size: Up to 20

Recommended Frequency and Length: At least weekly in 60-90 minute sessions

Therapeutic Focus: Mental Health Treatment, Alcohol and Substance Use Disorder Treatment, and Co-Occurring Disorders

Proven Outcomes: Promising Outcomes for Alcohol Use and Alcohol Use Disorder, General Substance Use, General Functioning, and Well-Being. By a 6-month follow up, participants in the intervention group had used drugs or alcohol on fewer days, relative to the control group. This difference was statistically significant (Magura et al., 2008). At the time of the follow up (3 months after study induction for the Michigan site, 6 months after for the New York City sites), participants in the intervention group reported having used any substances (alcohol or drugs) on significantly fewer days than comparison participants; however, there were no significant between-group differences in the number of days of drug use (Rosenblum et al., 2014).

Population: Young Adult (Ages 18-25), Adult (Ages 26-55), and Older Adult (Ages 55+)

Treatment Setting: Residential Facility, Outpatient Facility, Correctional Facility, Mental Health Treatment Facility, and Substance Abuse Treatment Center

Modality: Use of Recovery Basic Guide

Facilitator Training & Certification:

Training through materials available at hazelden.org

Bibliography:

Magura, S., Rosenblum, A., Villano, C. L., Vogel, H. S., Fong, C., & Betzler, T. (2008). Dual-focus mutual aid for co-occurring disorders: A quasi-experimental outcome evaluation study. The American Journal of Drug and Alcohol Abuse, 34, 61–74.

Rosenblum, A., Matusow, H., Fong, C., Vogel, H., Uttaro, T., Moore, T. L., & Magura, S. (2014). Efficacy of dual focus mutual aid for persons with mental illness and substance misuse. Drug and Alcohol Dependence, 135, 78–87.

Integrated Group Therapy (IGT) for Co-occurring Bipolar and Substance Use Disorders

Florida DCF Classification: Promising Practice

Program Author: Roger D. Weiss, M.D.

Program Contact: rweiss@mclean.harvard.edu

Overview: Integrated Group Therapy (IGT) for Co-occurring Bipolar and Substance Use Disorders is a manualized treatment based on principles of cognitive-behavioral therapy as well as psychoeducational approaches. The goal of IGT is improving both substance use and mood, with an emphasis on abstinence from alcohol and drugs, and on medication adherence. Most sessions deal with topics explicitly relevant to both disorders (e.g., "Dealing with Depression without Using Alcohol or Drugs" and "Identifying and Fighting Triggers for Mania, Depression, and Substance Use"). IGT is designed to be administered in conjunction with pharmacologic treatment for Bipolar Disorder as well as other treatments such as individual psychotherapy, other group treatment, and self-help/mutual-help support groups.

Recommended Group Size: The ideal group size is 6 to 8 attendees, with each mental health or addiction professional managing a group between 5 and 10 attendees.

Recommended Frequency and Length: IGT consists of 12 weekly, hour-long, small group sessions delivered by substance use counselors or other mental health professionals.

Therapeutic Focus: Co-occurring Bipolar Disorder and Substance Use Disorders

Proven Outcomes: Reducing general substance use; improving receipt of mental health and/or substance use treatment (Weiss et al., 2009).

Population: Adults (ages 18 and above). Participants must be adults with current Bipolar Disorder and Substance Use Disorders, taking a mood stabilizer, and willing to enter a group therapy that addresses both disorders. Patients who are currently manic cannot enter the group until the manic episode has resolved.

Treatment Setting: Mental health treatment center

Modality: Individual and group therapy

Facilitator Training & Certification:

IGT is designed to be delivered by substance use counselors and other mental health or addiction professionals. Half- or full-day, in-person, training to facilitate the program or supervise its implementation is not required, but is available from the program developer. The treatment manual, Integrated Group Therapy for Bipolar Disorder and Substance Abuse, is available to purchase through Guilford Press.

Bibliography:

Substance Abuse and Mental Health Services Administration. (n.d.). Integrated Group Therapy (IGT) for Co-occurring Bipolar and Substance Use Disorders. Retrieved from https://nrepp.samhsa.gov/ProgramProfile.aspx?id=147

Weiss, R. D., Griffin, M. L., Jaffee, W. B., Bender, R. E., Graff, F. S., Gallop, R. J., & Fitzmaurice, G. M. (2009). A “community-friendly” version of integrated group therapy for patients with bipolar disorder and substance dependence: A randomized controlled trial. Drug and Alcohol Dependence, 104(3), 212–219.

Psychiatric Rehabilitation Recovery Program

Florida DCF Classification: Promising Practice

Program Author: Boston University Center for Psychiatric Rehabilitation staff: William Anthony, Mikal Cohen, Barry Cohen, Marianne Farkas, Karen Danley, Patricia Nemec, Rick Forbess

Program Contact: Rick Forbess - rforbess@bu.edu
https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=241

Overview: The manualized program was developed by BCPR utilizing evidence-based Psychiatric Rehabilitation ("Choose-Get-Keep" Process) technology. It is administered utilizing a Readiness Assessment which assesses an individual's readiness to participate in the recovery process. Individuals are served according to their assessed phase of rehabilitation readiness via Engagement, Readiness Development, Choosing, or Achieving (Getting) groups. Each phase of Recovery has a manualized array of resources and teaching strategies to assist individuals in working toward their overall Recovery goals.

Recommended Group Size: 8-12 individuals

Recommended Frequency and Length: Frequency: Minimum 1x/week; Length: Dependent on needs and preferences of participants

Therapeutic Focus: Any mental illness that is the primary reason for a person's inability to function in an age appropriate community role. Groups will focus on building skills and supports for recovery based on individuals' needs, strengths and preferences.

Proven Outcomes: Ability to meet basic survival needs; Improved Housing Status; Increased Use of Human Services; Improvement in Quality of Life; Reduced Psychological Symptoms of Anxiety, Depression, and Thought Disturbance

Population: Adults with severe mental illness

Treatment Setting: All settings including community and inpatient mental health treatment facilities

Modality: Individual and small group

Facilitator Training & Certification:

No certification is required. Instructors should be very familiar with the full range of recovery goals as outlined in the "Choose-Get-Keep" model, as well as the use of the assessment tools utilized within the curriculum. Hands-on training/mentoring by skilled practitioners is recommended, in order for providers to develop strong skills for engaging a person in the process, assessing and developing the person's hope and confidence about participating in the process, making informed choices about which specific living, learning, working, or socializing environmental role the person wants to function in, as well as assessing and developing skills and supports for functioning in a chosen environment. Further information is available from Boston University Center for Psychiatric Rehabilitation: https://cpr.bu.edu/

Bibliography:

Substance Abuse and Mental Health Services Administration. (n.d.). Psychiatric Rehabilitation Process Model. Retrieved from https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=241

- SAMHSA's NREPP lists the Psychiatric Rehabilitation Process Model as an Evidence-based practice, though research studies were conducted in community-based programs. This meets the definition of a Promising Practice for the inpatient setting.

Relapse Prevention

Florida DCF Classification: Promising Practice

Program Author: Department of Children and Families Mental Health Treatment Facilities Workgroup

Program Contact:

Overview: This program focuses on providing skills necessary for successful transition back to the community by the creation of a relapse prevention plan through the presentation of modules focused on different aspects of mental health recovery.

Recommended Group Size: Up to 15

Recommended Frequency and Length: Ongoing, sessions occur up to five days a week for one hour

Therapeutic Focus: Facilitators provide psychoeducation on the following topics: Developing/Improving Support Systems, Anger/Conflict Management; Personal Self Care; Overview of Mental Health Disorders; Thinking Errors/The Triangle of Thoughts, Feelings and Behaviors; and Stages of Change

Proven Outcomes: The primary focus is to facilitate learning of coping tools and the development of a relapse prevention plan to prevent return to an inpatient setting after discharge from hospitalization. The development of a comprehensive relapse prevention plan is supported by the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS).

Population: Adults in an inpatient setting

Treatment Setting: Inpatient

Modality: Group preferred, individual training options available

Facilitator Training & Certification: Qualified Rehab Staff with at least a Bachelor's Degree and experience working with individuals in an inpatient setting

Bibliography:

Action Planning for Prevention and Recovery: https://store.samhsa.gov/shin/content/SMA-3720/SMA-3720.pdf

Burdick, D. (2013). Mindfulness Skills Workbook for Clinicians and Clients: 111 Tools, Techniques, Activities & Worksheets. Eau Claire, WI: PESI Publishing & Media.

Curran, L. (2013). 101 Trauma-Informed Interventions: Activities, Exercises and Assignments to Move the Client and Therapy Forward. Eau Claire, WI: PESI Publishing & Media.

“Getting on with Life: My Recovery Management Journal” from Twin Valley Behavioral Healthcare, 2007.

Macnaughton, E. (2003). "Module 4: Developing an Early Warning System and Action Plan." In Mental Disorders Toolkit: Information and Resources for Effective Self-Management of Mental Disorders. Canadian Mental Health Association, BC Division.

Nagaraja, D. (2008). Buddha at Bedtime: Tales of Love and Wisdom for You to Read with Your Child to Enchant, Enlighten and Inspire. Toronto: Duncan Baird Publishers.

Najavitis, L. (2011). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York, NY: Guilford Press.

NurrieStearns, M., & NurrieStearns, R. (2010). Yoga for Anxiety: Meditations and Practices for Calming the Body and Mind. Oakland, CA: New Harbinger Publications, Inc.

NurrieStearns, M., & NurrieStearns, R. (2013). Yoga for Emotional Trauma: Meditations and Practices for Healing Pain and Suffering. Oakland, CA: New Harbinger Publications, Inc.

“Tips for preventing relapse of mental illnesses” from Canadian Mental Health Association, BC Division.

Wellness Recovery Action Plan (WRAP)

Florida DCF Classification: Promising Practice

Program Author: Mary Ellen Copeland, Ph.D.

Program Contact: Matthew Federici, Executive Director, Copeland Center for Wellness and Recovery (mfederici@copelandcenter.com)
Kristen King, WRAP Project Manager kristen@wrapandrecoverybooks.com

Overview: Wellness Recovery Action Plan (WRAP) is a manualized group intervention for symptom and illness management for individuals with mental health disorders. WRAP guides participants through the process of identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources daily.

Recommended Group Size: WRAP groups range in size from 8 to 12 participants and are led by two trained co-facilitators.

Recommended Frequency and Length: The intervention is typically delivered over eight weekly, 2.5-hour sessions. It can be adapted for shorter or longer periods to more effectively meet the needs of participants, as long as all essential components are covered in no less than 16 hours of instruction and interaction. Participants sometimes choose to continue meeting after the formal 8-week period to support each other in using and continually revising their WRAP plans.

Therapeutic Focus: Anxiety disorders, depression, non-specific mental health disorders and symptoms, substance use

Proven Outcomes: Reducing anxiety disorders and symptoms, reducing depression and depressive symptoms (Cook et al., 2012), improving hopefulness (Cook et al., 2009; Cook et al., 2011), significantly improving physical and mental health (Cook et al., 2009)

Population: 26-55 years old (adult), 55+ (older adult). Male, female, transgender

Treatment Setting: Mental health outpatient programs, residential facilities, peer-run programs, Hospital, medical center, school, substance abuse treatment center

Modality: Individual and group therapy

Facilitator Training & Certification: WRAP facilitator training, workshops, seminars, and consultations are offered for interested facilitators. For more information, see https://copelandcenter.com/our-services/wrap-facilitator-training

Bibliography: APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) *Catalog of Clinical Training Opportunities: Best Practices for*

Recovery and Improved Outcomes for People with Serious Mental Illness. Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf

Substance Abuse and Mental Health Services Administration. (n.d.). Wellness Recovery Action Plan. Retrieved from https://nrepp.samhsa.gov/ProgramProfile.aspx?id=1231

Practices with Demonstrated Effectiveness

Exercise and Nutrition

Florida DCF Classification: Practice with Demonstrated Effectiveness

Program Author: Robert Paul Liberman, MD
The Social and Independent Living Skills (SILS) modules produced by the UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation served as models for Exercise and Nutrition. The format and structure of Exercise for Nutrition is modeled after the SILS curriculum.

Program Contact: Liberman Social and Independent Living Skills (SILS) curriculum contact: http://www.psychrehab.com/

Overview: Designed to teach the individual how to better manage a healthier lifestyle by making healthier choices regarding exercise and nutrition as part of their daily routine. Learning to make healthier nutritional choices and engaging in some type of daily exercise has been proven to increase a healthier lifestyle now and in the future. Skill areas include: Physical activity; healthy lifestyle Nutrition: making health choices Making Lifestyle changes: setting personal goals.

Recommended Group Size: 4-10 participants recommended

Recommended Frequency and Length: Sessions are typically conducted 1-3 times per week. Sessions last 45-90 minutes.

Therapeutic Focus: History of unhealthy lifestyle choices especially in the area of physical health.

Proven Outcomes: The Social and Independent Living Skills (SILS) modules have been widely implemented throughout the US, translated into 23 languages, and implemented in more than 30 countries (Journal of Mental Health). There are more than 40 Type 1 or Type 2 studies and two meta-analyses that addresses improvements in social functioning, and reductions in relapse (Benton & Schroeder, 1990; Corrigan, 1991). The structured curriculums have been validated in controlled clinical trial and field tested (Eckman, Liberman, Phipps & Blair, 1990; Eckman et al., 1992; Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992). Overall, there is excellent and well-replicated evidence for the efficacy of social skills training in the acquisition of the skills taught, with durability extending for at least 1 year.

Population: Individuals with serious and persistent mental illness.

Treatment Setting: Community Mental Health, Rehabilitation, hospital and private office practices Treatment Facility, and Substance Abuse Treatment Center

Modality: Group Therapy

Facilitator Training & Certification: The modules are highly structured, permit practitioners with diverse educational and clinical backgrounds to implement them with equal ease and accuracy. No special training or qualifications are required to conduct a module.

Bibliography:

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007) Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness. Retrieved from http://www.apa.org/practice/resources/grid/catalog.pdf

UCLA Social and Independent Living Skills Modules. (n.d.). Retrieved from https://www.psychrehab.com/pdf/Prostectus.pdf

Life Skills

Florida DCF Classification: Practice with Demonstrated Effectiveness

Program Author: Christine Helfrich, PhD, OTR/L, FAOTA, under several grants from NIDILRR.

Program Contact: https://naric.com/?q=en/content/order-life-skills-manual

Overview: The Life Skills Manual: Strategies for Maintaining Residential Stability is designed for adults who desire to learn practical life skills to live independently in the community. It is intended to teach life skills to a wide variety of individuals who need assistance in this area. The curriculum consists of four modules, Food and Nutrition Management, Money Management, Home and Self Care, and Safe Community Participation. The entire curriculum is meant to be adaptable to a wide range of settings. The content was created in partnership with individuals who were trying to live independently in the community, individuals who were homeless, service delivery workers from a range of disciplines that work with individuals for whom life skills are challenging, peer leaders, peer recovery specialists, and various consultants in order to create an effective, feasible, and age-appropriate curriculum.

Recommended Group Size: This program is provided in group format with up to 12 participants at a time, per module.

Recommended Frequency and Length: Approximately 24 sessions of 60-minute duration.

Therapeutic Focus: Sessions focus on psychosocial education and life skills development.

Proven Outcomes: In a study of 51 adults with mental illness who were also experiencing homelessness, Helfrich et al. (2007) found that individuals with mental illness who were experiencing homelessness had significant improvements in practical skills testing on room and self-care management (e.g., personal and public hygiene, health, clothing, home cleaning, and home organization) at the three and six month follow-ups.

Population: This intervention is intended for the often underserved and undervalued populations of people who have found themselves homeless, often with a disability, and in need of access to rehabilitation services.

Treatment Setting: Adaptable to a wide-range of settings.

Modality: Individual, group Therapy

Facilitator Training & Certification: The modules are highly structured, permitting practitioners with diverse educational and clinical backgrounds to implement them with equal ease and accuracy. No special training or qualifications are required to conduct a module.

Bibliography:

Helfrich, C.A., Fogg, L.F. (2007). Outcomes of a life skills intervention for homeless adults with mental illness. *Journal of Primary Prevention, 28*, 313-326. doi 10.1007/s10935-007-0103-y

Mairs H and Bradshaw T (2004). Life skills training in schizophrenia. *The British Journal of Occupational Therapy, 67*(5):217-224. doi:10.1177/030802260406700505

Perkins, D.D., Zimmerman, M.A. (1995). Empowerment theory, research, and application. *American Journal of Community Psychology, 23* (5), 569-579.

Moral Reconation Therapy (MRT)

Florida DCF Classification: Practice with Demonstrated Effectiveness

Program Author: Kenneth Robinson, Ed.D.

Program Contact: ccimrt@ccimrt.com

Overview: Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning.

Recommended Group Size: Five to fifteen

Recommended Frequency and Length: Participants meet in groups once or twice weekly (for approximately one and one half to two hours). It is designed to be completed by the average individual in 20-30 sessions and can complete all steps of the MRT program in a minimum of 3 to 6 months.

Therapeutic Focus: Mental health treatment, substance use treatment, co-occurring disorders, offender population

Proven Outcomes: In a meta-analysis of 33 studies and 30,259 offenders, Ferguson (2012) found MRT to have a small but significant effect (r=0.16) on recidivism. Researchers in another study found a significant positive correlation between the last MRT step completed at the time of initial testing (after 6 months of program implementation) and the degree of principled reasoning (p=0.03) and perceived purpose in life (p=0.01) (Little et al., 1989).

Population: Forensic: 13-17 (Adolescent), 18-25 (Young Adult), 26-55 (Adult)

Treatment Setting: Correctional

Modality: Individual, group therapy

Facilitator Training & Certification:

Correctional Counseling, Inc. (CCI) is the sole-source provider of MRT training, materials, and certifications. A three-day, on-site training is scheduled regionally for potential facilitators. For more information, see https://www.ccimrt.com/training/trainingsbytype/

Bibliography:

Robinson, K [PowerPoint slides] MRT™ http://old.ndcrc.org/sites/default/files/nadcp_webinar_presentation_final_march_2016.pdf

Substance Abuse and Mental Health Services Administration. (n.d.). Moral Reconation Therapy. Retrieved from https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=34

Narrative Therapy

Florida DCF Classification: Practice with Demonstrated Effectiveness

Program Author: Program informed by the following authors on narrative therapy: Erbes, C.R., Stillman, J.R., Wieling, E., Bera, W., and Leskela, J. (2014) and Vromans, L.P. & Schweitzer, R.D. (2010)

Program Contact: https://dulwichcentre.com.au/narrative-therapy-research

Overview: Group is focused on overall psychological development. Topics include learning about improved communication skills, ability to understand different perspectives, and increasing repertoire of healthy coping skills.

Recommended Group Size: Tailored to fit the needs and resources of the context and population

Recommended Frequency and Length: Ongoing, 1-hour sessions per week

Therapeutic Focus: Diagnosis of a personality disorder or a major mental illness that interferes with healthy interactions with others

Proven Outcomes: Vromans and Schweitzer (2010) investigated depressive symptom and interpersonal relatedness outcomes from eight sessions of manualized narrative therapy for 47 adults with major depressive disorder. Post-therapy, depressive symptom improvement (d=1.36) and proportions of clients achieving reliable improvement (74%), movement to the functional population (61%), and clinically significant improvement (53%) were comparable to benchmark research outcomes. Post-therapy interpersonal relatedness improvement (d=.62) was less substantial than for symptoms. Three-month follow-up found maintenance of symptom, but not interpersonal gains. Benchmarking and clinical significance analyses mitigated repeated measure design limitations, providing empirical evidence to support narrative therapy for adults with major depressive disorder.

Erbes, Stillman, Wieling, Bera, and Leskela (2014) conducted a pilot investigation of the use of narrative therapy with 14 veterans with a diagnosis of PTSD (11 treatment completers) is described. Participants completed structured diagnostic interviews and self-report assessments of symptoms prior to and following 11 to 12 sessions of narrative therapy. After treatment, 3 of 11 treatment completers no longer met criteria for PTSD and 7 of 11 had clinically significant decreases in PTSD symptoms as measured by the Clinician Administered PTSD Scale. Pre- to posttreatment effect sizes on outcomes ranged from 0.57 to 0.88. These preliminary results, in conjunction with low rates of treatment dropout (21.4%) and a high level of reported satisfaction with the treatment, suggest that further study of narrative therapy is warranted as a potential alternative to existing treatments for PTSD.

Population:	18-25 (young adult), 26-55 (adult), 55+ (older adult), civil or forensic
Treatment Setting:	Inpatient and outpatient
Modality:	Group or individual therapy
Facilitator Training & Certification:	Licensed therapists or psychologists (or therapists supervised by a licensed therapist or psychologist) with education and training in narrative therapy
Bibliography:	Erbes CR, Stillman JR, Wieling E, Bera W, Leskela J. (2014). A pilot examination of the use of narrative therapy with individuals diagnosed with PTSD. *Journal of Traumatic Stress*, *27*(6):730-3. doi: 10.1002/jts.21966. Epub 2014 Nov 10. Lynette P. Vromans & Robert D. Schweitzer (2010) Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes, *Psychotherapy Research*, 21:1, 4-15, DOI: 10.1080/10503301003591792

Wellness Self-Management (WSM)

Florida DCF Classification:	Practice with Demonstrated Effectiveness
Program Author:	The New York State Office of Alcoholism and Substance Abuse Services and the Office of Mental Health
Program Contact:	wellness@oasas.ny.gov
Overview:	Wellness Self-Management is a structured, comprehensive curriculum-based clinical practice designed to assist adults to effectively manage serious mental health problems. The WSM program is based on Illness Management and Recovery (IMR), a nationally recognized evidence-based practice for adults with serious mental health problems. WSM is designed to have increased usability and sustainability, especially when delivered in groups, compared to IMR. In addition to IMR-related topics such as recovery, mental health wellness, and relapse prevention, the WSM approach includes lessons emphasizing the connection between physical and mental health. WSM differs from IMR by organizing the curriculum into a workbook that belongs to the participants, adding a physical health chapter, using self-directed action steps, organizing the process around a specific group facilitation format and embedding core competencies within the workbook.
Recommended Group Size:	8-10 members
Recommended Frequency and Length:	45-60 minutes, at least once a week, for usually a year or more
Therapeutic Focus:	Serious mental health illness, substance use
Proven Outcomes:	Reports from participants and group leaders found that 75% of participants showed significant progress in their identified goal areas over the course of WSM (Salerno et al., 2011).
Population:	People with mental illness, ages 18-65
Treatment Setting:	Inpatient and outpatient mental health settings, prison mental health units
Modality:	Individual, group (optimally closed) format
Facilitator Training & Certification:	Online trainings available, but no WSM specific licensing or certification required
Bibliography:	Salerno, A., Margolies, P., Cleek, A., Pollock, M., Gopalan, G., & Jackson, C. (2011). Wellness Self-Management: An Adaptation of the Illness Management and Recovery Practice in New York State. *Psychiatric Services (Washington, D.C.)*, *62*(5), 456–458. http://doi.org/10.1176/appi.ps.62.5.456

Enrichment Activities

In addition to providing evidence-based practices, promising practices, and practices with demonstrated effectiveness, Florida's SMHTFs offer numerous enrichment activities. The treatment groups are analogous to classroom learning where skills needed for mental illness recovery are taught. Enrichment activities provide multiple opportunities to practice those skills in daily life and are instrumental in engaging individuals in recovery-based programming.

Creative/Expressive Arts Activities

Arts and Crafts activities (e.g., collages, still life drawings, book making, murals, self-portraits, guided imagery, printmaking, origami, painting, pottery, leather art, jewelry making, sewing, embroidery, and mask making) are offered to help individuals express themselves through the use of various art materials. Music activities (e.g., listening to music, learning to play a musical instrument, musical performance, or learning about music history) are available to assist individuals in learning how to use and understand the benefits of music in their everyday life.

Educational Activities

Florida's SMHTFs offer various educational opportunities such as Adult Basic Education, GED classes, Computer Skills Labs, and College Correspondence Distance Learning. In addition, library services provide residents with choices such as reading books, magazines, or newspapers, listening to a wide assortment of music, watching videos, researching legal issues, or obtaining information about medications and treatment. Some SMHTFs provide opportunities to access the internet (with Recovery Team approval and a signed agreement to adhere to library rules of usage), obtain materials and services from the Bureau of Braille and Talking Book Library Services, the State of Florida Library loan of books or videos, or interlibrary loan.

Leisure Activities

Horticultural activities are available to assist residents in learning new skills or regaining those that were lost. These activities can help improve mood state, coordination, and balance while enjoying the fresh air, sunshine, and all that nature in Florida has to offer. Opportunities are available for individuals of Incompetent to Proceed forensic status to play themed games (e.g., Tic-Tac-Toe) in which advancing in the game requires correct answers to questions about competency-related issues. Reminiscing activities that use memorabilia, mementos, and sharing of past experiences are also offered.

On-Unit Programming and Structured Activities

While on the units or living areas, residents are provided with activities that are aimed at enhancing trust, cooperation, and a working relationship between the resident and the recovery team/facility staff. Some of the activities include indoor and outdoor recreation activities, board games, group discussions, and activities to promote expression of personal values and increase commitment to actively participate in their recovery process.

Peer Support Activities

Peer support and self-help groups are offered so residents may share their concerns, provide each other with support and suggest strategies that have worked for them with the goals of increasing hope, empowerment, and recovery.

Religious, Spiritual, and Faith Services

Religion, spirituality, and faith can be a great source of support and hope for individuals on a journey of mental illness recovery. At Florida's SMHTFs, residents can engage in organized church services or discussions related to scripture and biblical topics. Chaplaincy Services are also available as needed on an individual basis. Volunteers from local churches of various denominations provide religious services to the residents, especially during times of faith specific holidays.

Sports and Recreational Activities

The SMHTFs have gyms equipped with elliptical machines, stationary bicycles, steppers, and weight lifting machines. Floor mats are available to the residents for yoga, stretching, and other exercises. Good physical health for life is encouraged through exercise activities such as tennis, aerobics, softball, volleyball, basketball, tai chi, walking and shuffleboard. One of the SMHTFs has a swimming pool with a lifeguard on duty.