Clinical Practice Guidelines

Solano County Guidance on Evidence Based and Best Practices

July 2020

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Purpose

Solano Behavioral Health provides mental health (MH) services and supports that are person-centered, safe, effective, timely, and equitable. This document, as guided by our Mental Health Plan, is a compilation of national standard evidence-based practices (EBPs) and best practices across the children's, youth, and adult system of care. These guidelines are not intended to be mandatory, exhaustive, or definitive and it is recommended that professional judgment is used when determining the most appropriate treatment intervention that is discussed in collaboration with a client/caregiver and accounts for the client's unique characteristics, culture, and preferences. The EBPs for these Practice Guidelines were selected because they have been utilized in Solano County and are recognized as empirically supported treatments that have undergone rigorous methodological studies and support flexibility to ensure culturally responsive services.

Our hope is that this document is beneficial for:

- our community, clients and family members for educational purposes and informed choice
- our staff for practice improvement and continuing education
- our contractors to guide EBP implementation standards

Solano County Guidance:

Throughout the document you will see sections sharing information about:

Solano County Implementation: if and how the practice is being implemented in Solano County either for county-run services or throughout contractors. This will help identify how accessible the practice is and highlight the need for expansion and cross-training.

Intended Population: who the evidence based or best practice is intended to serve per research:

0-5	Children	Youth/Young Adults	Adults	Other

Who Can Use This Intervention: this is focused on *Scope of Practice*, which refers to how the law defines what members of a licensed profession may do in their licensed practice. It is important that staff working within Solano BH provide services that are within their scope of practice and scope of competency. The tables identify which staff in Solano BH can utilize the models based upon their professional scope of practice, and/or training and certification. Please make sure to reference these tables as you utilize the therapeutic models in the Practice Guidelines.

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre-A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4-year exp in MH)	Staff without BA/BS and 4 yrs. exp/or AA & 6 yrs. exp.
Topic										

**Some services are provided under the direction of another licensed practitioner (or in some cases, a registered or waivered practitioner). This means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery (this includes review and cosigning of clinical documentation). An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the service provided.*

Assertive Community Treatment (ACT):

Assertive Community Treatment (ACT) is a self-contained trans-disciplinary team staffed with a team leader, psychiatrist, nurses, social workers, therapists, and specialists, such as in the area of co-occurring substance use treatment, employment and educational services, supportive housing, and peer-support services.

Bay Area ACT Learning Community

Solano BH uses ACT within the adult Full Service Partnerships. Additionally, Solano has invested funding and resources to implement this model and support the Bay Area with a learning community. Resources for ACT have been developed that include a "Solano ACT Resource Guide", shared drive for counties, and videos. All documents shared in the Learning Community meetings and trainings are housed in a **Google Drive** for people to view/download as needed-

GOOGLE DRIVE LINK:
https://drive.google.com/drive/folders/1gWCgdNLlm0fY9q_x7HlGFLhOeLjXhOcr?usp=sharing

Videos: View past webinars on our Solano County BH Vimeo page, Password: ACTLC

VIMEO LINK: https://vimeo.com/showcase/6025860

Anyone with these links can access:

- Articles on the TMACT
- TMACT Summary Scale
- ACT team roles
- Comprehensive Assessment Guide
- Case Example Integrated Assessment
- ACT transition assessment scale
- Daily Staff Schedules (blank)
- Recovery plan (blank)
- Weekly client schedule (blank)

Figure 1- Services Provided by ACT

About ACT: Team members work closely together to help adults with severe mental illness live in their homes instead of an institution or the streets. They provide a comprehensive array of services, such as helping find and maintain safe and affordable housing, get a job, learn about their mental health challenges and treatment choices, assist with harm reduction and substance abuse recovery, develop practical life skills, and provide medication oversight and support.
ACT teams also assists with the overall health care needs of people served and aim to work closely with individuals' families and other natural supports. To be most effective, ACT is to be recovery-oriented, strengths-based, and person-centered. Treatment is assertive in that the team is proactive and persistent in efforts to engage individuals who would likely benefit from this level of support. To provide intensive, comprehensive, and flexible services, small and large teams serve no more than 50 and 120 individuals, respectively.

Since its original implementation in Madison, Wisconsin in the 1970s, a fundamental charge of ACT is to be the first-line, if not sole provider of all services that ACT service recipients need. Extensive research showing ACT's positive effect on individuals' outcomes, particularly regarding reduced hospitalization, earned ACT the status as an evidence-based practice (EBP) in the 1990s. Although key ingredients of this model have remained the same, ACT, too, has evolved to harness the current psychosocial evidence-based treatments and practices to be delivered through the platform of ACT.

Characteristics

- Most ACT programs have similar structures, so the following may give some guidance on what the program will offer.
- A recovery focused treatment plan will be centered around personal strengths, needs, and desires for the future
- ACT is offered long-term but not unlimited; the goal is to eventually transition people to other services or for you to maintain what you have learned on your own
- The focus of ACT is on community integration and getting people back to living a normal life
- ACT follows a holistic approach to treatment, meaning that all areas of life are goals for improvement
- ACT usually has a ratio of about 10-12 clients per staff with sharing caseloads by specialized team members
- Most clients have multiple contacts with team members each week
- ACT is available 24 hours a day, 7 days a week to ensure that people always have the help you need, usually with a warmline.
- An ACT team generally includes a supervisor or Team Leader, a psychiatrist, clinicians, case managers, nurses, peer support specialists, and more- typically 10 or so staff.
- ACT is a considered a higher level of care service, for people stepping down from hospitals or institutions- people are often transitioned from ACT teams as goals in treatment and recovery are supported.

The Benefits

- Overall, research evidence on assertive community treatment has been positive with some caveats. A 2016 evidence review showed that ACT reduced self-reported psychiatric symptoms, hospital stays, and emergency department visits among people with mental illness and substance abuse.

- In general, from the dozens of randomized controlled trials that have been conducted, it can be concluded that ACT is more effective than standard services in reducing hospital use, but findings for other outcomes are less clear.
- While studies have shown improvements in housing, symptom management, and quality of life for ACT, these findings were most evident for people who tended to return to hospitals often.
- It has been noted that ACT may be most helpful in communities that do not have well-coordinated mental health care systems, which result in overuse of hospitals by those with serious mental illness.
- For example, ACT may show better outcomes in the United States than in the United Kingdom, because the former has a poorly coordinated system for mental health care that results in more hospital stays, while the latter has a well-coordinated system that already includes many aspects of ACT in its standard care.
- Other research has shown ACT to be more effective than standard care in reducing the risk of hospital stays and incarceration, specifically in poor inner-city neighborhoods, and reducing alcohol use or incarceration among those with antisocial personality disorder.
- Furthermore, among the homeless, it has been shown that ACT results in more satisfaction with care and more stable housing situations than standard care. This is easy to understand when you consider the ACT model—homeless individuals meet service providers where it is convenient for them are more likely to benefit from services than those who must travel to receive help.
- Finally, in a Cochrane review of 38 clinical trials from the United States, Canada, Europe, and Australia, it was shown that ACT was more effective than standard care in lowering the time spent in hospitals and improving social functioning and independent living. At the same time, mental health and quality of life were not shown to improve more than when standard care was offered.
- Overall, the research evidence suggests that ACT is most helpful for people with serious mental illness as a method to keep them out of the hospital and in the community.

Solano County Implementation: ACT is being utilized within the adult Full Service Partnership programs for both county-run and CBO FSPs. Implementation started late 2018. Staff have continuous training and support from the model developer and leadership for improving fidelity.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
ACT		X	X	x	x	x	x	X	x	x

Sources: https://www.institutebestpractices.org/act/description/ / https://www.centerforebp.case.edu/practices/act

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) evolved from Marsha Linehan's efforts to create a treatment for multiproblematic, suicidal women. Linehan combed through the literature on efficacious psychosocial treatments for other disorders, such as anxiety disorders, depression, and other emotion-related difficulties, and assembled a package of evidence-based, cognitive-behavioral interventions that directly targeted suicidal behavior. Initially, these interventions were so focused on changing cognitions and behaviors that many patients felt criticized, misunderstood, and invalidated, and consequently dropped out of treatment altogether.

Through an interplay of science and practice, clinical experiences with multiproblematic, suicidal patients sparked further research and treatment development. Most notably, Linehan weaved into the treatment interventions designed to convey acceptance of the patient and to help the patient accept herself, her emotions, thoughts, the world, and others. As such, DBT came to rest on a foundation of dialectical philosophy, whereby therapists strive to continually balance and synthesize acceptance and change-oriented strategies.

Ultimately, this work culminated in a comprehensive, evidence-based, cognitive-behavioral treatment for borderline personality disorder (BPD). The standard DBT treatment package consists of weekly individual therapy sessions (approximately 1 hour), a weekly group skills training session (approximately 1.5–2.5 hours), and a therapist consultation team meeting (approximately 1–2 hours). At present, eight published, well-controlled, randomized, clinical trials (RCTs) have demonstrated that DBT is an efficacious and specific treatment for BPD and related problems.

Clients for whom DBT has the strongest and most consistent empirical support include parasuicidal women with BPD. There also are some promising data on DBT for women with BPD who struggle with substance use problems. Preliminary data suggest that DBT may have promise in reducing binge-eating and other eating-disordered behaviors. On the one hand, the most conservative clinical choice would be to limit DBT to women with BPD. On the other hand, DBT is a comprehensive treatment that includes elements of several evidence-based, cognitive-behavioral interventions for other clinical problems. As such, DBT often is applied in clinical settings to multiproblematic patients in general, including those patients who have comorbid Axis I and II disorders, and/or who are suicidal or self-injurious.

The 4 Modules of Dialectical Behavior Therapy

1. Mindfulness

- The essential part of all skills taught in skills group are the core mindfulness skills.
- Observe, Describe, and Participate are the core mindfulness "what" skills. They answer the question, "What do I do to practice core mindfulness skills?"
- Non-judgmentally, One-mindfully, and Effectively are the "how" skills and answer the question, "How do I practice core mindfulness skills?"

2. Interpersonal Effectiveness

The interpersonal response patterns –how you interact with the people around you and in your personal relationships — that are taught in DBT skills training share similarities to those taught in some assertiveness

and interpersonal problem-solving classes. These skills include effective strategies for asking for what one needs, how to assertively say 'no,' and learning to cope with inevitable interpersonal conflict.

People with borderline personality disorder frequently possess good interpersonal skills. They experience problems, however, in the application of these skills in specific contexts — especially emotionally vulnerable or volatile situations. An individual may be able to describe effective behavioral sequences when discussing another person encountering a problematic situation but may be completely incapable of generating or carrying out a similar set of behaviors when analyzing their own personal situation.

This module focuses on situations where the objective is to change something (e.g., requesting someone to do something) or to resist changes someone else is trying to make (e.g., saying no). The skills taught are intended to maximize the chances that a person's goals in a specific situation will be met, while at the same time not damaging either the relationship or the person's self-respect.

3. Distress Tolerance

Most approaches to mental health treatment focus on changing distressing events and circumstances. They have paid little attention to accepting, finding meaning for, and tolerating distress. This task has generally been tackled by religious and spiritual communities and leaders. Dialectical behavior therapy emphasizes learning to bear pain skillfully.

Distress tolerance skills constitute a natural development from mindfulness skills. They have to do with the ability to accept, in a non-evaluative and nonjudgmental fashion, both oneself and the current situation. Although the stance advocated here is a nonjudgmental one, this does not mean that it is one of approval: acceptance of reality is not approval of reality.

Distress tolerance behaviors are concerned with tolerating and surviving crises and with accepting life as it is in the moment. Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons. Acceptance skills include radical acceptance, turning the mind toward acceptance, and willingness versus willfulness.

4. Emotion Regulation

People with borderline personality disorder or who may be suicidal are typically emotionally intense and labile — frequently angry, intensely frustrated, depressed, and anxious. This suggests that people grappling with these concerns might benefit from help in learning to regulate their emotions.

- Dialectical behavior therapy skills for emotion regulation include:
- Learning to properly identify and label emotions
- Identifying obstacles to changing emotions
- Reducing vulnerability to "emotion mind"
- Increasing positive emotional events
- Increasing mindfulness to current emotions
- Taking opposite action
- Applying distress tolerance techniques

Solano County Implementation: DBT trainings were offered in Solano (2016-2017) and staff across children and adult programs have been able to access new online or in person trainings via state trainers.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Dialectic Behavioral Therapy		X	X					X		

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2963469/

EMDR (Eye Movement Desensitization and Reprocessing)

Eye Movement Desensitization and Reprocessing (EMDR) is a form of therapy that helps people heal from trauma or other distressing life experiences. It has been extensively researched and proven effective for the treatment of trauma. After the therapist and the client agree that EMDR therapy is a good fit, and begin to work together, the client will be asked to focus on a specific event. Attention will be given to a negative image, belief, and body feeling related to this event, and then to a positive belief that would indicate the issues was resolved. While the client focuses on the upsetting event, the therapist will begin sets of side-to-side eye movements, sounds, or taps. The client will be guided to notice what comes to mind after each set. They may experience shifts in insight or changes in images, feelings, or beliefs regarding the event. The client has full control to stop the therapist at any point, if needed. The sets of eye movements, sounds, or taps are repeated until the event becomes less disturbing. More than 30 positive controlled outcome studies have been done on EMDR therapy. Some of the studies show that 84%-90% of single-trauma victims no longer have post-traumatic stress disorder after only three 90-minute sessions.

A therapist trained in EMDR therapy uses a standardized protocol that incorporates elements from several treatment approaches. There are 8 phases of treatment as briefly described below.

8 Phases of EMDR Therapy Treatment

Phase 1: The first phase is a history-taking session(s). The therapist assesses the client's readiness and develops a treatment plan. Client and therapist identify possible targets for EMDR processing. These include distressing memories and current situations that cause emotional distress. Other targets may include

related incidents in the past. Emphasis is placed on the development of specific skills and behaviors that will be needed by the client in future situations.

Initial EMDR processing may be directed to childhood events rather than to adult onset stressors or the identified critical incident if the client had a problematic childhood. Clients generally gain insight on their situations; the emotional distress resolves and they start to change their behaviors. The length of treatment depends upon the number of traumas and the age of PTSD onset. Generally, those with single event adult onset trauma can be successfully treated in under 5 hours. Multiple trauma victims may require a longer treatment time.

Phase 2: During the second phase of treatment, the therapist ensures that the client has several different ways of handling emotional distress. The therapist may teach the client a variety of imagery and stress reduction techniques the client can use during and between sessions. A goal of EMDR therapy is to produce rapid and effective change while the client maintains equilibrium during and between sessions.

Phases 3-6: In phases three to six, a target is identified and processed using EMDR therapy procedures. These involve the client identifying three things:

1. The vivid visual image related to the memory
2. A negative belief about self
3. Related emotions and body sensations.

In addition, the client identifies a positive belief. The therapist helps the client rate the positive belief as well as the intensity of the negative emotions. After this, the client is instructed to focus on the image, negative thought, and body sensations while simultaneously engaging in EMDR processing using sets of bilateral stimulation. These sets may include eye movements, taps, or tones. The type and length of these sets is different for each client. At this point, the EMDR client is instructed to just notice whatever spontaneously happens.

After each set of stimulation, the clinician instructs the client to let his/her mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. Depending upon the client's report, the clinician will choose the next focus of attention. These repeated sets with directed focused attention occur numerous times throughout the session. If the client becomes distressed or has difficulty in progressing, the therapist follows established procedures to help the client get back on track.

When the client reports no distress related to the targeted memory, (s)he is asked to think of the preferred positive belief that was identified at the beginning of the session. At this time, the client may adjust the positive belief if necessary, and then focus on it during the next set of distressing events.

Phase 7: In phase seven, closure, the therapist asks the client to keep a log during the week. The log should document any related material that may arise. It serves to remind the client of the self-calming activities that were mastered in phase two.

Phase 8: The next session begins with phase eight. Phase eight consists of examining the progress made thus far. The EMDR treatment processes all related historical events, current incidents that elicit distress, and future events that will require different responses

Solano County Implementation: Solano has invested funding and trainings for an EMDR trainings from 2019 for several cohorts of staff across children and adult program. They continue to receive training from internal and external consultants.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
			x	

Who Can Use This Intervention?

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EMDR		X	X					X		

Sources: https://www.emdr.com/what-is-emdr/

https://www.emdria.org/page/120

Motivational Interviewing

Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change). Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change.

Core elements

MI is practiced with an underlying **spirit** or way of being with people:

- **Partnership**. MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.
- **Evocation**. People have within themselves resources and skills needed for change. MI draws out the person's priorities, values, and wisdom to explore reasons for change and support success.
- **Acceptance**. The MI practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths, and respects a person's right to make informed choices about changing or not changing.
- **Compassion**. The MI practitioner actively promotes and prioritizes clients' welfare and wellbeing in a selfless manner.

MI has **core skills** of OARS, attending to the language of change and the artful exchange of information:

- **Open questions** draw out and explore the person's experiences, perspectives, and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (Elicit-Provide-Elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.
- **Affirmation** of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.
- **Reflections** are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.
- **Summarizing** ensures shared understanding and reinforces key points made by the client.
- **Attending to the language of change** identifies what is being said against change (sustain talk) and in favor of change (change talk) and, where appropriate, encouraging a movement away from sustain talk toward change talk.
- **Exchange of information** respects that both the clinician and client have expertise. Sharing information is considered a two way street and needs to be responsive to what the client is saying.

"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

(Miller & Rollnick, 2013, p. 29)

MI has four fundamental **processes**. These processes describe the "flow" of the conversation although we may move back and forth among processes as needed:

1. Engaging: This is the foundation of MI. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person's experience and perspective while affirming strengths and supporting autonomy.
2. Focusing: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.
3. Evoking: In this process the clinician gently explores and helps the person to build their own "why" of change through eliciting the client's ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person's talk about change.
4. Planning: Planning explores the "how" of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person's own insights and expertise.

Solano County Implementation: Solano has trained staff in past but is funding a new series of trainings for 2020-2021 for staff across children and adult program. They continue to receive training from internal and external consultants.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

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Motivational Interviewing	x	X	X	x	x	x	x	X	x	x

Source: https://motivationalinterviewing.org/

Harm Reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet [people who use drug] "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve [people who use drugs] reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, HRC considers the following principles central to harm reduction practice.

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that [people who use drugs] and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Solano County Implementation: Solano trained staff in early 2020 for Harm Reduction with Co-Occurring disorders and is funding a more trainings for 2020-2021 for staff across children and adult program. They continue to receive training from internal and external consultants

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

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Harm Reduction	x	X	X	x	x	x		X	x	x

Source: https://harmreduction.org/about-us/principles-of-harm-reduction/

CBT (Cognitive Behavioral Therapy)

Cognitive behavioral therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders and severe mental illness. Numerous research studies suggest that CBT leads to significant improvement in functioning and quality of life. In many studies, CBT has been demonstrated to be as effective as, or more effective than, other forms of psychological therapy or psychiatric medications.

It is important to emphasize that advances in CBT have been made on the basis of both research and clinical practice. Indeed, CBT is an approach for which there is ample scientific evidence that the methods that have been developed actually produce change. In this manner, CBT differs from many other forms of psychological treatment.

CBT is based on several core principles, including:

- Psychological problems are based, in part, on faulty or unhelpful ways of thinking.
- Psychological problems are based, in part, on learned patterns of unhelpful behavior.
- People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

CBT treatment usually involves efforts to change thinking patterns. These strategies might include: Learning to recognize one's distortions in thinking that are creating problems, and then to reevaluate them in light of reality. Gaining a better understanding of the behavior and motivation of others. Using problem-solving skills to cope with difficult situations. Learning to develop a greater sense of confidence is one's own abilities.

CBT treatment also usually involves efforts to change behavioral patterns. These strategies might include:

- Facing one's fears instead of avoiding them.
- Using role playing to prepare for potentially problematic interactions with others.
- Learning to calm one's mind and relax one's body.

CBT for Psychosis

For many of the people we serve in Solano BH, CBT for Psychosis (CBTp) is more aligned with the needs of the population. Cognitive Behavioral Therapy for Psychosis (CBTp) is an evidence-based treatment approach shown to improve symptoms and functioning in patients with psychotic disorders. CBTp aims to enhance function despite difficult symptoms and experiences such hallucinations, negative symptoms, thought disturbances, and delusions. CBTp forms a collaborative treatment alliance in which patient and therapist can explore distressing psychotic experiences and the beliefs the patient has formed about these experiences, with the goal of reducing distress and disability caused by these experiences. CBTp is a structured, time-limited, and goal-based treatment modality. CBTp can be delivered in individual and group modalities, has long-lasting benefits after the termination of therapy, and is cost effective.

Solano County Implementation: Solano has been able to get training via a contractor for a small group of FSP staff in mid-2020 the goal is to provide more CBTp training across all staff in 2021.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

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Cognitive Behavioral Therapy		X	X					X		

Source: https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

https://www.nasmhpd.org/sites/default/files/DH-CBTp_Fact_Sheet.pdf

https://www.mirecc.va.gov/visn2/docs/CBTp_Manual_VA_Yulia_Landa_2017.pdf

SFBT (Solution Focused Brief Therapy)

Solution-Focused Brief Therapy (SFBT), also called Solution-Focused Therapy, Solution-Building Practice therapy was developed by Steve de Shazer (1940-2005), and Insoo Kim Berg (1934-2007) and their colleagues beginning in the late 1970's in Milwaukee, Wisconsin. As the name suggests, SFBT is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought clients to seek therapy.

The entire solution-focused approach was developed inductively in an inner city outpatient mental health service setting in which clients were accepted without previous screening. The developers of SFBT spent hundreds of hours observing therapy sessions over the course several years, carefully noting the therapists' questions, behaviors, and emotions that occurred during the session and how the various activities of the therapists affected the clients and the therapeutic outcome of the sessions. Questions and activities related to clients' report of progress were preserved and incorporated into the SFBT approach.

Since that early development, SFBT has not only become one of the leading schools of brief therapy, it has become a major influence in such diverse fields as business, social policy, education, and criminal justice services, child welfare, domestic violence offenders treatment. Described as a practical, goal-driven model, a hallmark of SFBT is its emphasis on clear, concise, realistic goal negotiations. The SFBT approach assumes that all clients have some knowledge of what would make their life better, even though they may need some (at times, considerable) help describing the details of their better life and that everyone who seeks help already possesses at least the minimal skills necessary to create solutions.

Key Concepts and Tools: All therapy is a form of specialized conversations. With SFBT, the conversation is directed toward developing and achieving the client's vision of solutions. The following techniques and questions help clarify those solutions and the means of achieving them.

- Looking for previous solutions: SF therapists have learned that most people have previously solved many, many problems and probably have some ideas of how to solve the current problem. To help clients see these potential solutions they may ask, "Are there times when this has been less of a problem?" or "What did you (or others) do that was helpful?"
- Looking for exceptions: Even when a client does not have a previous solution that can be repeated, most have recent examples of exceptions to their problem. These are times when a problem could occur, but does not. The difference between a previous solution and an exception is small, but significant. SF therapists may help clients identify these exceptions by asking, "What is different about the times when this is less of a problem?"
- Present and future-focused questions vs. past-oriented focus: The questions asked by SF therapists are usually focused on the present or on the future. This reflects the basic belief that problems are best solved by focusing on what is already working, and how a client would like their life to be, rather than focusing on the past and the origin of problems. For example, they may ask, "What will you be doing in the next week that would indicate to you that you are continuing to make progress?"
- Compliments: Compliments are another essential part of solution focused brief therapy. Validating what clients are already doing well, and acknowledging how difficult their problems are encourages the client to change while giving the message that the therapist has been listening (i.e., understands) and cares.

- Inviting the clients to do more of what is working: Once SF therapists have created a positive frame via compliments and then discovered some previous solutions and exceptions to the problem, they gently invite the client to do more of what has previously worked, or to try changes they have brought up which they would like to try – frequently called "an experiment."
- Miracle Question (MQ): This unusual sounding tool is a powerful in generating the first small steps of 'solution states' by helping clients to describe small, realistic, and doable steps they can take as soon as the next day. The miracle question developed out of desperation with a suicidal woman with an alcoholic husband and four "wild" children who gave her nothing but grief. She was desperate for a solution, but that she might need a 'miracle' to get her life in order.
- Scaling Questions: Scaling questions (SQ) can be used when there is not enough time to use the MQ and it is also useful in helping clients to assess their own situations, track their own progress, or evaluate how others might rate them on a scale of 0 to 10. It is used in many ways, including with children and clients who are not verbal or who have impaired verbal skills.
- Coping Questions: This question is a powerful reminder that all clients engage in many useful things even in times of overwhelming difficulties. Even in the midst of despair, many clients do manage to get out of bed, get dressed, feed their children, and do many other things that require major effort. Coping questions such as "How have you managed to carry on?" or "How have you managed to prevent things from becoming worse?" open up a different way of looking at client's resiliency and determination.
- Consultation Break and Invitation to Add Further Information: Solution focused therapists traditionally take a brief consultation break during the 2nd half of each therapy session during which the therapist reflects carefully on what has occurred in the session. Some time prior to the break, the client is asked "Is there anything that I did not ask that you think it would be important for me to know?".

Solano County Implementation: Solano has yet to offer this training for staff. Online training will be available soon through the developer website: https://solutionfocused.net/#on-line

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Solution Focused Brief Therapy		X	X					X		

Source: https://solutionfocused.net/what-is-solution-focused-therapy/

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that helps children who have experienced traumatic events and their non-offending caregivers. TF-CBT therapy reduces PTSD symptoms, anxiety, depression and behavioral problems; therapy also supports non-offending caregivers through treatment and improves parent-child communication about the trauma. This treatment approach is appropriate for clinic based and community based mental health settings.

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

Process:

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

Why Should Agencies and Clinicians Consider Implementing TF-CBT?

Agencies and clinicians consider implementing a new treatment out of a wish to deliver services that have been proven to be effective. TF-CBT is recognized as being one of the most effective interventions for children who have significant psychological symptoms related to trauma exposures. More than a dozen scientifically rigorous studies have demonstrated that TF-CBT helps children and families recover from the negative effects of traumatic experiences, including PTSD symptoms, depression, and related difficulties. Many of the studies compared TF-CBT to other treatments commonly provided to traumatized children, such as supportive therapy, child-centered therapy, play therapy, or usual community treatment, and showed that children receiving TF-CBT improved faster and more completely than the children who received other treatments.

Studies that followed children for as long as one to two years after the end of treatment found that these improvements were sustained. This supports the promise of TF-CBT to potentially prevent the long-term problems associated with childhood trauma. A list of relevant studies, and seminal facts about them, can be found here (http://icctc.org/PMM%20Handouts/TF-CBT_Implementation_Manual.pdf). Here are some important facts. TF-CBT:

- works for children who have experienced any trauma, including multiple traumas.
- is effective with children from diverse backgrounds.
- works in as few as 12 treatment sessions.
- has been used successfully in clinics, schools, homes, residential treatment facilities, and inpatient settings.
- works even if there is no parent or caregiver to participate in treatment.
- works for children in foster care.
- has been used effectively in a variety of languages and countries.

Solano County Implementation: Solano offered sponsored training and cohort supervision several years ago. There is a need for retraining staff to use this modality in daily practice. Online trainings can be found here: https://tfcbt2.musc.edu/en

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
	x	x		

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Trauma Focused Cognitive Behavioral Therapy		X	X					X		

Sources: **TFCBT Certification program:** https://tfcbt.org/about-tfcbt/

https://www.nctsn.org/interventions/trauma-focused-cognitive-behavioral-therapy

Consumer Operated Services Program ("Wellness Centers")

A Consumer-Operated Service is an evidence-based modality offered via a peer-run program that emphasizes self-help and recovery. It is owned, administratively controlled, and operated by mental health consumers. Consumer-Operated Services may be called by other names such as consumer-run

organizations, peer support programs, wellness centers, peer services, or peer service agencies. Consumer-Operated Services often collaborate with other mental health service providers and community organizations, but they retain autonomy and their own identity, distinct from other agencies.

- Independent Administratively controlled and managed by mental health consumers.
- Autonomous Decisions about governance, fiscal, personnel, policy, and operational issues are made by the program.
- Accountability Responsibility for decisions rests with the program.
- Consumer controlled the governance board is at least 51% mental health consumers.
- Peer workers Staff and management are people who have received

How Do Consumer-Operated Services Help People? Consumer-Operated Services may offer a range of help and support to participants. They provide opportunities for people to learn about recovery, take on new roles and responsibilities, and make new friends. When people feel accepted for who they are, they begin to think about themselves differently and are more likely to make positive changes. Consumer Operated Services generate hope and increase people's sense of well-being.

What Is the Purpose of Consumer-Operated Services? Consumer-Operated Services typically focus on the following four basic functions:

- **Mutual support:** Peers can often help one another without designating who is the "helper" and who is the "helpee." They may switch back and forth in these roles or act simultaneously.
- **Community building:** Consumer-Operated Services offer participants opportunities to feel they are part of an inclusive and accepting community, develop new social and support networks, and learn to think about themselves differently.
- **Providing services:** Consumer-Operated Services vary, reflecting the needs of a community, the expectations of a funder, and the interests or talents of participants. For many participants, Consumer-Operated Services augment their more traditional mental health services. They may also serve as an alternative to traditional services, especially for people who choose not to participate in traditional services. Services may include the following:
    - Drop-in centers;
    - Self-help and peer support groups;
    - Peer counseling;
    - Advocacy services;
    - Assistance with basic needs or benefits;
    - Help with housing, employment, education;
    - Social and recreational opportunities;
    - Arts and expression;
    - Crisis response and respite; and/or
    - Navigation, information and resources.
- **Advocacy** has been a core element of the consumer self-help movement from its inception. Consumers now get involved at local, state, and federal levels to promote change. In addition, Consumer-Operated Services encourage individual advocacy, including both self-help and peer advocacy (peers advocating for one another)

What Makes Consumer Operated Services Unique? Consumer-Operated Services are not simply mental health services delivered by PSSs. They have a different world view, structure, and approach to "helping"

than traditional treatment services. Many who have used traditional services firmly believe that "there has to be another way."

Solano County Implementation: Solano contracts for several Wellness Centers across Solano County through a local contractor. These wellness centers have drop in services and offer an array of support including vocational, educational and navigation services.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Trauma Focused Cognitive Behavioral Therapy			X					X	X	X

Source: https://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633

Wellness Recovery Action Planning

The Wellness Recovery Action Plan (WRAP) is a self-help wellness tool developed by Mary Ellen Copeland, a person with lived experience. WRAP can be used for both mental and physical health conditions. There are specific WRAP resources for people who have fibromyalgia, people in the military, for kids, for those who have dual diagnoses and it also has been translated to other languages. WRAP is often facilitated by Peer Support Specialists, who have been trained in the Foundations of WRAP and Advanced WRAP Training. However, WRAP can be facilitated by anyone and all levels of staff. Introductory WRAP training is essential to a recovery oriented system of care workforce.

WRAP helps people identify the most important components of staying well and is organized in five sections:

1. **The Wellness Toolbox** is important to get a Personal Wellness Vision in mind. Before starting to write your plan, think about this question: What am I like when I'm well? This is what we're after – however you define it, you deserve to feel good. Then, brainstorm all the ways you take care of yourself – all the things that you know help you cope, stay well and feel great. These two things stay at the front of your WRAP.

2. **The Daily Maintenance Plan** So what does it take, every single day, for you to feel this good? It's important to identify all the core components of your daily regimen to be well and stay well. This is a big commitment. It's what you agree is necessary AND that you commit to doing on a daily basis. In addition, write out a daily schedule that includes what you're putting on the plan.
3. **Triggers** are those things that throw you off balance. Triggers can be things that remind you of people or events from your past, which though gone, can create the same old negative feelings and responses in you. This section of the WRAP asks you to name your triggers and how you will avoid them, or ways to cope when they happen.
4. **Early warning signs** are the first indicators that you are not feeling well. These are the subtle changes that point to the need for action in order to get back on track with your wellness. It's important to look at what the first clues are – this empowers you to take steps that will correct the problem. Once your EWS are identified, your next step is to create action steps that will help you get back to feeling well.
5. **When Things Are Breaking Down:** even when your symptoms are getting worse, there is still time to act – time to get back to feeling well. This section asks you to identify the moderate signs of not feeling well. This is usually an increase in the early warning signs, such as having a whole week of isolating or feeling angry all day for a few days. Each person defines what the next level is. This section also asks that you come up with action steps – what would help you turn the tide here and get you back to feeling well.
6. **The Crisis Plan:** Sometimes, despite our efforts, we may need to take care of ourselves by letting others care for us, or by being hospitalized. This section identifies what you want to have happen when you are unable to care for yourself. It is a form of a Psychiatric Advance Directive: durable power of attorney for mental healthcare.

Solano County Implementation: Solano has been sponsoring WRAP trainings for several years. Solano is working to coordinate a WRAP facilitator Training in 2020. All Peer Support Specialists in Solano BH are trained with an Intro to WRAP, as well as various staff across the county and contractors. More trainings can be found locally and here: https://peersnet.org/programs/wrap/#facilitator-trainings

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
	x	x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Wellness Recovery Action Plan	X	X	X	X	X	X	X	X	X	X

Source: https://copelandcenter.com/wellness-recovery-action-plan-wrap /

Peer Support Services & Peer Specialists

Peer support services are services that are designed and delivered by people who, themselves, have lived experienced with mental health and/or substance use disorders either as a person receiving services (youth or adult) or as the parent or family member. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.

Peer support is offered by qualified Peer Support Specialists (PSS), usually certified or credentialed. This service is invaluable for individuals receiving the service and family members, as well as people who work in the behavioral health field. Because of their own experiences with behavioral health challenges, and in navigating a very complex and fractured service delivery system, and with the skills they have learned in training and through work experience, Peer Specialists are qualified to provide a unique type of support to individuals and families working their way towards recovery and healing. PSS are often able to connect with people receiving services in a manner that activates self-management. When an individual takes ownership of their situation and treatment, they are far more likely to work in concert with their clinical providers, which makes the system of care stronger and more effective. Improvements have been shown in a number of outcomes, including: reduced inpatient service use, better engagement with care, and higher levels of patient activation.

The most important credential Peer Support Specialists hold, is their personal stories of Recovery. They sometimes refer to this special degree as their *ITE* which stands for "I'm the Evidence" that recovery is real. The essence of "sharing your story" testifies to how someone has been able to push through and overcome mental illness, addictions, and/or personal hardships, getting to the place where they are today.

PSS Services: "offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people" (Mead, 2003; Solomon, 2004). In behavioral health, peers offer their unique lived experience with mental health conditions to provide support focused on advocacy, education, mentoring, and motivation. The following lists several functions of PSS within clinical treatment:

1. Coaching and consultation to clients to promote recovery and self-direction. Consistently works with peers by assisting them with building skills that help promote their own recovery and self-sufficiency. Examples include but are not limited to:
    a. Social and communication skills training (e.g., practicing skills on how to strike up a conversation with a client who wants to meet more people in his neighborhood)
    b. Functional skills training to enhance independent living (e.g., activities of daily living [ADLs]), safety planning, transportation planning/navigation skill building, money management)
    c. Providing education to clients about how to take an active role in their own treatment and their role in their treatment planning meeting, which includes asserting preferences and values, even if not well received by some team members (e.g., not wanting to take select medications)

2. Facilitating wellness management and recovery strategies. Takes a lead role within their clinical or services team on implementing wellness management and recovery strategies. These can be formal/manualized or informal strategies, such as:
    a. Group or individual Illness Management & Recovery (IMR);
    b. Group or individual Wellness Recovery Action Planning (WRAP);
    c. Facilitating Psychiatric Advance Directives
    d. Examples of Informal Wellness Management Strategies:
    e. Working with clients on recovery plans, relapse prevention, goal setting, advocacy, etc.
3. Participating in all team activities equivalent to fellow team members: The PSS is treated just like other team members and fully and actively participates in all team activities such as:
    a. clinical team meetings;
    b. Treatment planning meetings;
    c. Documentation within clients' charts;
    d. Community-based contacts with clients
4. Modeling skills for and providing consultation to fellow team members:
    a. Regularly provides modeling and consultation, as consistently reported by other team members as well as the peer specialist. Modeling and consultation must reflect a recovery philosophy.
    b. Modeling includes demonstration of behaviors and attitudes consistent with recovery-oriented and wellness management and recovery services in the daily team meeting and other meetings or in the field.
    c. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation).

Solano County Implementation: Solano has received free OSHPD Peer Personnel Training and Placement grants via training organizations for several years. All Peer Support Specialists in Solano BH are trained as Certified Peer Support Specialists, as well as various PSS across the county and contractors. Trainings offered are typically aligned with nationally approved curriculums via MHA National and a list of those organizations can be found here: https://www.mhanational.org/national-certified-peer-specialist-ncps-approved-trainings

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention? People with lived experience receiving mental health and/or substance use services – this is a pre-requisite, and can include anyone in the categories below

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.

Peer Support Services	X	X	X	X	X	X	X	X	X	X

Sources: https://smiadviser.org/category/peer-specialists / https://www.mhanational.org/what-peer / https://mentalhealthrecovery.com/info-center/what-peer-support-really-means/

IPS Supported Employment and Education

Individual Placement and Support (IPS) is the evidence based model of supported employment for people with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression) and co-occurring substance use disorders. IPS supported employment is essential to recovery oriented systems of care and helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment. IPS supported employment helps people living with complex conditions work at regular jobs of their choosing, including education and technical training as ways to advance career paths. Mainstream education and technical training are included as ways to advance career paths. IPS helps about 60% of people who receive the services become a part of the competitive labor market.

People with behavioral health conditions want to work and experience personal and societal goals by doing so. On average, 63% of people with mental health challenges are interested in getting a job. Poverty and social isolation negatively influence people's physical health, mental health and substance use. Working helps people integrate within their communities, increase their income, and feel better about themselves. People who work report decreased psychiatric symptoms and improved quality of life, leading to a reduction in high cost services. For people who become steady workers, their health treatment costs dramatically decrease.

Embedding IPS education and employment services in behavioral health clinical programs promotes recovery and is grounded in the principles of Psychiatric Rehabilitation. There is a culture shift in the way we support people, which happens when practitioners understand that "supported employment in itself can be the main motivating factor for which an individual with SMI seeks treatment; individuals may not be ready to admit that they have an illness, but if they are struggling with employment they may accept help from programs that offer supported employment." (SAMHSA CBHSQ Report, 2017).

IPS is almost three times more effective than other vocational approaches in helping people with SMI work competitively and approximately half of IPS clients become steady workers and remain employed ten years later (Policy Bulletin 2). The service is guided by eight practice principles and a 25 item fidelity scale.

CHARACTERISTICS

- Practitioners focus on each person's strengths
- Work promotes recovery and wellness
- IPS uses a multidisciplinary team approach – vocational specialists working with mental health teams
- Services are individualized and last as long as the person needs and wants them

IPS IS FOUNDED ON 8 PRACTICE PRINCIPLES

1. **Focus on Competitive Employment**: Agencies providing IPS services are committed to competitive employment - regular jobs in the community that anyone can apply for - as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.
2. **Eligibility Based on Client Choice (Zero Exclusion)**: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
3. **Integration of Rehabilitation and Mental Health Services**: IPS programs are closely integrated with mental health treatment teams.
4. **Attention to Worker Preferences**: Services are based on each person's preferences and choices, rather than providers' judgments.
5. **Personalized Benefits Counseling**: Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
6. **Rapid Job Search**: IPS programs use a rapid job search approach (seeking jobs within 30 days) to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.
7. **Systematic Job Development**: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.
8. **Time-Unlimited and Individualized Support**: Job supports are individualized and continue for as long as each worker wants and needs the support.

Solano County Implementation: Solano began to implement IPS via a contractor on July 2019. IPS employment specialists were embedded throughout the adult services teams- ICCs, FSP. In July 2020, IPS was expanded to begin serving transition age youth and employment/education specialists are now working with several TAY FSP teams and the early psychosis program. The Team includes one supervisor, 2 peer support specialists (Employment mentors) and several employment/education specialists.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention? Staff in specialty roles such as Vocational Specialists or Employment Specialists, can include any of the categories below.

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.

IPS Supported Employment/ Education		X	X					X	x	x

Source: www.ipsworks.org

Family Psychoeducation

Family psychoeducation (FPE) is an evidence-based practice that gives consumers and families information about behavioral health illnesses, helps them build, social supports, and enhances problem-solving, communication, and coping skills. Over 30 randomized clinical trials demonstrated that psychoeducation programs improve symptomatic recovery and enhance psychosocial and family outcomes. Individuals who participate in FPE experience fewer relapses and less time in the hospital. Families who participate report greater knowledge of serious mental illnesses and less stress, confusion, and isolation.

Among potential resources for people with serious mental illnesses (SMI) and their families, professionally delivered family psychoeducation (FPE) is designed to engage, inform, and educate family members, so that they can assist the person with SMI in managing their illness. The model has been found to work well with consumers who are disengaged from their families and have difficult treatment histories. Joining sessions give practitioners the opportunity to help consumers engage family members again in a constructive and supportive manner.

Phases: Family Psychoeducation FPE services are provided in three phases:

1. Joining Sessions- Initially, FPE practitioners meet with consumers and their respective family members in introductory meetings called joining sessions. The purpose of these sessions is to learn about their experiences with mental illnesses, their strengths and resources, and their goals for treatment. FPE practitioners engage consumers and families in a working alliance by showing respect, building trust, and offering concrete help. This working alliance is the foundation of FPE services.
2. Educational Workshop- usually offered in a 1-day educational workshop based on a standardized educational curriculum to meet the distinct educational needs of family members. FPE practitioners also respond to the individual needs of consumers and families throughout the FPE program by providing information and resources. To keep consumers and families engaged in the FPE program, it is important to tailor education to meet consumer and family needs, especially in times of crisis
3. Ongoing FPE Sessions- After completing the joining sessions and 1-day workshop, FPE practitioners ask consumers and families to attend ongoing FPE sessions. When possible, practitioners offer ongoing FPE sessions in a multifamily group format. Consumers and families who attend multifamily groups benefit by connecting with others who have similar experiences. The peer support and mutual aid provided in the group builds social support networks for consumers and families who are often socially isolated and offers a structured problem-solving approach. This approach helps consumers and families make gains in working toward consumers' personal recovery goals.

FPE is not a short-term intervention. Studies show that offering fewer than 10 sessions does not produce the same positive outcomes (Cuijpers, 1999). It is currently recommend providing FPE for 9 months or more. When provided in the multifamily group format, ongoing FPE sessions also help consumers and families develop social supports.

How does FPE work?

- Consumers define who family is -Family includes anyone that consumers identify as being supportive in their recovery process.
- Collaboration is key- FPE recognizes consumer and family strengths and experiences in living with mental illnesses and partners with them to support personal recovery goals.
- Education promotes understanding -Consumers and families who are educated about mental illnesses can more effectively support one another.
- Ongoing guidance and training are effective- Learning techniques to reduce stress and improve communication and coping skills can strengthen family relationships and promote recovery.
- The problem-solving approach works- FPE focuses on current issues that consumers and families face and addresses them through a structured problem-solving approach.
- Multifamily groups enhance support- The multifamily group format allows consumers and families to connect with others and to receive peer support and mutual aid.

Solano County Implementation: Solano implements Psychoeducation via peer and family groups both through the Solano BH Wellness Recovery unit, NAMI Solano (https://namisolanocounty.org/classes-support-groups/) and other organizations. Info can be found on our website: http://solanocounty.com/depts/bh/wellness_recovery.asp

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
x	x	x	x	

Who Can Use This Intervention? Ideally, peers/family members with lived experience, in addition to:

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Family Psycho education	X	X	X	X	X	X	X	X	X	X

Source: https://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4422

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a two-day, two-trainer, workshop designed for members of all caregiving groups. Family, friends, and other community members may be the first to talk with a person at risk, but have little or no training. ASIST can also provide those in formal helping roles with professional development to ensure that they are prepared to provide suicide first aid help as part of the care they provide.. The Suicide Prevention Resource Center (SPRC) designated this intervention as a "program with evidence of effectiveness" based on its inclusion in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

Training Objectives

- After training, ASIST participants should be able to:

- Recognize that caregivers and persons at risk are affected by personal and societal attitudes about suicide.
- Discuss suicide in a direct manner with someone at risk.
- Identify risk alerts and develop related safeplans.
- Demonstrate the skills required to intervene with a person at risk of suicide.
- List the types of resources available to a person at risk, including themselves.
- Make a commitment to improving community resources.
- Recognize that suicide prevention is broader than suicide first-aid and includes life promotion and self-care for caregivers.

ASIST Suicide Intervention Model (SIM):

- *Connect*
  - *Explore invitations*
  - *Ask about suicide*
- *Understand*
  - *Listen to reasons for dying and living*
  - *Review risk*
- *Assist*
  - *Develop a safeplan*
  - *Follow-up on commitments*

The ASIST SIM includes assessment of suicide risk and the development of a safeplan. The safeplan provides for various options depending upon present and future risk, available resources, and the needs of the person at risk. Options include not only referral to formal mental healthcare professionals but also to friends, family members, and other sources of support.

Solano County Implementation: Solano BH has offered ASIST Trainings through the MHSA program via community trainers. Ongoing trainings are available as needed for anyone in the community.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Applied Suicide Intervention Skills Training	X	X	X	X	X	X	X	X	X	X

Source: https://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist

https://legacy.livingworks.net/resources/research-and-evaluation/

Integrated Dual Disorders Treatment (Co-occurring Disorders)

The Integrated Dual Disorder Treatment (IDDT) is an evidence based model that combines substance abuse services with mental health services and helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. IDDT is multidisciplinary and combines pharmacological, psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. Treatment is individualized to address the unique circumstances of each person's life.

Up to 56% of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime. Historically, people with co-occurring disorders have been excluded from mental health treatment because of their substance use disorder. Likewise, they have been excluded from substance abuse treatment because of their severe mental health symptoms. As a result, they frequently have not gotten the help they need. One need of a lot of people entering substance rehabilitation is treatment of more than one disorder. These are called co-occurring disorders, and integrated treatment is often the best way to treat them.

What are Co-Occurring Disorders? In a 2002 report to Congress, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined co-occurring disorders as happening any time a person has "at least one mental disorder as well as an alcohol or drug use disorder," which might interact with each other in different ways, and each "can be diagnosed independently of the other." It goes on to explain that there are no specific ways that these disorders must appear together and that each disorder can range in severity, with both being mild or severe, or one being more severe than the other.

The most common psychiatric disorders that appear when a person has co-occurring disorders include: • Anxiety and mood disorders • Bipolar disorder	The most frequently abused by people with co-occurring disorders: • Alcohol • Hallucinogens • Marijuana

• Borderline personality disorder • Major depression • Post-traumatic stress disorder • Schizophrenia	• Nicotine • Opiates • Prescription drugs • Sedatives • Stimulants

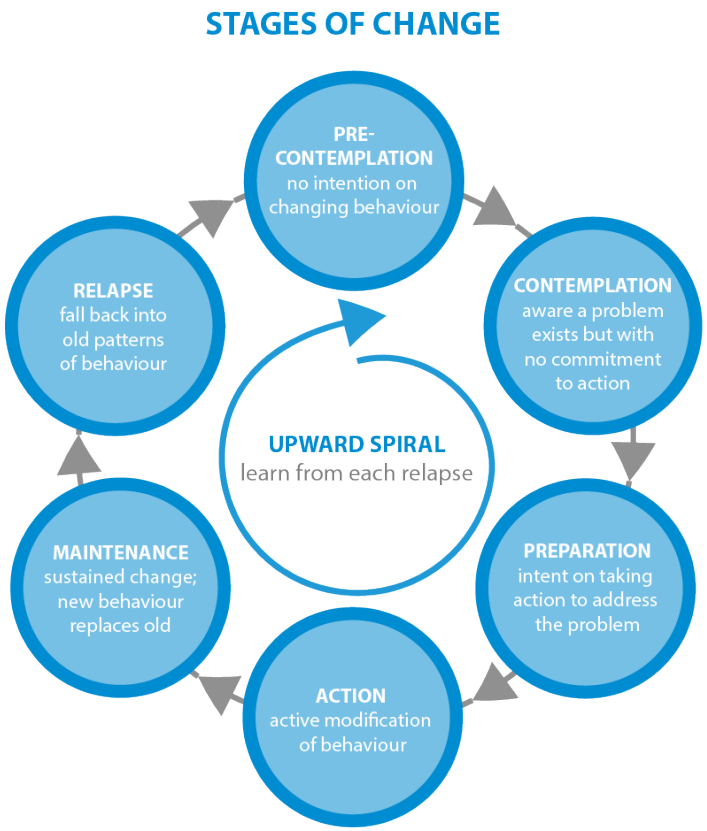
Core Components: IDDT promotes recovery among people with co-occurring disorders by providing service organizations with specific strategies for delivering services. The implementation of integrated treatment facilitates service system change, organizational change, and clinical change. IDDT is built upon the following core treatment components:

- Multidisciplinary Team
- Stage-Wise Interventions (stages of change, stages of treatment)
- Access to Comprehensive Services (e.g., residential, employment, etc.)
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interventions
- Substance Abuse Counseling
- Group Treatment
- Family Psychoeducation
- Participation in Alcohol & Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Treatment of Non-Responders

Approach to Treatment: Practitioners in the Integrated Treatment program (called integrated treatment specialists) develop integrated treatment plans and treat both serious mental illnesses and substance use disorders so that consumers do not get lost, excluded, or confused going back and forth between different mental health and substance abuse programs. Consumers receive one consistent, integrated message about substance use and mental health treatment.

IDDT has *7* Practice Principles:

1. Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
2. Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
3. Co-occurring disorders are treated in a stage-wise fashion with different services provided at different "stages of change".
4. Motivational interventions are used in all stages, but especially in the persuasion stage
5. Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
6. Multiple formats for services are available, including individual, group, self-help, and family.
7. Medication services are integrated and coordinated with psychosocial services.



Solano County Implementation: Components of the IDDT model are a foundation of the Co-Occurring Integration initiative Solano started in late 2018 to cross-train staff on SUD/MH as well as work with staff dedicated as "SUD Liaisons" across our Solano BH services. Additionally, IDDT is an integral part of the ACT model. ACT is being utilized within the adult Full Service Partnership programs for both county-run and CBO FSPs. Implementation started late 2018. Staff have continuous training and support from the model developer and leadership for using IDDT approaches.

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
		x	x	

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
IDDT		X	X	X	X	X	X	X	X	X

Source: https://www.centerforebp.case.edu/client-files/pdf/iddtclinicalguide.pdf

https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366

Mental Health First Aid

Mental Health First Aid is an evidence based public education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect persons to the appropriate professional, peer, social, and self-help care. The program also teaches the common risk factors and warning signs of specific types of illnesses, like anxiety, depression, substance use, bipolar disorder, eating disorders, and schizophrenia. Mental Health First Aid is included on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP).

Just as CPR helps you assist an individual having a heart attack, Mental Health First Aid helps you assist someone experiencing a mental health or substance use-related crisis. In the Mental Health First Aid course, you learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Mental Health First Aid training teaches us to ask, "What happened?" instead of, "What's wrong with you?"

Mental Health First Aid teaches about *recovery* and *resiliency* – the belief that individuals experiencing these challenges can and do get better, and use their strengths to stay well.

ALGEE: Mental Health First Aid teaches participants a five-step action plan, *ALGEE*, to support someone developing signs and symptoms of a mental illness or in an emotional crisis:

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Interventions Learned: When you take a course, you learn how to apply the Mental Health First Aid action plan in a variety of situations, including when someone is experiencing:

- Panic attacks
- Suicidal thoughts or behaviors
- Nonsuicidal self-injury
- Acute psychosis (e.g., hallucinations or delusions)
- Overdose or withdrawal from alcohol or drug use
- Reaction to a traumatic event

The opportunity to practice — through role plays, scenarios, and activities — makes it easier to apply these skills in a real-life situation.

Solano County Implementation: Solano BH has offered MHFA Trainings through the MHSA program via community trainers. Ongoing trainings are available as needed for anyone in the community and more courses may be found here: https://www.mentalhealthfirstaid.org/take-a-course/

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
	x	x	x	x

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Mental Health First Aid	X	X	X	X	X	X	X	X	X	X

Source: https://www.mentalhealthfirstaid.org/wp-content/uploads/2014/05/About-MHFA.pdf

Wrap Around Case Management

Wraparound is an evidence based, strengths focused planning process that occurs in a team setting to engage with children, youth, and their families. Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs-driven approach. The intent is to build on individual and family strengths to help families achieve positive goals and improve well-being. Wraparound is also a team-driven process. From the start, a child and family team is formed and works directly with the family as they identify their own needs and strengths. The team develops a service plan that describes specific strategies for meeting the needs identified by the family. The service plan is individualized, with strategies that reflect the child and family's culture and preferences. California Wraparound is intended to allow children to live and grow up in a safe, stable, permanent family environment. For children and families in the foster care system, the Wraparound process can:

- Enhance strengths by creating a strength-based intervention plan with a child and family team;
- Promote youth and parent involvement with family voice, choice, and preference;
- Use community-based services;
- Create independence and stability;
- Provide services that fit a child and family's identified needs, culture, and preferences;
- Create one plan to coordinate responses in all life domains; and
- Focus on achieving positive goals.

Wraparound differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound.

The young person and their family members work with a Wraparound facilitator to build their Wraparound team, which can include the family's friends and people from the wider community, as well as providers of services and supports.

With the help of the team, the family and young person take the lead in deciding team vision and goals, and in developing creative and individualized services and supports that will help them achieve the goals and vision. Team members work together to put the plan into action, monitor how well it's working, and change it as needed.

As the name suggests, this strategy involves "wrapping" a comprehensive array of individualized services and support networks "around" young people, rather than forcing them to enroll in pre-determined, inflexible treatment programs (National Wraparound Initiative Advisory Group 2003)

Outcomes: There is now strong evidence that, when Wraparound is done well (i.e., with "fidelity"), young people with complex needs are more likely to be able to stay in their homes and communities, or, should a crisis occur, to be in out-of-home placements only for short periods of time. Young people in Wraparound tend to have better outcomes than similar young people who don't receive Wraparound, across different areas of their lives including mental health, and functioning in their homes, schools and communities. And all of this saves money by minimizing the time that young people spend in out-of-home high cost facilities like residential treatment centers or psychiatric hospitals.

How a Wraparound Program Works: Numerous public agencies and research organizations have offered their own definitions of what constitutes a fully realized wraparound program. While these definitions vary slightly, there is a general consensus that true wraparound programs feature several basic elements, including

- A collaborative, community-based interagency team that is responsible for designing, implementing, and overseeing the wraparound initiative in a given jurisdiction. This team usually consists of representatives from the juvenile justice system, the public education system, and local mental health and social service agencies. In most cases, one specific agency is designated the lead agency in coordinating the wraparound effort.

- A formal interagency agreement that records the proposed design of the wraparound initiative and spells out exactly how the wraparound effort will work. At a minimum, this agreement should specify who the target population for the initiative is; how they will be enrolled in the program; how services will be delivered and paid for; what roles different agencies and individuals will play; and what resources will be committed by various groups. The comprehensive integrated service delivery system that emerges from these agreements is often referred to as "*a system of care.*"
- Care coordinators who are responsible for helping participants create a customized treatment program and for guiding youth and their families through the system of care. In most wraparound programs, these care coordinators are employees of the designated lead agency, which may be a public program or a private nonprofit agency.
- Child and family teams consisting of family members, paid service providers, and community members (such as teachers and mentors), who know the youth under treatment and are familiar with his or her changing needs. Assembled and led by the 2 care coordinators, these teams work together to ensure that the individual child's needs are being met across all domains—in the home, the educational sphere, and the broader community at large.
- A unified plan of care developed and updated collectively by all the members of the child and family team. This plan of care identifies the child's specific strengths and weaknesses in different areas, targets specific goals for them, and outlines the steps necessary to achieve those goals.
- Systematic, outcomes-based services. Almost all wraparound programs require clearly defined performance measures, which are used to track the progress of the wraparound initiative and guide its evolution over time. Recent literature on wraparound also emphasizes the importance of recruiting committed and persistent staff and creating programs that are culturally competent and strengths-based (Bruns et al. 2004).

Solano County Implementation: Solano BH has offered MHFA Trainings through the MHSA program via community trainers. Ongoing trainings are available as needed for anyone in the community and more courses may be found here: https://www.mentalhealthfirstaid.org/take-a-course/

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
	x	x		

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
Wrap Case Management		X	X	X	X	X		X	X	X

Source: https://nwi.pdx.edu/wraparound-basics/ / https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/wraparound

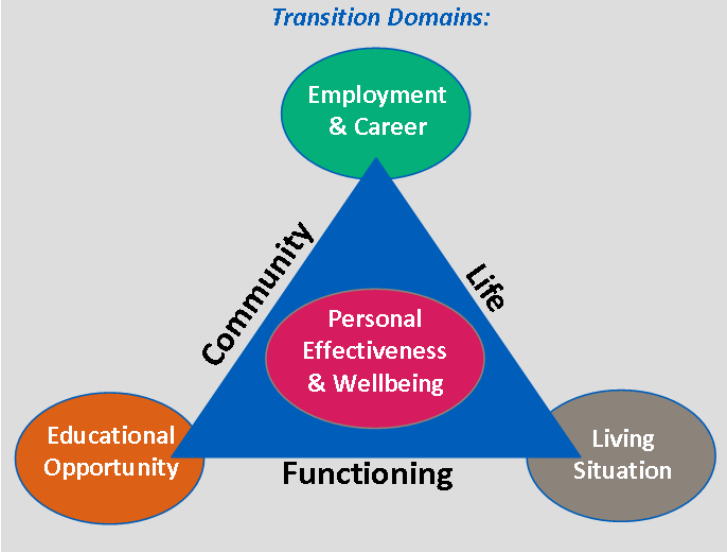
Transitions to Independence Process (TIP)

The Transition to Independence Process (TIP) Model is a strength-based, youth-driven framework that was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties (EBD) to:

a. Engage youth and young adults in their own futures planning process
b. Provide youth with developmentally appropriate, non-stigmatizing, culturally competent, and appealing services and supports
c. Involve youth and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to their relevant transition domains.

The TIP Model™ is an evidence-supported practice based on numerous published studies that demonstrate improvement in real-life outcomes for youth and young adults with emotional/behavioral difficulties (EBD).

Youth and young adults are guided in setting and achieving their own short-term and long-term goals across relevant Transition Domains, such as: employment/career, educational opportunities, living situation, personal effectiveness/wellbeing, and community-life functioning. TIP promotes youth "*voice and choice*" in goal setting, treatment options, and approaches to services.



Why TIP? Emerging adults experience dramatic changes across all areas of development during their transition to adulthood (Arnett, 2004). Young people's decisions, choices, and associated experiences set a foundation for their transition to future adult roles in the domains of employment, education, living situation, and community-life functioning. This period of transition is especially challenging as young people have higher secondary school dropout rates, higher rates of arrest, incarceration, and unemployment, and lower rates of independent living compared to their peers without disabilities. High rates of trauma that is prolonged, cumulative and recurrent – and has a profound impact on developing brains.

Difficulties in accessing appropriate supports and services continue to plague young people and their parents and providers. Fragmented services, varying eligibility criteria, different funding mechanisms, and different philosophies across the child and adult mental health systems offer challenges to obtaining appropriate services for young people with EBD. The fragmentation and silo nature of services systems complicate access to other needed services related to employment, career training, housing, and postsecondary education (Clark & Unruh, 2009b; Davis & Koroloff, 2006).

Guidelines: The TIP Model™ is operationalized through 7 guidelines and their associated Core Practices that drive the work with young people to improve their outcomes and provide a transition system that is responsive to them and their families.

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

To ensure the continuity of planning, services, and supports, the TIP system is implemented directly by transition facilitators who work with the young people, their parents, and other informal and formal support people. The term transition facilitator is used to emphasize the function of facilitating the young person's future, not directing it. Different sites and service systems use similar youth-friendly terms such as transition specialist, resource coordinator, mentor, transition coach, TIP facilitator, service coordinator, or life coach. The role of transition facilitators with young people, their parents, and other informal and formal key players is described in detail in the Transition Handbook.

Solano County Implementation: Solano BH started implementation of the TIP model for use within all TAY FSP teams in county-run and contractor programs. Training started in 2019 and has continued through 2020 with a goal towards fidelity and training trainers: https://www.starstrainingacademy.com/tip-model-institute/

Intended Population:

0-5	Children	Youth/Young Adults	Adults	Other
	x	x		

Who Can Use This Intervention?

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Voc Nurse, Psych Tech	Trainee or Registered for LCSW, MFCC, PhD (post BA/BS and pre A/MS/PhD)	MHS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs exp/or AA & 6 yrs exp.
TIP		X	X	X	X	X		X	X	X

Source: https://www.cibhs.org/sites/main/files/file-attachments/tues_10_30_granada_tip_model_clark.pdf?1435162671