Behavioral Health Programs and Practices

for Emerging Community Care Hubs

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Introduction

The behavioral health programs and practices described in this document provide support for and promote the well-being of older adults and people with disabilities. The programs and practices were selected based on their suitability for implementation in community-based venues, where they may be provided by the Community Care Hub (CCH) or via contractual arrangements with community-based organizations in their CBO network. They have been implemented in real-world settings and have been shown to be effective if implemented with fidelity to their original designs.

Standardized implementation guides and training for service providers are available for most of the programs and practices described here. Most have standard process and outcome measures that enable organizations to monitor progress and evaluate program outcomes. In addition to facilitating continuous quality improvement in implementation, evaluation activities will help inform people who use the services and other community stakeholders about the impact of the program, and the results may be useful in fundraising endeavors.

The document contains a section for each program/practice, summarizing the available evidence of its effectiveness and identifying resources for organizations interested in adopting it. These programs vary considerably in the number of studies that have been conducted. The citation selected for each is a study that presents the most central outcomes for which the intervention was designed.

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a 2-day training program aimed at developing "suicide first aid" skills and competencies. The program is available to anyone seeking to increase the immediate safety of persons at risk of suicide. Since people at risk are often inclined to reach out first to family and friends, ASIST fulfills a "gatekeeper" role that seeks to build and empower a broad network of community helpers. ASIST also provides those in more formal helping roles with professional development to ensure they are prepared to provide suicide first aid help as part of the care they provide. The ASIST Suicide Intervention Model (SIM) has three phases of caregiving: connecting, understanding, and assisting. The counselor's task in the "assisting" phase is to establish a "Safe plan" that specifically addresses each element of risk identified in the previous phases of the intervention.

Research

Summary	Evaluation of the ASIST training program, examining counselor skills and caller response.
Citation	Gould, M., Cross, W., Pisani, A., Munfakh, M., & Kleinman, M. (2013). Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior*, *43*(6), 676–691.
Study design	Randomized control trial to test whether the ASIST program increased the effectiveness of Lifeline's telephone crisis services, with an intervention group of 17 lifeline suicide crisis centers receiving ASIST from counselors who received ASIST training, and a wait-list control group. Data was derived from 1,507 monitored calls from 1,410 suicidal individuals. "Silent monitors" assessed changes in counselors' and callers' behaviors in both groups.
Population	1,410 suicidal individuals, 764 were directed to intervention group
Outcomes	Of the twenty-three counselor behaviors assessed, six were significantly enhanced by the ASIST training. Four of the seven caller behavioral changes that were assessed were significantly associated with the counselors' ASIST training. Suicidal callers whose counselors had been ASIST-trained were significantly more likely than callers whose counselors had not been ASIST-trained to be rated by the silent monitors as becoming less depressed, less overwhelmed, less suicidal, and more hopeful during the course of the call.
Comments	Differences between the intervention and control groups may have been attenuated by overlap in the training received by both. The authors note that a critical issue identified by the study that should be addressed in future training is inadequate assessment of suicide risk.

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Suicide Prevention Resource Center (SPRC)	This PDF offers information on program description, evaluation, implementation and cost of training and implementation materials. ASIST is developed and disseminated by LivingWorks Education Inc. Individuals interested in providing their own ASIST workshops may become Registered ASIST Trainers.	Organizations interested in ASIST	PDF

Brief Intervention and Treatment for Elders (BRITE)

BRITE represents an extension of the Screening, Brief Intervention and Referral to Treatment (SBIRT) program to nonmedical services that serve older adults. It was developed by the Florida BRITE Project and funded by a 5-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The study described below is a test of the SBIRT model conducted in community settings (for information on SBIRT, see page 18). The mission of the BRITE project is to serve individuals ages 55+ to identify non-dependent substance use or prescription medication issues and to provide effective service strategies prior to the need for more extensive or specialized substance use treatment. The vision is that BRITE will be incorporated into primary care settings, hospital emergency rooms, trauma centers, and other community and aging services settings as a comprehensive, integrated, sustainable public health approach to the delivery of services for older adults who are at risk of developing substance use disorders. BRITE has been listed in the tier of highest-level criteria for evidence-based disease prevention and health promotion programs under Title III-D of the Older Americans Act.

Research

Summary	A comparison of standard substance use treatment and an adaptation of the SBIRT model, which is normally conducted in a primary care setting, to test effectiveness when delivered by health care, aging services, mental health, and substance use treatment provider agencies.
Citation	Schonfeld, L., R. W. Hazlett, et al. (2015). Screening, Brief Intervention, and Referral to Treatment for Older Adults With Substance Misuse. *Am J Public Health, 105*(1), 205-211.
Study design	A pre-post multi-site study with 6-month follow-up. Staff from 29 agencies screened for substance use risk in 75 sites across 18 Florida counties. Clients at no or low risk received feedback about screening; moderate risk led to brief intervention; moderate or high risk led to brief treatment; and highest severity led to referral to treatment. Six-month follow-up was conducted with a random sample of clients.
Population	The characteristics of those screening negative (n=76,765) and those screening positive (n=8,165) were significantly different for mean age (younger for positive), gender (higher percent males for positive), and race (higher percent White people for positive).
Outcomes	Over 5 years, 85,001 client screenings were recorded. Of these, 8,165 clients were at moderate or high risk. Most received brief intervention for alcohol or medication misuse; about 20% did not receive brief intervention. Health educators screening solely within medical sites recorded fewer positive screens than those from mental health, substance use, or aging services in a variety of community-based and health care sites. Six-month follow-ups for a random selection of 171 individuals revealed a significant decrease in substance use. Agency types differed in follow-up rates: aging services achieved the highest (57.4%) and health care providers the lowest (13.5%).
Comments	The authors note that Area Agencies on Aging that include BRITE services may be reimbursed through their respective state units on aging that receive AoA funding.

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Florida Dept. of Children and Families	This PDF includes the mission and vision of BRITE along with a profile for Florida that shows how this program has been implemented and its benefits. There are 18 programs thus far located around the state of Florida. This program demonstrates that Screening, Brief Intervention and Referral to Treatment can be extended to nonmedical services that serve older adults.	Older adults at risk for or experiencing substance use problems	PDF

Coleman Care Transitions Program (CTI)

The Care Transitions Intervention® (CTI) is an evidence-based, short-term model. It complements a health care system's care team by empowering the client to develop self-care skills and helps them assume a more active role in their health through a whole-person approach. The intervention is built on four conceptual domains: 1) assistance with medication self-management, 2) a patient-centered record owned and maintained by the patient, 3) timely follow-up with primary or specialty care, and 4) a list of "red flags" indicative of a worsening condition and instructions on how to respond to those, operationalized by means of a personal health record and visits and telephone calls with a transition coach.

Research

In addition to the base randomized control trial described here, CTI has published reports on several other applications of the approach—including veterans and children—along with additional cost analyses.

Summary	An intervention designed to encourage patients and their caregivers to assert a more active role during care transitions may reduce rehospitalization rates.
Citation	Coleman, E.A., Parry, C., Chalmers, S., & Min, S. (2006). The Care Transitions Intervention: Results of a Randomized Controlled Trial. *Archives of Internal Medicine*, *166*(17), 1822-1828.
Study design	The study was conducted in collaboration with a large not-for-profit capitated delivery system in Colorado. A randomized control trial, the study involved 750 older adults assigned to intervention or treatment as usual. Inclusion criteria included age 65+, non-psychiatric admission to the system's hospital community dwelling, no documentation of dementia, have documentation of at least one of eleven diagnoses: stroke, congestive heart failure, coronary artery disease, cardiac arrhythmias, chronic obstructive pulmonary disease, diabetes mellitus, spinal stenosis, hip fracture, peripheral vascular disease, deep venous thrombosis, and pulmonary embolism. Measures were 1) rate of non-elective rehospitalization at 30, 90, and 180 days after discharge; 2) rate of rehospitalization for the same condition that prompted the index hospitalization; and 3) non-elective hospital costs. The analysis adjusted for various patient characteristics (e.g., age, sex, race, chronic disease score, etc.).
Population	Individuals 65 or older with chronic medical conditions and high rates of prior hospital and emergency department use.
Outcomes	1) The intervention group had fewer rehospitalizations at all three time-intervals, statistically significant at 30 and 90 days. 2) The intervention group had fewer rehospitalizations for the same condition at all three-time intervals, statistically significant at 90 and 180 days. 3) Intervention patients had significantly lower hospital costs at 90 and 180 days.
Comments	The authors note that the intervention achieved reductions in rehospitalization even in a system where that had been a focus for many years; differences would likely be greater where there is less prior effort to reduce rehospitalizations.

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Care Transition Intervention	This webpage gives an overview of the CTI program, including the program's history along with key findings/benefits. It also shares bios of CTI team members and provides a brief description of the Transitions Coach position.	All interested in CTI	Webpage
CTI	This webpage lists the training components and the duration of each training. It also outlines the training process, shares training dates/availability, and includes links to a contact form.	Organizations interested in adopting and implementing CTI	Webpage

Collaborative Care for the Management of Depressive Disorders

Collaborative care for the management of depressive disorders is a multicomponent intervention at the health care system level that uses case managers to link primary care providers, patients, and mental health specialists. Case managers in the collaborative care model support primary care providers with functions such as education, follow-up to track depression outcomes and adherence to treatment, and adjustment of treatment plans for patients who do not improve.

Research

Summary	The Community Preventive Services Task Force recommends Collaborative Care as an evidence-based practice primarily based on two meta-analyses that showed strong evidence of effectiveness in improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression. The Task Force also finds that collaborative care models provide good economic value.
Citation	Community Preventive Services Task Force (2010). Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders Task Force Finding and Rationale Statement.
Study design	Literature review
Population	Adults 20-64 years or older adults (age 65+); study populations consisted mostly of white populations with overrepresentation of African Americans and underrepresentation of other minorities.
Outcomes	Statistically significant effects for "multiple depression related outcomes of sufficient magnitude to be of clinical significance and public health benefit." Health outcomes include symptoms, adherence, remission, recovery, quality of life and functional status, and satisfaction. Economic outcomes: 14 studies provided evidence of program costs; costs per person per year ranged from $104 to $2,160 with a median of $454, with the variation explained by various program features. Of five cost-benefit studies, four showed that averted health care costs, averted productivity losses, or estimates of what patients were "willing to pay" for treatment exceeded program costs. Six studies reported incremental net costs per quality-adjusted life year (QALY). For five of these studies, the estimates ranged from $3,000 to $71,000, with four reporting less than $21,000, indicating the interventions were cost-effective by the conventional threshold.
Comments	Most of the programs employed physicians in the role of "primary care provider"; for the few studies that used nurses or physicians, most used nurses in the role of "case manager." Three that used social workers and masters-level mental health workers had some evidence of smaller intervention effects. Most studies employed psychiatrists or psychologists in the role of "mental health specialists."

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
The Community Guide	This webpage provides a brief description of Collaborative Care to Manage Depression, along with its purpose and benefits.	Adults, healthcare providers, and older adults	Webpage
The Community Guide	This page gives a summary of findings of the Community Preventive Services Task Force, benefits of intervention, considerations for implementation and links to supporting evidence and materials.	Organizations interested in implementing Collaborative Care for the Management of Depressive Disorders	Webpage

Engagement-Focused Care (transitions from inpatient and emergency psychiatric facilities)

Patient engagement is a developmental process that involves the patient's ability to take a more active role in their treatment or to feel more comfortable expressing their preferences or needs with their providers—even if living with a disease. Engagement-focused care (EFC) involves getting individuals into treatment rapidly and helping them communicate better with their provider using a shared decision-making coach.

Research

Summary	EFC had two components not typically found in transitional care models: 1) an access group intake process and 2) shared decision-making (SDM) coaching for patients. Patients participated in an access group post-hospital discharge to accommodate individual needs, and an SDM coach met with the patient prior to and sometimes following appointments with the prescriber.
Citation	Velligan, D. I., M. M. Fredrick, et al. (2017). Engagement-focused care during transitions from inpatient and emergency psychiatric facilities. *Patient Preference and Adherence*, *11*, 919-928.
Study design	Comparative effectiveness trial
Population	147 subjects were male and 179 were female. In terms of race and ethnicity, 160 were Hispanic, 135 were Anglo, 24 were African American, 3 were Asian, and the remaining individuals were of mixed ethnic background. Mean age of participants was 38.0.
Outcomes	61% of both groups were engaged in services following discharge. There was greater improvement of quality of life in the intervention group. In the decision-making process at baseline, 26% of subjects wanted mostly active roles, 22% wanted primarily passive roles, and 52% wanted a collaborative process. There was no change at follow-up. Both groups improved in symptomology while in treatment and rated their satisfaction with their treatment as very good. In the 6 months post discharge, 41% of standard care subjects and 35% of intervention subjects had at least one hospitalization, crisis visit, or incarceration, but these differences were not statistically significant.
Comments	Attrition rates between consent and first assessment were 31.85% for the standard care group and 28.9% for the intervention group, 139 were lost to follow-up.

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Velligan et al, 2017	This article examines engagement-focused care (EFC) versus treatment as usual in a university-based transitional care clinic (TCC) with a 90-day program serving individuals with SMI discharged from hospitals and emergency rooms	Organizations interested in the evidence for EFC	Journal article
National Alliance on Mental Illness (NAMI)	This document reports on NAMI's exploration of how the quality of relationships and interactions affect outcomes for people with mental illness and their families to better understand the process of engagement in mental health care	Organizations and providers interested in patient engagement in mental health care	PDF

Healthy IDEAS

Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors) is a service delivery model that extends the reach of current community-based aging services by integrating depression awareness and self-management interventions into existing case-management programs. Components consist of four evidence-based interventions (screening and assessment, education, referral and linkage to health and mental health professionals, and behavioral activation), with face-to-face and telephone meetings delivered by case managers As one of the Administration for Community Living's "Evidence-based Prevention Programs for Older Adults," Healthy IDEAS uses evidence-based practices to identify and address depression symptoms in those most at risk of being unrecognized and undertreated for depression.

Research

Summary	Assessment of program effects on depression and quality of life
Citation	Quijano, L. M., M. A. Stanley, et al. (2007). Healthy IDEAS: A depression intervention delivered by community-based case managers serving older adults. *Journal of Applied Gerontology 26*(2): 139-156.
Study design	Pre and post intervention study of a single cohort followed for six months
Population	Ninety-four high-risk older adults; population consisted of 79% women, 44% Hispanic, with a mean age 72 at baseline and 67 at follow-up.
Outcomes	Depression (Change in GDS-15 score): improved significantly at 6 months Self-management (Make an appointment for depression, identify symptoms, know what to do if depression increases, feel better by increasing activities): significantly improved at 6 months Social and physical activity: non-significant positive trend Quality of life (less pain, health not interfering with social life): significantly improved Medical and mental health utilization in past 3 months: non-significant positive trend
Comments	The lack of a comparison group allows for possible alternative causes.

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Healthy IDEAS program	This PDF gives an overview of the program, including who delivers the program, benefits, how it works, and recognition the program has received.	Organizations that serve elderly populations	PDF flyer
Healthy IDEAS program	This page provides information on training and requirements. Training is a multiphase process; the webpage gives a brief description of each phase along with a link to contact for more information.	Case managers	Webpage

Home-Based Depression Care Management

Home-based depression care management is a general term for a variety of home-based interventions designed to treat depression in older adults, including active screening for depression, measurement-based outcomes, trained depression care managers, case management, education, and a supervising psychiatrist, considered by an expert panel to be effective.

Research

Summary	Consensus-based recommendations were formulated by an expert panel of mental health and public health researchers and community-based aging services providers. Panelists considered feasibility and appropriateness for community-based delivery, as well as strength of evidence for program effectiveness as indicated by a systematic literature review of articles published through 2005.
Citation	Steinman, L. E., J. T. Frederick, et al. (2007). Recommendations for Treating Depression in Community-Based Older Adults. *American Journal of Preventive Medicine 33*(3): 175-181.
Study design	Expert panel and systematic review
Population	Community-living older adults with depression
Outcomes	The panel recommended individual cognitive behavioral therapy (CBT). Interventions not recommended as primary treatments for late-life depression included education and skills training, comprehensive geriatric health evaluation programs, exercise, and physical rehabilitation/occupational therapy. There was insufficient evidence for making recommendations for several intervention categories, including group psychotherapy and psychotherapies other than CBT. Many of the interventions that were not recommended or had insufficient evidence did not treat depression primarily and/or did not include a clinically depressed sample to establish efficacy. These interventions may provide other benefits but should not be presumed to effectively treat depression by themselves.
Comments	Expert opinion level of evidence

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
The Community Guide	This document provides a brief overview of home-based depression care management, which includes intervention involvement, results, and accomplishments. Also, this provides information on estimated costs of implementation and applicability.	Older adults & healthcare providers	Webpage
Bruce et al., 2015	This article provides information on the effectiveness of integrating depression care management into home-based care. This includes importance, intervention, results, and outcomes.	Organizations interested in the effectiveness of home-based depression care	Journal article

Motivational Interviewing (MI)

Motivational Interviewing is a conversational approach designed to elicit motivation to change a specific negative behavior. MI engages, elicits change talk (statements about the person's desire, ability, reasons and need for change), and evokes motivation to make positive changes. It is widely used by practitioners from a range of disciplines in a variety of settings, including community-based organizations.

Research

Summary	Meta-analysis of studies addressing motivational interviewing
Citation	Lundahl, B. W., C. Kunz, et al. (2010). A Meta-Analysis of Motivational Interviewing: Twenty-Five Years of Empirical Studies. *Research on Social Work Practice 20*(2): 137-160.
Study design	Meta-analysis of 119 studies addressing a range of outcomes: alcohol use, marijuana use, tobacco use, miscellaneous drug use (e.g., cocaine, heroin), increases in physically healthy behavior (e.g., exercise, eating patterns), reductions in risk-taking behavior (e.g., unprotected sex), gambling, emotional or psychological well-being (e.g., depression or stress and client motivation: engagement in treatment such as keeping appointments and/or participation in treatment), and self-reported intention to change (e.g., movement in the Stages of Change model). The analysis examined a number of potential moderators including type of comparison group, client level of distress, use of a manual, role in treatment (e.g., part of a broader intervention), fidelity, and manner of delivery. Meta-analysis accommodates the fact that the primary studies use many different measures with different populations by means of a metric known as effect size that standardizes results onto a single scale. An effect size refers to the magnitude of the effect or the strength of the intervention, expressed in standard deviations. Conventionally, effect sizes around 0.20 are considered small though statistically significant, 0.50 is moderate and 0.80 is large. Because most of the studies reported on multiple outcomes, a total of 842 effect sizes were computed.
Population	Sample characteristics coded a moderating variable included average age, percent who were male or female, and percent who were White, African American or Hispanic.
Outcomes	The average effect size across all outcomes was 0.22 (statistically significant, classified as a small but statistically meaningful effect). 25% of the 842 effect sizes were either neutral or negative, 50% of the effect sizes were greater than classification of a small effect size, and 25% were larger than a medium effect size. Effect sizes were lower for studies that compared MI with another specific treatment such as 12-step than if the comparison was no treatment.
Comments	Well-designed studies of interventions such as MI typically result in effect sizes similar to this. Based on this meta-analysis, MI is equally, though not more, effective as other interventions, and more effective than no treatment.

Resources

Developer	Description of Content	Target Audience	Resource Type
Motivational Interviewing Network of Trainers 2020	This website has information on MI training, learning, implementation and research. It also provides information about the MI Network of Trainers and news updates related to MI.	Individuals and organizations interested in MI	Website
Motivational Interviewing Network of Trainers	This PDF contains the definition of MI according to Miller (founder) & Rollnick, the usefulness and core elements of MI.	Clinicians and other providers serving individuals requiring behavior change	PDF (Understanding MI)
Motivational Interviewing Network of Trainers 2020	This resource contains information on the requirements and process of implementation of MI in an organization	Organizations interested in implementing MI	PDF (Implementing MI)

Peer Support

Peer support services are delivered by people with personal experience as service users of behavioral health services. Peer support services are theorized to help service users develop self-advocacy skills and build confidence to pursue their goals through establishing trust and rapport built on shared experiences. Those providing peer support services are referred to by a range of terms—including peer specialists, peer advocates (often mental health-focused), and recovery coaches (often used in the substance use recovery community). Nearly all states have established peer training and certification trainings, and a majority of state Medicaid programs reimburse peer support services. Several states have peer specialist training and certification programs specifically for older adults (e.g., Massachusetts' Supporting Older Adults Remotely – SOAR).

Research

Summary	The study examines a program known as Peer Mentoring, for which the primary goal is reduction in hospital use.
Citation	Sledge, W. H., M. Lawless, et al. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatry Services 62*(5): 541-544.
Study design	Randomized controlled design, with follow-up at nine months after an index discharge from an academically affiliated psychiatric hospital. Measures were number of hospitalizations and hospital days.
Population	Patients were 18 years of age or older with major mental illness and had been hospitalized three or more times in the prior 18 months. Seventy-four patients were recruited, randomly assigned to usual care (N=36) or to a peer mentor plus usual care (N=38) and assessed at nine months.
Outcomes	Participants who were assigned a peer mentor had significantly fewer rehospitalizations (.89 ± 1.35 versus 1.53 ± 1.54; p=.042 [one-tailed]) and fewer hospital days (10.08 ± 17.31 versus 19.08 ± 21.63 days; p<.03, [one tailed]).
Comments	According to the authors, despite limitations of the study (small sample size, single location, etc.), "The recovery mentor program has promise as an effective adjunctive component in a multifaceted approach to engaging and treating persons with serious and relapsing psychiatric illness." There is now a variety of peer support models and an extensive body of research. This study was selected as being the most relevant to the business case for peer support services. A Cochrane systematic review of research on peer supports found that much of it demonstrates positive results for both personal recovery and clinical outcomes, though the number of high-quality studies is limited, and the heterogeneity of peer support models presents challenges for synthesizing this evidence. (Chien WT, Clifton AV, Zhao S, Lui S. Peer support for people with schizophrenia or other serious mental illness. *Cochrane Database Systematic Reviews*. 2019).

Peer Support Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Pillars of Peer Support	This page provides links to resources that include information on studies on certification, webinars, a PDF on guidelines for peer specialists and supervisors, along with supervision resources.	Peer supporters, specialists, and supervisors	Webpage
Pillars of peer support training	This page provides links to upcoming training through the Copeland Center, along with recent webinar series and recordings. Also, allows registration for upcoming free webinars and provides certificates for webinars reviewed.	Individuals and organizations interested in peer support training	Webpage

Developer/Author	Description of Content	Target Audience	Resource Type
Professional National Association of Peer Supporters	This site provides education information, building a community, resources, and recent posts sponsored by N.A.P.S.	Individuals and organizations interested in peer support training	Webpage
Pillars of Peer Support	This page contains the original toolkits which included PDFs on peer support services from 2009-2014.	Individuals and organizations interested in peer support	Webpage
SAMHSA Peer Support Resources	This page has information on core competencies for peer workers, the peer support role, and links to additional peer support resources. In English and Spanish.	Individuals and organizations interested in peer support	Webpage
University of Illinois at Chicago	This page offers an interactive map showing a National Overview of Peer Support Training & Certification Programs	Individuals and organizations interested in per support training	Webpage with interactive map
Center for Substance Abuse Treatment	A PDF explaining peer recovery support services, peer mentoring and coaching, adaptability of per support services and cross-project principles.	Individuals and organizations interested in peer recovery support	PDF

Permanent Supportive Housing (PSH)

Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment, and employment services. PSH, sometimes called supported housing, links subsidized housing with access to flexible, voluntary supportive services to help people with disabilities maintain stable housing and live productively in the community.

Research

Summary	PSH (also known as Housing First) has been the subject of extensive research; a literature review by the Corporation for Supportive Housing (CSH) presents the results of nearly 30 studies (CSH Literature Review of Supportive Housing). Outcomes reported in the CSH review for three of the most recent randomized control trials are presented here.
Study design	Randomized control trial, more than 2,000 participants followed for two years.
Population	Participants recruited from shelters, or the streets, represent a wide diversity of demographic characteristics.
Citation	Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry (2014). National At Home/Chez Soi Final Report. Calgary, AB: Mental Health Commission of Canada. Retrieved from: www.mentalhealthcommission.ca
Outcomes	• **Stable Housing:** 62% percent of Housing First (HF) participants were housed all of the time, 22% some of the time, and 16% none of the time. Of treatment as usual (TAU) participants, 31% were housed all of the time, 23% some of the time, and 46% none of the time. • **Healthcare**: Both HF and TAU groups reported declines in ER visits with lower levels among HF participants over the course of the study. Outpatient HF participants also had lower levels of visits to hospitals for outpatient care (these included day hospital visits but not visits for laboratory or diagnostic tests). • **Criminal Justice:** The majority (89%) of participants had at least one interaction with police officers, around one-third of participants were actually arrested during the study timeframe. Both the HF and TAU groups reported substantial declines in their contacts with justice services (police, security services, courts, and other justice services), with no significant difference between the groups. When reasons for arrests were investigated, however, HF participants reported fewer arrests for public nuisance offenses and drug-related offenses over time, whereas TAU participants reported no such decline. • **Quality of Life**: Improvements in community functioning and quality of life were somewhat greater in HF than in TAU; improvements in participants' mental health and substance-related problems, but these changes were similar among both groups.

Citation	Basu, A., Kee, R., Buchanan, D. and Sadowski, L. S. (2012), Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care. *Health Services Research, 47*: 523–543.
Study design	Randomized control trial
Population	Homeless adults
Outcomes	• **Shelter**: 0.07 fewer shelter days than control, 8.13 more days in respite care than control • **Stable Housing:** 29.66 fewer days with family/friends than control, 109.9 more days in paid housing than control, 62 fewer days homeless than control • **Healthcare**: 0.47 fewer hospitalizations than control, 2.64 fewer days in hospital than control, 1.27 fewer ER visits than control, Outpatient 3.84 more outpatient visits than control (includes mental health clinics, hospital clinics, substance abuse treatment visits) • **Criminal Justice:** 0.05 fewer arrests than control, 4.06 more days in jail than control, 0.03 fewer convictions than control,7.73 fewer days in prison than control

Citation	Aidala, Angela A., William McAllister, Maiko Yomogida, and Virginia Shubert. Frequent Users Service Enhancement 'FUSE' Initiative: New York City FUSE II Evaluation Report. Columbia University Mailman School of Public Health (2013).
Study design	Randomized Control Trial
Population	Homeless adults
Outcomes	• **Shelter:** Intervention group had 146.7 fewer days in shelter than comparison group. The percentage of FUSE II participants with any shelter episode over the study period was reduced on average by 70%. • **Stable Housing:** At 12 months, over 91% of FUSE II participants were housed in permanent housing, compared to the 28% who would have been housed had they not received FUSE II housing and services. • **Healthcare:** Comparison group had an average of 1.2 ambulance rides; FUSE II participants had fewer than one ambulance ride (mean 0.67). No significant difference in hospitalization days or emergency room visits. • **Mental Health:** Comparison group had 8 days of hospitalization for psychiatric reasons, 4.4 days more than intervention group. No difference in alcohol and other drug use (AOD use) inpatient hospital days and detoxification days. In the intervention group, the percent with any recent use of hard drugs was half that of comparison group and the percent of current alcohol or substance use disorder is one third less than comparison group.

Resources on PSH

Developer	Description of Content	Target Audience	Resource Type
Corporation for Supportive Housing	This page provides information about who offers supportive housing, benefits and characteristics of quality supportive housing, common models and features of supportive housing.	Individuals and organizations interested in PSH	Webpage
National Health Care for the Homeless Council, Inc	This page gives an overview of supportive housing and links to technical assistance and training programs, as well as publications on supportive housing	Organizations interested in implementing supportive housing programs	Webpage

Person-Centered Trauma-Informed Care (PCTI)

PCTI care is a holistic approach to service provision developed by the Center on Aging and Trauma. PCTI care infuses knowledge about trauma into agency programs and procedures as a way to promote the well-being and empowerment of trauma survivors.

Research

Summary	Emphasis on trauma-informed practice in behavioral health care has increased dramatically, and organizational interventions that train staff about trauma-informed practice are frequently used to promote trauma-informed systems change.
Citation	Purtle J. (2020), Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. *Trauma, Violence, & Abuse*, *21*(4):725-740.
Study design	A systematic review of 23 studies that evaluated the effects of organizational interventions that included a "trauma-informed" staff training component.
Population	Patients were 18 years of age or older with major mental illness and had been hospitalized three or more times in the prior 18 months. Seventy-four patients were recruited, randomly assigned to usual care (N=36) or to a peer mentor plus usual care (N=38) and assessed at 9 months.
Outcomes	Of those reviewed, 17 studies used a single group pretest/posttest design, 5 used a randomized controlled design, and 1 used a quasi-experimental design with a nonrandomized control group. The duration of trauma-informed trainings ranged from 1 hour to multiple days. Staff knowledge, attitudes, and behaviors related to trauma-informed practice improved significantly pre-/post training in 12 studies and 7 studies found that these improvements were retained at ≥1 month follow-up. Of those reviewed, 8 studies assessed the effects of a trauma-informed organizational intervention on client outcomes, 5 of which found statistically significantly improvements.
Comments	According to the authors, "The strength of evidence about trauma-informed organization intervention effects is limited by an abundance of single group, pretest/posttest designs with short follow-up periods, unsophisticated analytic approaches, and inconsistent use of assessment instruments."

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
The Jewish Federations	This page provides a brief overview of PCTI care. The models' purpose focuses on creating environments that promote the safety and well-being of all clients and staff.	Holocaust survivors, older adults with a history of trauma, and their family caregivers	Webpage
Substance abuse and Mental Health Services Administration (SAMHSA)	Guidance for trauma-informed approaches	Organizations interested in person-centered trauma-informed care	PDF

Program to Encourage Active Rewarding Life for Seniors (PEARLS)

PEARLS is a national evidence-based program for late-life depression. It consists of an EBP—Problem-Solving Treatment (PST)—modified with greater emphasis on social and physical activation, delivered by trained masters-level social workers at a community senior services organization, and if indicated, recommendations to patients' physicians regarding antidepressant medications. PEARLS brings high quality mental health care to community-based organizations that reach vulnerable older adults. Sessions take place in the client's home or another community setting and focus on brief behavioral techniques. PEARLS counselors empower individuals to take action and make lasting changes so they can lead more active and rewarding lives. Other topics include depression, problem-solving treatment, behavioral activation (BA), and social activities

Research

Summary	Randomized controlled trial (RCT) of the PEARLS program
Citation	Ciechanowski P, Wagner E, Schmaling K, Schwartz S, Williams B, Diehr P, Kulzer J, Gray S, Collier C, LoGerfo J. (2004), Community-integrated home-based depression treatment in older adults: A randomized controlled trial. *JAMA 291*(13):1569-77
Study design	RCT design with 72 patients in the treatment group and 66 in the usual care group. Outcomes assessed at baseline, 6 and 12 months. At 12-month follow-up, there were 67 in the treatment group and 60 in the usual care group. A difference in differences analysis (comparison of changes in outcomes over time between usual care and intervention groups) was conducted.
Population	138 patients 60 years of age or older with minor depression (51.4%) or dysthymia (48.6%); major depression excluded receiving home-based services from senior service agencies or living in senior public housing. Many were medically ill and low-income, most were homebound. 79% female, 58% Caucasian, 36% African American, 4% Asian American, 1% Indians or Alaska Natives, and 1% Latino
Outcomes	At the 12-month follow-up, the treatment group had greater improvement in depression status, functional well-being, and emotional well-being. There was no change noted in social well-being, physical well-being, outpatient visits, emergency department visits or hospitalizations in the two groups.
Comments	1) Demonstrates that PEARLS can be disseminated within community agencies already providing care for isolated, low-income older adults by adding depression management to established case management; 2) Further research is needed to determine how much each component contributed to the overall intervention effect; 3) Despite the significant effect of the intervention, only a third of patients in the intervention group and 12% in the usual care group experienced remission (similar to other late-life depression studies using antidepressants and psychotherapy)

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
PEARLS	This page provides a brief overview of the program which includes target audience, health outcome, program type, who the program is delivered by, and format. It also contains contact information for training information.	Organizations serving older adults with depression	Webpage
University of Washington	This page has detailed information about PEARLS, implementation requirements, cost, training, and other benefits.	Organizations interested in adopting and implementing PEARLS	FAQ Webpage

Resources for Enhancing Alzheimer's Caregiver Health (REACH) and REACH II

The REACH program is an in-home, tailored, caregiver support intervention administered through the Department of Veterans Affairs, the Rosalynn Carter Institute, and other sites. REACH provides education and support for caregivers to improve overall caregiver health and reduce the burden from caregiving and the risk for depression. REACH II was designed to address the needs of culturally diverse caregivers of persons with dementia, including White, Hispanic, and African American caregivers. REACH II has been successfully adapted to use in the community (e.g., by personnel in local Area Agencies on Aging) and has been effectively adapted for use with family caregivers of persons with acquired physical disabilities (e.g., spinal cord injury).

Research on REACH I

Summary	Meta-analysis was used to examine nine active conditions compared with six control conditions of REACH project at 6 months on caregiver burden and depressive symptoms.
Citation	Gitlin, L. N., Burgio L., Czaja S., Mahoney D., Gallagher-Thompson D., Burns R., et al. (2003). Effect of multi-component interventions on caregiver burden and depression: The REACH multi-site initiative at 6 months follow-up. *Psychology and Aging*, *18*, 361-374.
Study design	Meta-analysis of results from randomized controlled studies at six sites (cities). Each site tested different theory-driven interventions: individual information and support strategies, group support and family systems efforts, psychoeducational and skill-based training approaches, home-based environmental strategies, and enhanced technology systems. The REACH sites overall retained 89% of the participants through the first follow-up time point of 6 months.
Population	Racially and ethnically diverse (White/Caucasian, Black/African American, and Hispanic/Latino) sample of 1,222 caregivers
Outcomes	**Burden**: At 6 months the difference between total active and control groups, though statistically significant, was small. For women, the active interventions were superior to the control conditions. **Depression**: For the 6-month scores, only one intervention site was more efficacious than the control. Although not statistically significant, mean scores at baseline and 6 months for the active treatment group showed a slight decline, whereas the mean scores for control group conditions showed a very small increase. There were no statistically significant differences between combined active and control group conditions for White (n = 611) and African American (n = 260) caregivers. However, the estimate for Hispanic (n = 207) caregivers indicated that active interventions were superior to control group. Those with high school or less education assigned to active interventions improved in comparison with caregivers of the same educational level who were in the control group conditions. However, for both outcomes higher educated individuals in active interventions were not significantly different at 6 months.
Comments	This study had a more rigorous design than much previous research, and according to the authors, the results confirm the conclusions from recent reviews of the caregiver intervention research that there is no single, easily implemented, and consistently effective method for eliminating the multiple stresses of providing care to persons with dementia.

Research on REACH II

Summary	REACH II is a multicomponent intervention package with one component addressing caregiver (CG) self-care and health behaviors. CGs received educational materials on self-care and preventative health practices and a "health passport" that provided reminder information regarding health maintenance activities and a place to track pertinent health information. CGs were also referred to the healthy living feature of a computerized telephone support system.
Citation	Elliott AF, Burgio LD, Decoster J. (2020). Enhancing caregiver health: Findings from the resources for enhancing Alzheimer's caregiver health II intervention. *J Am Geriatr Soc. 58*(1):30-7.
Study design	Randomized, multisite clinical trial in five cities examining caregiver self-reported health, burden and bother. Intervention subjects received individual risk profiles and the REACH intervention through nine in-home sessions and three telephone sessions over 6 months.
Population	642 caregivers randomly assigned to control or intervention groups, 495 included in the analyses, 166 African American, 169 Hispanic, and 160 Caucasian.
Outcomes	The intervention improved caregiver health in four domains of health (general self-rated health, sleep, mood improvement, and physical improvement). Hispanics and whites were more likely to report improvements in these domains than African Americans, although all racial and ethnic groups benefited from the intervention. Depression was a potent mediator.
Comments	As a more cohesive intervention than REACH I, REACH II accordingly had stronger results.

REACH Resources

Developer/Author	Description of Content	Target Audience	Resource Type
American Psychological Association	This page contains links to a brief overview of the purpose, strategy used, and research outcomes of the REACH I and REACH II studies.	Alzheimer's caregivers, family caregivers for persons with dementia	Webpage
Family Caregiver Alliance	This page contains the transcript of a Q&A with the developers of the REACH Community program and gives information on how it was developed, how it works, where it has been implemented, and how organizations adopt it.	Caregivers and organizations interested in REACH	Webpage
Best Practice Caregiving	This page is a comprehensive program profile and provides information on program components, programs costs, sources of funding, implementation and research evidence.	Caregivers and organizations interested in REACH	Webpage

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care. SAMHSA frequently offers grant funding to eligible state governments, federally recognized American Indian/Alaska Native (AI/AN) tribes, and public and private non-profit health care or behavioral health care systems for SBIRT services.

Research

Summary	Re-analysis of data from a previous evaluation of the SAMHSA program that reported large positive effects but was widely criticized for poor methodology
Citation	Aldridge, A., R. Linford, et al. (2017). Substance use outcomes of patients served by a large US implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). *Addiction 112(S2)*: 43-53.
Study design	Evaluation of SAMHSA SBIRT grantee programs using multi-site pre-post, clustered design. Each program developed its own SBIRT model. Most used the validated Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST). Services were provided by specialists (e.g., social workers, substance abuse counselors, health educators) who were associated with the SBIRT project, pre-screening and screenings were also conducted at some sites by a combination of medical generalists (e.g., nurses) and self-administration. All projects incorporated motivational interview techniques. This report used multi-level models on matched pre–post patients to account for the clustering of observations and to explore possible bias from sample selection and attrition.
Population	Sample of 754,525 patients, 171,921 of whom screened positive for hazardous or harmful use and were recommended to brief intervention (BI), 10% sample randomly selected for follow up with 48% response rate. Separate comparison of outcomes for BI, brief treatment (BT) and referral for treatment (RT).
Outcomes	Estimates of substance use reduction were smaller than the previous analysis but still positive. Prevalence of alcohol use was lower 6 months later by 35.6%, heavy drinking by 43.4% and illicit drug use by 75.8%. Greater intervention intensity was associated with larger decreases.
Comments	The authors note that without a comparison group, "study design does not support causal conclusions and estimated decreases in reported substance use are due, at least in part, to a well-known set of confounders and natural substance use patterns that may be unrelated to any particular SBIRT intervention." However, the authors compared their results to a review of 32 controlled trials of Brief Interventions targeting alcohol problems and found that their results were within ranges of estimates from a large number of past SBIRT trials. Other studies have shown that SBIRT lacks efficacy in settings other than primary care such as emergency rooms and that effectiveness is limited for other drugs and mental health conditions such as depression and anxiety [Field, C. A., Baird, J., Saitz, R., Caetano, R., & Monti, P. M. (2010). The mixed evidence for brief intervention in emergency departments, trauma care centers, and inpatient hospital settings: what should we do? *Alcohol Clin Exp Res,* 34(12), 2004-2010].

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
SAMHSA	This page provides links to information about SBIRT, coding for reimbursement, SBIRT grantees, and a link to find more resources on SBIRT.	Organizations interested in early intervention and treatment to people with or at risk for substance use disorders	Webpage
SAMHSA Technical Assistance Publication Series (TAP 33)	This document provides information on system-level implementation of SBIRT, sustainability, and case examples.	Organizations interested in implementing SBIRT	PDF

Wellness Recovery Action Planning (WRAP)

WRAP® is a personalized wellness and recovery process with the goal to help individuals monitor their feelings and behaviors, increase personal empowerment, and improve quality of life. It can be used by individuals and by health care systems and mental health systems to address all kinds of physical, mental health and life issues.

Research

Summary	The study compared WRAP, a peer-led illness self-management intervention, to usual care.
Citation	Cook JA, Copeland ME, et al. (2012). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. *Schizophr Bull 38*(4): 881-891.
Study design	A total of 519 adults with severe and persistent mental illness were recruited from outpatient community mental health settings in six Ohio communities and randomly assigned to the 8-week intervention or a waitlist control condition. Outcomes were assessed at end of treatment and at 6-month follow-up.
Population	One fifth (21%) reported diagnoses of schizophrenia or schizoaffective disorder, another 38% reported bipolar disorder, and another a quarter (25%) reported a depressive disorder. Most were not employed (85%) nor married/cohabiting (88%). About three fourths had a history of psychiatric inpatient treatment.
Outcomes	Primary outcome was reduction of psychiatric symptoms, with secondary outcomes of increased hopefulness and enhanced quality of life. Compared to controls, at immediate post-intervention and at 6-month follow-up the WRAP participants reported: 1) significantly greater reduction of symptoms; 2) significantly greater improvement over time in hopefulness; and 3) enhanced improvement over time in quality of life. Positive changes persisted for at least 6 months after the intervention's conclusion.
Comments	This is a well-designed study with careful randomization and blinding and using an intention-to-treat (ITT) analysis. One possible confounding factor is that both the intervention and control groups were involved with other peer support services, thus possibly resulting in underestimating the effect that would occur in settings with fewer peer support resources.

Resources

Developer/Author	Description of Content	Target Audience	Resource Type
Advocates for Human Potential, Inc. (AHP)	This page offers information on uses/benefits of WRAP, key recovery concepts, action plan and access to WRAP wellness tools	Individuals, healthcare and mental health systems interested in addressing all kinds of physical, mental health and life issues	Webpage
Copeland Center	This page provides information about starting a WRAP program and facilitator training.	Individuals and organizations interested in WRAP	Webpage