American Psychological Association

Recovery to Practice Initiative Curriculum:
Reframing Psychology for the Emerging Health Care Environment

9. Interventions III: Promising or Emerging Practices and Supporting Services

NOTE: There are three Interventions modules. They are designed to be used together and are not intended to be used separately or as stand alone modules

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Overview

This is the third of three modules on Interventions. The three modules are designed to be used together; they cannot stand alone as the content of any one is not sufficient to understand or provide Psychosocial Rehabilitation (PSR) interventions.

In Interventions I, the guiding principles that underlie the provision of all PSR services are discussed along with an integrative framework model that can be used to coordinate PSR services. The guiding principles are essential for the successful implementation of the interventions discussed in Interventions II and Interventions III. In Interventions II, interventions that have been proven through empirical research to achieve specific outcomes are presented; these are known as evidence based practices (EBPs). In Interventions III, interventions that have shown promise of achieving specified outcomes are presented; these are known as promising or emerging practices. Interventions III also presents supporting services that are widely acknowledged to be essential services for helping people recover from the effects of serious mental illness.

Importantly, research evidence has been accumulating that an integrated approach that combines multiple interventions within a recovery oriented context may be the most effective approach (Lyman, Kurtz, Farkas, George, Dougherty, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery oriented system (Davidson & Chan, 2014). Such an approach must be targeted to the unique needs of each individual including those in forensic and criminal justice systems (Epperson, Wolff, Morgan, Fisher, Frueh & Huening, 2011; Strauss, 2014). In addition, it has become apparent that cognitive impairment is likely at the heart of the functional skill deficits so commonly experienced by people with serious mental illnesses (Harvey, & Penn, 2010) leading to the conclusion that integrated approaches should include cognitive enhancement approaches as a fundamental component (Pfammatter, Brenner, Junghan & Tschacher, 2011; Roder, Mueller & Schmidt, 2011) and underscores the importance of social cognition for improving community functioning. Indeed, some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).

Notwithstanding the above, each of the EBPs, promising practices, and supporting services are discussed separately in the interventions modules (Interventions II and Interventions III) because as of the publication date of this curriculum, no definitive combination of approaches has been determined to be most effective, although some combination of cognitive therapies (cognitive remediation, social cognition training, cognitive behavioral therapy), supported employment, psychoeducation (client/family approaches, illness management approaches), and social and communication skills training, seems to be most promising. As the research literature evolves, additional interventions, especially those that contain a cognitive or learning component, may be identified as critically important. Furthermore, identification of which interventions work best for whom, under which
conditions, at which stage of illness, and potentially at which age of each individual, may lead to the development of personalized approaches tailored for each individual.

Learning Objectives

At the end of this module you will be able to:

- Define promising / emerging practices and identify at least three promising or emerging practices identified in the PORT study
- Define Supporting services and identify at least three supporting services described in this module
- State at least two reasons why supporting services are important adjuncts to the EBPS and promising/emerging practices
- Identify at least three challenges faced by psychologists and other practitioners who advocate for provision of the promising practices and supporting services

Resources

- Lecture Notes
- Required Readings
- Lecture Notes Citations
- Sample Learning Activity
- Sample Evaluation Questions
- Additional Resources

Required Readings


Activities
Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

As described in previous modules, studies over the past several decades have shown that many people with serious mental illnesses can and do recover when they are provided with supports and services that assist them to gain the skills needed to live a satisfying and productive life. Users of mental health services have consistently said that they want the same things for themselves that every citizen wants: a family, a safe place to live, meaningful activities, adequate income, job satisfaction, and an enjoyable social life. Where children and youth are concerned, the same is true: families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes (Bellonci, Jordan, Massey, Lieberman, Zubritsky & Edwall, 2012).

For people with serious mental illnesses, attainment of life goals often requires substantial assistance in the form of specially designed psychosocial rehabilitation (PSR) services. While some people with serious mental illness may recover without assistance, many are unable to recover sufficiently to achieve the quality of life that they desire without these specialized services (Silverstein, 2000). Several of these specialized services have been shown in multiple randomized clinical trials to be highly effective; these are known as evidence based practices (EBPs).

In addition to the EBPs that have been proven to help people learn the skills they need to live satisfying lives, there are services that have an emerging evidence base. These are known are promising practices. There are also services that people with lived experience of mental illness cite as important and helpful. These are known as supporting services. Both of these categories of services, promising and supporting, are reviewed in this third Interventions module.

It is important to keep in mind that none of the interventions are suggested as a “cure” for serious mental illness. Rather these interventions are a means to inform individuals and their families about the illness and to help individuals achieve the life goals they have for themselves. It is also important to keep in mind that all interventions must be provided within a recovery oriented framework and perspective that is person centered, draws on the strengths and capabilities of the individual, and is oriented to the goals of the person served (Davidson, 2010; Mueser, 2012).
Promising or Emerging Practices

In addition to the EBPs reviewed in the second Interventions module, the PORT study also indicated that reviews of treatments focused on medication management or adherence, cognitive remediation, psychosocial treatments for recent onset schizophrenia, and peer support and peer-delivered services do not yet have enough evidence to merit a recommendation as an EBP. However, each of these is an emerging area of interest and each is currently undergoing considerable research and shows promise as an emerging promising practice. These PSR practices are reviewed below.

Medication Management or Medication Adherence, also known as Illness Management and Recovery

Medication is used by many individuals with serious mental illness to help decrease symptoms of the illness. Management of the dosage and side effects is a critically important aspect of a person’s decision to continue to use prescribed medications. Medication is a potentially important and yet often difficult component of most treatment regimens. Taking medications, for a variety of reasons (side effects, weight gain, health concerns, etc.) can be difficult and for some individuals, non-adherence to prescribed medications may result in relapse. As a result, identifying ways to assist those prescribed medication to adhere to the treatment can be important. However, to date, there are not sufficient data to support any of the interventions designed to maintain adherence. Approaches tailored to the needs of the individual and that involve the person, his or her family, and clinicians, offer the best success to date. The consumer’s concerns and preferences must be an integral part of the overall process. Use of medication should be driven by the evidence base for psychotropic medications, taking into account knowledge from the most recent research literature (Buchanan, Kreyenbuhl, Kelly, Noel, et al., 2010) and the emerging literature showing initial results related to long term use of these medications (Harrow & Jobe, 2007; Harrow & Jobe, 2013; Harrow, Jobe & Faull, 2012; McGorry, Alvarez-Jimenez & Killackey, 2013; Wunderlink, Nieboer, Wiersma, Sytema & Nienhuis, 2013).

A widely used approach consists of teaching illness management skills and usually involves a series of sessions where mental health providers help individuals with serious mental illness learn a broad range of coping strategies for living with their mental illness. Illness Management and Recovery (IMR) (Gingerich & Mueser 2011) consists of combining a set of specific EBPs for teaching people with serious mental illness how to manage their disorder in collaboration with professional staff and family members in order to achieve their own recovery goals. The coping strategies taught in most illness management programs are a subset of those utilized in other EBPs and are designed to help individuals build healthy, wellness oriented lifestyles. Programs usually run for three to six months and consist of educational and skills building sessions. Programs are designed so that family members can also attend, with permission of the individual.
Several programs have been developed to help individuals learn the skills they need to take charge of their illness including its symptoms and its management. In addition to IMR, a peer led approach is the Wellness Recovery Action Plan (WRAP) (Copeland, 2002). WRAP and other programs that teach illness management and wellness skills have been found to help individuals feel more empowered to take charge of their illness, feel more hopeful and experience enhanced quality of life (Cook, Copeland, Jonikas, Hamilton, Razzano, et al., 2012). WRAP has also recently been found to reduce individuals’ perceived need for, and use of, mental health services (Cook, Jonikas, Hamilton, Goldrick, Steigman, et al., 2013), confirming the importance of peer led illness management groups in combination with other EBPs.

Research on illness management programs indicates that provision of several key components, especially when utilizing a peer co-facilitator, can help those with serious mental illness reduce the severity of symptoms and cope better with the symptoms they have (Merinder, 2000; Mueser, Bond & Drake, 2001; Mueser, Corrigan, Hilton, Tanzman, et al., 2002). These components include:

- Psychoeducation
- Behavioral skills to learn how to take medication as prescribed and follow the medication regimen
- Cognitive behavioral strategies to assist with symptom management.

Topics covered in an illness management program include:

- Recovery strategies
- Practical facts about mental illness
- The stress-vulnerability model and coping strategies
- Building social support
- Reducing relapses
- Using medication effectively
- Coping with stress
- Coping with problems and symptoms
- Getting one’s needs met in the mental health system (Mueser, Deavers, Penn & Cassisi, 2013)

Because of the breadth of the topics covered, and the short duration of most programs (3 - 6 months), in-depth training in any one of them, is not possible. As a result, most individuals will also benefit from other EBPs that provide greater coverage of given topics.
Cognitive Enhancement: Cognitive Remediation and Social Cognition Training

Neuropsychological functioning is often negatively affected in people with serious mental illnesses, resulting in impaired thinking ability and inability to function well in social, educational, and work settings. The phrase “social cognition” encompasses several components of neuropsychological functioning most notably those associated with one’s ability to perceive cues related to social interaction such as perception of another’s affect and to empathize with another person, and an ability to pick up on social cues. As noted in the Overview of this module, “…it has become apparent that cognitive impairment is likely at the heart of the functional skill deficits so commonly experienced by people with serious mental illnesses (Harvey, & Penn, 2010) leading to the conclusion that integrated approaches should include cognitive enhancement approaches as a fundamental component (Pfammatter, Brenner, Junghan & Tschacher, 2011; Roder, Mueller & Schmidt, 2011) and underscores the importance of social cognition for improving community functioning. Indeed, some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).”

Cognitive remediation has been shown to improve neuropsychological functioning and life skills outcomes in social, educational, and employment settings by improving cognitive functioning. Recent studies have led to the conclusion that cognitive remediation holds the greatest promise when delivered in conjunction with other rehabilitation interventions such as supported employment. Importantly, in order to impact on aspects of social cognition (also important in a variety of settings such as work, education, social interactions, etc.), cognitive remediation has been found especially effective when combined with social cognition training which includes emotional processing skills and affect recognition, illness management skills, attributional bias and mentalizing exercises (Horan, Kern, Tripp, Hellemann, et al., 2011; Kurtz & Richardson, 2012; Lindenmayer, McGurk, Khan, Kaushik, Thanju, et al., 2013; Roder, Mueller & Schmidt, 2011).

Cognitive remediation programs generally provide computer assisted training exercises designed to help clients re-learn cognitive skills aimed at improving learning, memory, attention, concentration, and executive functions that control and regulate adaptive abilities and behaviors, such as initiating, monitoring and changing behavior as needed. Several studies have found increased cognitive functioning after remediation efforts (Anaya, Martinez, Ayuso-Mateos, Wykes, Vieta, & Scott, 2012; Fisher, Holland, Subramaniam & Vinogradov, 2009; McGurk, Twamley, Sitzer, McHugo, et al., 2007; Pfammatter, Junghan & Brenner, 2006; Wykes, Reeder, Landau, Everitt, et al., 2007) and some studies have found enhanced employment outcomes when cognitive remediation is paired with supported employment (Lindenmayer, McGurk, Mueser, Kahn, et al., 2008; McGurk, Mueser & Pascaris, 2005), although one recently published study found these effects mainly for those with lower community functioning capability (Bell, Choi, Dyer & Wexler, 2014). Recently evidence has begun to accumulate which indicates that emotional distress and negative
symptoms may also be positively impacted (Sanchez, Pena, Bengoetxea, Ojeda, Elizagarate, et al., 2014). Other studies have found only small effects of cognitive remediation efforts on neuropsychological or functional outcomes (Dickinson, Tenhula, Morris, Brown, et al., 2010).

Because of the importance of the range of neuropsychological processes for attainment of one’s life goals, this is an important area where more research is needed to identify the conditions under which maximum benefit can be obtained from these interventions.

**Psychosocial Treatments for Recent Onset Schizophrenia**

Although serious mental illnesses can strike adults in the prime of their lives, these illnesses most frequently strike young people between the ages of 15 and 26 (Dickinson, Tenhula, Morris, Brown, et al., 2010), with a median age at which symptoms first appear of 14 (National Health Policy Forum, 2009).

Often, people with serious mental health and substance use disorders become ill early in their lives when the skills needed for success in life are just developing. When this happens, thinking ability is often severely compromised because of the negative effects these disorders have on cognitive processing capabilities. Education and work are disrupted, and often stopped completely along with the ability to form meaningful relationships with family and friends. Frequently, there is a period of symptomatology that occurs before full blown psychosis develops. This period has been called the “prodromal period”, and those in this state have been said to be at “ultra high-risk”, or to be experiencing an “attenuated psychosis syndrome” (Yung, Woods, Ruhrman, Addington, Schultze-Lutter, et al., 2012); the rate of onset of a psychotic disorder has been shown to be thirty six percent within three years (Fusar-Poli, Bonoldi, Yung, Borgwardt, Kempton, et al., 2012). Recently, clinical staging models have been applied to those with mental health disorders in an effort to help clinicians identify the best course of action for those who may not have progressed to full blown psychosis and to help prevent progression (Cross, Hermens, Scott, Ottavio, McGorry & Hickie, 2014; Hickie, Scott, Hermens, Naismith, Guastella et al., 2013). Previous models have focused on symptoms usually seen in early stages of illness such as anxiety and depression but do not account for the symptoms that may indicate signs of more serious illness. Innovatively, the model described by the authors above incorporates a range of symptoms and syndromes within a single staging model, thus allowing for attention to potential developing psychosis.

Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and psychosocial interventions during the first episode of psychosis may lead to improved outcomes (Baksheev, Allott, Jackson, McGorry & Killackey, 2012; Bertelsen, Jeppesen, Petersen, Thorup, et al., 2008; Bird, Premkumar, Kendall, Whittington, et al., 2010; Ehmann, Yager & Hanson, 2008; Marshall & Rathbone, 2011; Tandon, Keshavan & Nasrallah, 2008) and may prevent or delay relapse (Álvarez-Jiménez, Parker, Hetrick, McGorry, et al., 2011). Early intervention programs
generally include the provision of multimodal psychosocial interventions (CBT, family based psychoeducation, illness management, educational and vocational interventions), pharmacotherapy, and some form of case management with lower case-loads and an assertive approach to treatment, all within the context of intervening as early as possible. Interestingly, recent research has shown that omega-3 fatty acids (fish oil) prevented development of psychosis for the duration of the study period (12 months) (Amminger, Schafer, Papageorgiou, Klier, et al., 2010) and this could be a promising intervention to help the person avoid use of psychotropic medications. Confirmatory studies of this potentially helpful adjunct are needed.

Despite the promising results of early intervention research, the evidence also suggests that the effects are not sustained beyond the intervention period and continued intervention may be needed (Bertelsen, Jeppesen, Petersen, Thorup, et al., 2008; Bird, Premkumar, Kendall, Whittington, et al., 2010; Bosanac, Patton & Castle, 2010; Gleeson, Cotton, Alvarez-Jimenez, Wade, Gee, et al, 2013; McGorry, Nelson, Goldstone & Yung, 2010; Norman, Manchanda, Malla, et al., 2011; Pretia & Cella, 2010), especially during what is considered the five year critical period from onset of psychotic symptoms (Addington, Leriger & Addington, 2003; Birchwood, 2000; Birchwood, Todd, Jackson, 1998; Harrison, Hopper, Craig, Laska, et al., 2001; McGlashan, 2006; McGorry, 2002; Perkins, Gu, Boteva, et al., 2005; Wyatt & Hunter, 2001).

At the same time, emerging research is indicating that use of pharmacologic interventions following remission from first episode psychosis (FEP) may need to be used at much lesser doses and potentially discontinued altogether. In one of the first studies in this area, Harrow & Jobe identified individuals with schizophrenia who achieved greater symptom and functional recovery at all follow up periods over a fifteen year period (Harrow & Jobe, 2007). These results were confirmed following additional follow up at twenty years post initial hospitalization. The authors also measured individuals pre-morbid characteristics and identified greater levels of resiliency, better pre-morbid developmental achievements, less vulnerability to anxiety, better neurocognitive skills, and less vulnerability to psychosis as factors that contributed to individuals’ better outcomes (Harrow, Jobe & Faull, 2012; Harrow & Jobe, 2013).

In another study, Wunderlink and colleagues showed that following remission from FEP, discontinuing psychotropic medications over an 18 month period resulted in initially greater rates of relapse at three years post relapse, but at seven years, the rate of functional recovery was twice that for the discontinuation group compared to the maintenance therapy group with relapse rates at the seven year follow up similar in both groups (Wunderlink, Nieboer, Wiersma, Sytema & Nienhuis, 2013). Clearly, initially increased relapse rates are not desirable but may be an acceptable price to pay for significantly greater functional capability over the long term (McGorry, Alvarez-Jiminez & Killackey, 2013).

The results of these and other studies related to long term use of neuroleptic medications are an exciting development that needs to be watched closely by psychologists and other
mental health practitioners who may be prescribing psychotropic medications and by all those working with individuals with serious mental illnesses.

Somewhat distinct from the issue of long term medication use is a related but slightly different aspect of medication use, i.e., duration of untreated psychosis (DUP). Evidence suggests that the longer an individual remains without treatment after evidencing psychosis, the poorer the ultimate outcome (Marshall, Lewis, Lockwood, Drake, Jones & Croudace, 2005). There is also evidence that reducing DUP leads to better long term outcomes (McGlashan, Evensen, Haahr, Hegelstad, et al., 2011). This is also an important and emerging area of intense research interest that needs to be followed carefully.

While there are conflicting views about the importance of providing early intervention services (Yung, 2012), this is an area that many see as one of the most important, and considerable research is underway in this area. This is because the real tragedy of serious mental illness is the loss of life’s potential that happens when proven rehabilitative treatments are not provided. Engaging individuals who are experiencing a first episode of psychosis, especially those who are youth is especially important and may be facilitated by developmentally appropriate interventions (Green, Wisdon, Wolfe, Firemark, 2012). Likewise, providing intensive case management using an assertive community treatment model has been shown to facilitate greater social networks and may lead to improved clinical outcomes as a result of establishing or maintaining relationships with family and friends (Tempier, Balbuena, Garety & Craig, 2012).

**Peer Support and Peer Delivered Services**

Participation of consumers in the design and delivery of mental health services is one of the hallmarks of a mental health system that truly supports the principles of recovery. There are many models of consumer involvement in the delivery of services and peer support is the most widely known of these.

People with lived experience of mental illness consistently report that having the support of others who have gone through what they are going through is one of the most important and helpful services; several studies have confirmed these perceptions (Dumont & Jones, 2002; Nelson, Ochocka, Janzen & Trainor, 2006; Piat, Sabetti, Couture, Sylvestre, et al., 2009). Peer support programs are provided by individuals who have experienced a serious mental illness themselves and who have recovered sufficiently to be helpful to others who have similar problems. Peers listen, share their own experiences, and offer support, hope, encouragement, education, and practical suggestions. Peer leaders are trained to engage in active and supportive listening, and are trained to lead groups themselves or to work individually with current consumers. Training in basic communication skills may be needed to ensure that the peer support worker is skilled enough to offer a helpful intervention. Many believe that peer support programs help to normalize the experience of serious mental illness while traditional treatment tends to medicalize and stigmatize it.
In addition to peer support services, other types of peer delivered services are currently being delivered and researched. These can include peers serving as regular members of the mental health clinical team and peers organizing and running independent services. To date, there has not been sufficient research on these services to support their effectiveness, but given the importance that persons with lived experience attach to them, much more work in this area is needed.

Peer support is currently the focus of considerable research interest to determine if there is enough empirical evidence to include it as an EBP. Whether or not peer services are ultimately supported by research evidence, there is no question that those receiving services value it greatly. Because of the importance of peer support services, a full module of this curriculum entitled Peer Delivered Services, is devoted to the practice. Additional information is also available from the InterNational Association of Peer Supporters at www.inaops.org.

**Supporting Services**

In addition to the EBPs and the promising or emerging practices, there are several services that support individuals with serious mental illness and help them achieve a healthy and satisfying life. Many of these are supported by initial research, others are critically important to avoid life threatening situations, and others are needed to help people achieve a normal and successful life in the community. These are often called supporting services and are part of a comprehensive PSR system of services. Each of these supporting services is discussed below.

**Motivational Interviewing**

Motivational interviewing has been shown, in several clinical trials, to be a highly effective intervention that assists people to make changes in their lives (Miller & Rose, 2009). The strategy is particularly important when individuals are confronting behaviors that are difficult to change, such as addictive behaviors, but has been shown to be useful for a wide variety of situations and populations, including those with chronic mental health disorders (Arkowitz, Westra, Miller & Rollnick, 2008; Hettema, Steele & Miller, 2005; Lundahl, Kunz, Brownell, Tollefson, et al., 2010; Rollnick, Butler, Kinnersley, Gregory, et al., 2010; Rubak, Sandbaek, Lauritzen & Christensen, 2005). Motivational interviewing is considered an EBP for substance abuse. Research indicating the efficacy of the approach for people with serious mental illnesses is not conclusive (Barrowclough, Haddock, Wykes, Beardmore, et al., 2010) and it has not yet been designated an EBP or a promising practice for these conditions.

A major tenet of motivational interviewing is acceptance of the fact that clients who need to make changes in their lives approach counseling at different levels of commitment to change their behavior. The goal of motivational interviewing is to help individuals explore their ambivalence about their behavior. Motivational interviewing is non-judgmental and
non-confrontational and success is highly dependent on therapist training and empathic ability (Amrhein, Miller, Yahne, Knupsky, et al., 2004; Health Canada, 2008; Houck & Moyers, 2008; Miller & Mount, 2001; Miller & Rose, 2009; Miller, Yahne, Moyers, Martinez & Pirritano, 2004).

**Supported Housing**

Having a place to live is one of the most fundamental and important aspects of life. Yet, people with serious mental illnesses are often either homeless or at risk of becoming homeless (Padgett, 2007). Many believe that having decent, stable, affordable housing of one’s choice is the first step toward achieving recovery. For this reason the slogan “Housing First” has developed as one of the cornerstones of recovery services.

Research is currently underway to determine the benefits of providing housing before other services, especially for people with co-occurring disorders. Many studies have found decreased use of alcohol and drugs, reduced costs for police services, emergency room treatment, increased housing stability, and decreased psychiatric hospitalization when people have a stable place to live (Culhane, Metraux & Hadley, 2002; Gulcur, Stefancic, Shinn, Tsemberis, et al., 2003; Lipton, Siegel, Hannigan, Samuels, et al., 2000; Pearson, Montgomery & Locke, 2009).

Most people prefer to live independently and many people with serious mental illnesses do live independently. Others need varying levels of support. There are a range of options for helping people with serious mental illness live in the community. Supported housing is an intervention designed to assist people with serious mental illnesses find and maintain stable residences with the ongoing support of mental health professionals (Chilvers, Macdonald & Hayes, 2010). Models range from providing support for people living independently with casual support through to housing where staff persons are on site twenty four hours per day.

Often individuals need information and skills training to help them learn how to manage their home and frequently need treatment for co-occurring substance use disorders. Although information and skills development related to obtaining and maintaining appropriate housing are sometimes integrated into other clinical interventions, these can be provided as a separate service. Recent reviews have found that the best outcomes were achieved when housing was provided together with support utilizing the comprehensive assertive community treatment model (Coldwell & Bender, 2007; Nelson, Aubry & Lafrance, 2010; Rogers, Kash & Olschewski, 2009).

Considerable research on housing outcomes for individuals with mental health and addictive disorders has been conducted over the past several years. Outcome studies have generally concluded that functioning can improve, social integration can be facilitated, and residents are generally more satisfied in supported housing compared with conventional hospital care (Best, Boothroyd, Giard, Stiles, et al., 2006; Clarke, Febbrara, Hatzipantelis & Nelson, 2005; Fakhoury, Murray, Shepherd & Priebe, 2002; Forchuk, Ward-Griffin, Csiernik
& Turner, 2006; Parkinson, Nelson & Horgan, 1999; Rog, 2004). Some programs provide treatment for co-occurring substance use disorders with support embedded with the housing program and these have shown reduced service system costs (Gilmer, Stefancic, Ettner, Manning, et al., 2010; Mares & Rosenheck, 2009).

A recent comprehensive synthesis of the research literature found the following:

> Overall, our synthesis suggests that supported housing can improve the living situation of individuals who are psychiatrically disabled, homeless and with substance abuse problems. Results show that supported housing can help people stay in apartments or homes up to about 80% of the time over an extended period.... Housing services appear to be cost effective and to reduce the costs of other social and clinical services. In order to be most effective, intensive case management services (rather than traditional case management) are needed and will generally lead to better housing outcomes. Having access to affordable housing and having a service system that is well-integrated is also important.... Supported housing can improve clients’ quality of life and satisfaction with their living situation.... In addition, rapid entry into housing, with the provision of choices is critical (Rogers, Kash & Olschewski, 2009, p. 1).

To date, the most solid evidence for the benefits of assisting people achieve stable housing indicates that permanent, supportive housing appears to achieve the best results. Models of permanent, supportive housing are rated more positively by individuals and led to reduced homelessness, increased housing tenure, and decreased emergency room visits and hospitalization (Rog, Marshall, Dougherty, George, Daniels, et al., 2014). Additional research is needed to identify the best housing solutions for people with serious mental illnesses, many of whom have co-occurring substance use disorders. As mentioned, current results indicate that provision of safe and affordable supportive housing can help homeless individuals with serious mental illness remain in stable housing, use adjunct social services less and achieve stability. Providing stable housing and decreasing homelessness are desirable goals irrespective of other benefits.

**Supported Education**

Assisting individuals with serious mental illnesses to resume their normal educational trajectory is increasingly recognized as vital to their recovery and ability to return to a normal life. This is particularly important now as recent advances in pharmacologic treatments have allowed young persons who are newly diagnosed with mental illness to avoid long term hospitalization and more quickly resume the developmental trajectory of their lives.

The primary aim of supported education is to provide opportunities, resources, and supports to people with serious mental illnesses so that they may gain admittance to, and succeed in the pursuit of post-secondary education (Isenwater, Lanham & Thornhill, 2002; Mowbray, Collins & Bybee, 1999; Unger, Pardee & Shafer, 2000). The practice is
Increasingly recognized as one that is needed in a comprehensive service delivery system for people with serious mental illnesses.

Although supported education was developed primarily to help people return to postsecondary education, the principles and practices also apply to adolescents and adults who are completing high school or participating in adult education. Services assist people with a diagnosis of mental illness return to education and become better prepared to achieve their learning and recovery goals and/or become gainfully employed in the career of their choice (Mowbray, Brown, Furlong-Norman & Soydan, 2002). Supported education services usually consist of a helper who provides assistance to an individual who is applying for, or attending an educational institution and who needs help due to functional limitations associated with cognitive processing deficits. A range of services tailored to the needs of the individual, is generally recommended (Leonare & Bruer, 2007).

Supported education has been shown to assist individuals to successfully complete their educational goal (Robson, Waghorn, Sherring & Morris, 2010). People with serious mental illnesses indicate it has been helpful (Collins, Mowbray & Bybee, 2000; Gutman, Schindler, Furphy, Klein, et al., 2007); additional research is needed on this potentially valuable intervention.

The following are considered critical components in a supported education program:

- A supported education team/specialist designated to work with consumer-students
- Supported education programs have no non-educational eligibility requirements for entrance into the program
- Supported education specialists complete educational assessments with consumer-students
- Communication and collaboration occur between all stakeholders
- Supported education programs offer confidence and knowledge building activities
- Supported education programs offer preparatory options
- Preparatory classes are not required by supported education programs for school enrolment
- Programs offer support and assistance to acquire necessary resources for school attendance
- Programs provide enrollment and educational supports (Ratzlaff, McDiarmid, Marty & Rapp, 2005).

**Interventions to Provide Trauma Informed Care**

A large proportion of those with serious mental illness have experienced trauma. Trauma can be from many sources including physical, sexual, and emotional abuse, combat or war experiences, major illness, witnessing abuse or other traumatic events happening to others,
catastrophic events, etc. Many individuals are traumatized by the mental health system itself due to the stigma, lack of respect, uncaring attitudes and sometimes dehumanizing and even abusive practices that are demonstrated even today by some mental health professionals.

The severity of the trauma experienced by the majority of those in the system was summarized by Jennings, 2008:

The kinds of trauma experienced by persons who are or who become recipients of public mental health services are usually not associated with “single blow” traumatic events (Terr, 1991) such as natural disasters, accidents, terrorist acts, or crimes occurring in adulthood such as rape and domestic violence (Giller, 1999). Rather, the traumatic experiences of adults, adolescents and children with the most serious mental health problems are interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person’s life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse....They are traumatized further by coercive interventions and unsafe psychiatric environments (Jennings, 1994; Cusack, et al., 2003; Frueh, et al., 2000; Frueh, et al., 2005; Grubaugh, 2007; Robins, 2005) and at times sexual and physical abuse in inpatient or institutional settings, jails, and prisons (p. 2).

And from Herman:

The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992, p. 22).

Experiencing a psychotic episode for the first time can be highly traumatic and can lead to full PTSD or to PTSD symptoms. The trauma can emanate from terror experienced as a result of the psychotic symptoms themselves or from experiences encountered in the treatment system, or both (Mueser, Lu, Rosenberg & Wolfe, 2010).

Not everyone who witnesses or experiences trauma develops PTSD or less severe trauma reactions, but many do. Estimates of those who have experienced or witnessed trauma and subsequently developed a traumatic reaction range from 27 to 74 percent with reactions ranging from somatic concerns, non-specific distress, anxiety, depression, and simple or complex PTSD (Norris, 2005). Individuals experiencing their first psychotic episode who experienced physical or sexual abuse more often attempted suicide and had poorer treatment outcomes than those without similar histories of abuse (Conus, Cotton, Schimmelmann, McGorry, et al., 2010). Epidemiologic research indicates that several factors play a part in determining whether or not an individual will develop a trauma related
disorder. These include age at which the trauma was experienced with children being most vulnerable, emotional resilience, socio-economic status (developing versus developed country status), and severity of the traumatic event (Norris, Byrne, Diaz & Kaniasty, 2002).

Women who have experienced violence, physical, emotional, and sexual abuse and trauma often have co-occurring mental health and substance abuse problems and are at special risk (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions, 2006; Elklit & Shevlin, 2011). Homeless women are more vulnerable than homeless men, are poorer, and often have additional stressors due to child care responsibilities (Harris & Bachrach, 1990). Due to their increased vulnerability and poverty, women are also more likely to be unable to control sexual situations and may be more often exposed to HIV/AIDS and other sexually transmitted diseases (Darves-Bornoz, Lemperiere, Degiovanni & Gaillard, 1995). The result is that women have very different treatment needs than men (Bently, 2005). Women that have been abused by men will likely be unable to work through those issues in a mixed group – a mixed trauma group can actually exacerbate their trauma.

Services offered in women only groups are essential for women who have been abused both to help them recover and to avoid exacerbating their trauma. A PTSD group for women in these circumstances is essential. Some trauma services (Najavits, 2006) have been designed or modified specifically for women been but their availability is typically limited.

Children and adolescents can also be significantly affected by traumatic experiences including severe adversity (sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, and bullying) and develop PTSD, which is highly prevalent in those who have experienced trauma. There is accumulating evidence that children who experience severe adversity, physical abuse and especially those who are repeatedly abused are at increased likelihood for developing psychosis (Frounfelker, Vorhies Klodnick, Mueser & Todd, 2013; Rosenberg, Lu, Mueser, Jankowski & Cournoyos, 2007; Shevlin, Dorahy & Adamson, 2007; Varese, Smeets, Drukker, Lieverse, Lataster, et al., 2012) and that sexual trauma may even be a contributing factor in the development of psychosis for some individuals (Thompson, Nelson, Yuen, Lin, Amminger, et al., 2014). Additionally, the more trauma a child experiences the greater the likelihood of increased severity of psychotic symptomology (Lu, Yanos, Silverstein, Mueser, Rosenberg, et al., 2013).

Interventions must be specifically geared toward helping people with serious mental illnesses work through the devastating effects of the traumatic experiences they have had. According to SAMHSA:

Trauma-specific treatment services are “interventions designed to address the specific behavioral, intrapsychic, and interpersonal consequences of exposure to sexual, physical, and prolonged emotional abuse” (Substance Abuse and Mental Health Services Administration, 2000).

Harris and Fallot, 2001 described a trauma informed system as:
A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of adults, children and adolescents and families or caregivers seeking mental health and addictions services (Harris & Fallot, 2001). A “trauma informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent re-traumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in “traumatology”.

In contrast, trauma specific services are described as:

“Trauma-specific” services are designed to treat the actual sequelae of sexual or physical abuse trauma. Examples of trauma-specific services include grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help to render painful images more tolerable, and behavioral therapies which teach skills for the modulation of powerful emotions (Harris & Fallot, 2001). Treatment programs designed specifically for survivors of childhood trauma are consistent on several points: the need for respect, information, connection, and hope for clients; the importance of recognizing the adaptive function of “symptoms;” and the need to work in a collaborative empowering way with survivors of abuse (Saakvitne, 2000).

A recent review of interventions for people with serious mental illness and severe trauma found that both cognitive behavioral treatment (combined with psycho-education about PTSD, breathing retraining, and cognitive restructuring) (Mueser, Rosenberg, Xie, Jankowski, Bolton, Lu, et al., 2008) and exposure therapy (combined with group therapy focused on education, relaxation training and social skills building) (Frueh, Grubaugh, Cusack, Kimble, Elhai & Knapp, 2009) were found to be effective, with the cognitive behavioral treatment program evaluated in the largest clinical trial conducted to date. This comprehensive review notes that continued research is needed to address the extremely important but often overlooked issue of trauma experienced by people with serious mental illnesses (Grubaugh, Zinzow, Paul, Egede & Frueh, 2011).

With respect to psychological treatments for children and adolescents with PTSD, a recent review found that all psychological treatments studied were effective at helping those in this age group recover. CBT was found to be particularly effective (Gillies, Taylor, Gray, O’Brien, & D’Abrew, 2012).

Elements common to many treatment modalities for PTSD include education, exposure, exploration of feelings and beliefs, and coping-skills training. CBT is common to many of
the treatment paradigms. Components of these paradigms are listed in the excerpt below, taken from the website of the U.S. National Center for PTSD:

Cognitive-behavioral therapy (CBT) involves working with cognitions to change emotions, thoughts, and behaviors. Exposure therapy is one form of CBT that is unique to trauma treatment. It uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma. In some cases, trauma memories or reminders can be confronted all at once (“flooding”). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time (“desensitization”) (www.ncptsd.va.gov).

Along with exposure, CBT for trauma includes:

- Learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts (cognitive restructuring)
- Managing anger
- Preparing for stress reactions (stress inoculation)
- Handling future trauma symptoms
- Addressing urges to use alcohol or drugs when trauma symptoms occur (relapse prevention), and
- Communicating and relating effectively with people (social skills or marital therapy).

Alcohol and drug abuse commonly occur with PTSD because of the numbing effect of the drugs and their ability to help the person escape from the high levels of anxiety experienced. It is important to treat the substance use disorder along with the trauma disorder. Given the high co-morbidity of substance use disorders among those with mental health disorders and the prevalence of exposure to violence, abuse, and other traumatic experiences, concurrent treatment for these conditions can be critical. A manualized program not developed for people with serious mental illnesses but developed specifically for co-occurring substance abuse disorders and PTSD is called Seeking Safety. Seeking Safety is a CBT based program that has been found to be effective for a range of individuals with PTSD (Najavits, 2006; Najavits & Hien, 2013); a version of this program adapted for women who have experienced severe trauma is also available.

Pharmacotherapy is often also an important component of treatment and can reduce the anxiety, depression, and insomnia often experienced with trauma reactions and PTSD, making it possible for individuals to participate in treatment. Additional information can
be obtained from a SAMHSA webinar, available at

Smoking Cessation

The reasons why so many people with serious mental illnesses smoke and find it so difficult
to quit are only now beginning to emerge. The importance and urgency of helping people
stop smoking has recently been well stated by Schroeder and Morris:

Tobacco use exerts a huge toll on persons with mental illnesses and substance
abuse disorders, accounting for 200,000 of the annual 443,000 annual tobacco-
related deaths in the United States. Persons with chronic mental illness die 25
years earlier than the general population does, and smoking is the major
contributor to that premature mortality. This population consumes 44% of all
cigarettes, reflecting very high prevalence rates plus heavy smoking by users. The
pattern reflects a combination of biological, psychosocial, cultural, and tobacco
industry–related factors. Although provider and patient perspectives are
changing, smoking has been a historically accepted part of behavioral health
settings. Additional harm results from the economic burden imposed by
purchasing cigarettes and enduring the stigma attached to smoking. Tailored
treatment for this population involves standard cessation treatments including
counseling, medications, and telephone quitlines. Further progress depends on
clinician and patient education, expanded access to treatment, and the resolution
of existing knowledge gaps (Schroeder & Morris, 2010).

Smoking rates may be as high as 80 – 90 percent among people with serious mental
illnesses compared to prevalence rates of 20 – 30 percent in the general population
(Department of Family and Community Medicine, 2000). Many of those with serious
mental illnesses are very poor, and cigarettes consume a large proportion of their
discretionary spending. An additional factor is that it is harder to achieve community
integration when also experiencing stigma related to tobacco use (Schroeder & Morris,
2010).

Research indicates that several factors are common to successful smoking cessation
programs. These include:

- Advice to quit given by a physician
- Nicotine pharmacotherapy (both over the counter and by prescription)
- Counselling that is both long term and intensive, and
- A supportive public health environment and approach (World Health Organization,
  2003).
Other interventions have also been found to be useful including hypnosis, and telephone quitlines, and these can be considered to be adjunct interventions to those that have the most research evidence behind them. Recent research has found that in addition to the factors above, social support from friends and family and smoking cessation programming that is relevant and easily accessible to people with serious mental illnesses can help them quit smoking (Dickerson, Bennett, Dixon, Burke, Vaughan, et al., 2011).

Due to the very real and serious health consequences of smoking, interventions to help people with serious mental illnesses stop smoking should be a high priority in all systems of mental health care. Additional information about the health issues and difficulties people with serious mental illnesses have when trying to quit smoking can be found in the Health Disparities module of this curriculum.

Health Education

Because symptoms of mental illness often begin in adolescence, many young people have not learned skills needed for successful independent living. These include skills for staying healthy and safe, especially when it comes to avoiding risky sexual encounters and behaviors.

Emerging evidence suggests that young people with serious mental illness are at greater risk of contracting sexually transmitted diseases than their non-ill peers and that these young people have greater needs for preventive interventions (Brown, Lubman & Paxton, 2011).

Over the past two decades, the international community has reiterated calls for integrating and strengthening linkages between sexual and reproductive health services, and strategies and services for prevention and treatment of HIV/AIDS. Individuals with serious mental illness are often the most vulnerable to sexual exploitation and abuse, and the least likely to have information needed to protect themselves. Women with serious mental illness are recognized as the most vulnerable of all, but both men and women need the tools to lead safe, healthy, and productive lives in the community.

While some of this information would be expected to be covered in skills training programs (e.g., communication skills related to making friends, learning how to initiate or refuse intimate encounters, etc.), information about safe sex, HIV/AIDS and other STDs, information about the risks of drug injection and about safe injection practices, and other more general health information, is appropriately provided by a broadly trained health professional and should be provided to individuals who are at risk of engaging in unhealthy behaviors. An indication of the universal acceptance of the importance of providing comprehensive health information comes from the United Nations, whose Task Force on Child Health and Maternal Health of the UN Millennium Project stated:

Universal access to sexual and reproductive health information and services would have far-reaching effects for both ... maternal health and child health goals and for
virtually every other goal, including those for HIV/AIDS, gender, education, environment, hunger and income poverty (United Nations, 2005).

Clubhouses, Drop-in Centers, and Recovery Education Centers

Other service models such as clubhouses, drop in centers, and recovery education centers have been developed, but until recently, there has been little research to support them. The clubhouse model was the first rehabilitation intervention developed and it began at Fountain House in New York in 1948. Integral to the model are daily activities that provide individuals the opportunity to participate in all of the work activities of the clubhouse itself, from administration to outreach, to hiring, training and evaluation of staff, and including research on the effectiveness of the clubhouse. Fountain House also originated the concept of transitional employment and broadened the concept to supported employment, the practice that was ultimately formalized into the EBP in use today. In the late 1950s, the model was broadened to include housing supports and case management services were added. In the late 1990s, evaluation and links to medical and substance abuse treatment services were added, thus offering the full range of interventions. Currently, a wide array of supportive services is provided, all aimed at helping individuals live as independently and productively as possible. The Fountain House model has been replicated in countries all over the world and an intensive training program is offered at several sites to organizations that are interested in starting a clubhouse. The core elements of the Fountain House model are those that research has consistently found to be necessary components of successful mental health treatment systems:

- Education for clients and families
- Skills training for work and community living
- Case management
- Medication management, and
- Clinical follow up.

Recently, research has begun to accumulate on the effects of Fountain House and the clubhouse model. These studies have found that where the clubhouse adheres to the Fountain House model, members are more successful in paid employment, have longer job tenure, and move on to employment that is less supported than do those who are similarly ill and in other parts of the mental health treatment system, but not part of a structured clubhouse (Macias, Rodican, Hargreaves, Jones, et al., 2006; McKay, Johnsen, Banks & Stein, 2006; Schonebaum, Boyd & Dudek, 2006).

The Fountain House model has been subjected to rigorous research focused on variables not directly linked to its activities. Initial results from studies of cost effectiveness have shown lowered costs due to reduced recidivism (Cowell, Pollio, North, et al., 2003; McKay, Yates & Johnsen, 2007), and studies of physical well-being have indicated wellness benefits.
as well (Pelletier, Ngyuen, Bradley, et al., 2005; Pernice-Duca, 2008; Schiff, Coleman & Miner, 2008).

It is important to note that, as with the other PSR practices, fidelity to the model that has been researched and shown to be effective, is critical to achieving outcomes for persons in recovery. For drop-in centers and clubhouses that do not adhere to the Fountain House model, this has not typically been the case as many of these have sprung up as well intentioned programs but with little regard for fidelity to the original model. As discussed in the previous module, fidelity to the researched model is important.

**Leisure Services**

People with serious mental illnesses often have difficulties accessing and enjoying social relationships and leisure activities. The reasons for this range from lack of skills to build and sustain friendships, to lack of knowledge about community resources, to social isolation and stigma associated with mental illnesses. Whatever the reasons, individuals are frequently isolated and do not participate in leisure and social pursuits, especially when these involve other people or group activities. Because of their broad ranging effects, many, if not most, of the interventions described above are effective in assisting individuals to achieve greater participation in leisure activities and to be successful in activities in the personal life domain. But, often specialized leisure programs are needed to help people become comfortable integrating into regular community social activities and learn how to access regular social and leisure programming in the community where they live.

In addition to acquiring social and leisure skills, leisure activities can play a key role in the restoration and maintenance of mental health. Leisure can be an essential means of developing self esteem, building confidence and making connections with other people. Some literature exists regarding the effects of interventions aimed specifically at assisting individuals to benefit from leisure activities and a sampling of this literature is presented below.

For more than a decade leisure scholars have suggested that leisure could help people cope with stress (Iwasaki & Mannell, 2000) and some have found that stressors negatively impact immediate adaptational outcomes such as coping effectiveness, coping satisfaction, stress reduction and longer-term outcomes including health and stress (Hutchinson, Loy, Kleiber & Dattilo, 2003). High levels of stress and depression have been found in homeless women (Banyard & Graham-Bermann, 1998) and leisure activities can be one component in assisting them to cope with these effects (Klitzing, 2003).

Moderate intensity exercise or even rest, which may be considered forms of leisure, have been shown to have reductions on measures of psychological distress including depression, confusion, fatigue, tension, and anger (Bartholomew, Morrison & Ciccolo, 2005). These effects have been found to extend to those with a diagnosis of schizophrenia (Torres-Carbajo, Olivares, Merino, Vazquez, et al., 2005). Additionally, when therapeutic recreation was included as part of a social learning program, therapeutic recreation was found to
increase appropriate behaviors over time for residents with severe and persistent schizophrenia (Pestle, Card & Menditto, 1998). Leisure programs designed to increase knowledge and skills, and build confidence are an important part of the PSR armamentarium of services.

**Personal Life/Daily Living Skills**

Because symptoms of serious mental illness often appear during a young person’s transition to adulthood, skills needed for successful community integration are frequently not learned. Services that focus on helping people manage aspects essential to daily living are important and include personal care or self management, nutrition, physical health and safety, budgeting and finance, housekeeping, transportation, coping with stress, relationships, and the use of community resources.

Many of the skills useful for the above activities can be learned as part of the practices described in earlier sections of this module or in the previous Interventions modules. For example, skills training, an EBP covered in Interventions II, can be very broad and encompass training in any skill area needed by the individual. Programs in medication management and weight management (also covered in the second Interventions module) encompass several of the identified skills. Others such as building and maintaining relationships, are most often facilitated by peers and programs in family psychoeducation and skills training (see Interventions II). However, if the skill sets needed for successful management of one’s life are not included in other programs, service systems must develop programs to ensure that people who need essential skills for successful participation in community life receive such training and become proficient at using these skills.

**Challenges**

There are two principal challenges related to provision of the interventions presented in this module. The first is that while both the promising practices and the supporting services make intuitive sense, there is yet not sufficient research evidence that can be used to persuade often reluctant administrators that they will help people achieve their desired outcomes. The second is that many mental health systems either do not have, or are unwilling to allocate, the required resources to adequately fund the full range of PSR interventions. Many mental health advocates believe that all should be available to people who need them.

Two striking examples are the need for smoking cessation and weight management programs. Despite the fact that smoking and weight gain are linked to several life threatening illnesses, many mental health systems do not provide the PSR components of the programs, instead offering only limited guidance or medication interventions. For people with serious mental illnesses this is particularly unhelpful because of the recently discovered neurobiologic links between tobacco use, schizophrenia, depression, and psychotropic medications (Dani & Harris, 2005; Williams & Ziedonis, 2004). Quitting
smoking for people with serious mental illnesses is very challenging and without specialized support, can be extremely difficult. Yet, programs that provide strong support coupled with medical interventions to quit smoking are not prevalent. Likewise, many anti-psychotic medications induce weight gain, very often leading to metabolic syndrome, a life threatening condition. Yet, like smoking cessation, many mental health systems do not provide early intervention aimed at helping avoid weight gain and all too often, do not provide intense weight management and follow up services.

Provision of the full range of PSR interventions requires a strong commitment to allocating sufficient resources for adequate and appropriately trained staff and a commitment to maintaining the interventions over the long term. This can be difficult for many mental health systems which are often under-resourced and may not have the capability to provide the services even if they very much want to.

Summary

In addition to the underlying values and principles that are a pre-requisite for provision of any PSR service discussed in the first Interventions module, and to the EBPs discussed in the second Interventions module, there are a range of promising or emerging practices and supporting services that are generally regarded as highly useful for assisting people recover from the effects of serious mental illness and achieve their full functional capability. While these do not yet have sufficient evidence to consider them as EBPs, many practitioners and most consumers believe they are an essential component of a good recovery oriented mental health system.

All of the PSR interventions discussed in the Interventions modules, including those presented in this one, require adequate staff that are appropriately trained. They also generally require a commitment to continuing the intervention for considerable lengths of time (often 9 months or more, or for as long as the person needs the service) and these requirements are resource intensive. Many mental health systems either do not have sufficient funding to provide them or are unwilling to allocate adequate resources to provide them properly. This is a significant challenge for psychologists and other practitioners who want to offer the full armamentarium of PSR services and do so with the greatest possibility of success for people with serious mental illnesses.
Sample Learning Activity

There are two parts to this exercise. For the first part, the large group is to be divided into two groups. Each group is to choose the one intervention from the promising practices and supporting services that the group believes to be the most valuable. Both groups cannot choose the same intervention. Each group is to make a comprehensive list of the components of the practice and determine how each of the components would be implemented in practice. This information will be used in the second part of the exercise.

For the second part of the exercise, a role play is to be devised by each group using the participants to play out how each of the components of the practice would look. The full group is then reconvened. One person is to play the part of a consumer who will comment at the end on how he or she felt about the intervention, its components, how impactful it would be, and how it could be made more helpful to his or her recovery. The full group is to discuss each of the role plays.
### Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Following are false statements and not a reason(s) for providing gender specific trauma services:</td>
<td></td>
</tr>
<tr>
<td>a) men often have difficulty expressing emotion and need separate services to help them deal with their feelings</td>
<td></td>
</tr>
<tr>
<td>b) women frequently have child care responsibilities that necessitate service provision at times that are outside regular working hours</td>
<td></td>
</tr>
<tr>
<td>c) the neurobiologic mechanisms of men and women are different due to differing hormonal levels and their ability to process information can be affected in emotionally laden situations</td>
<td></td>
</tr>
<tr>
<td>d) all of the above</td>
<td>d is correct</td>
</tr>
<tr>
<td>e) a and b above</td>
<td></td>
</tr>
<tr>
<td>f) none of the above</td>
<td></td>
</tr>
<tr>
<td>2. The slogan “Housing First” means:</td>
<td></td>
</tr>
<tr>
<td>a) stable housing should be offered to everyone with a serious mental illness before assessments are completed and before medications and other interventions are considered</td>
<td></td>
</tr>
<tr>
<td>b) people with lived experience consider housing to be the most important service of any that are available and the one they would choose above all others</td>
<td></td>
</tr>
<tr>
<td>c) both of the above</td>
<td>d is correct</td>
</tr>
<tr>
<td>d) neither of the above</td>
<td></td>
</tr>
<tr>
<td>3. A smoking cessation program should be provided as part of a comprehensive PSR service even though it may be available in Primary Care because:</td>
<td></td>
</tr>
<tr>
<td>a) neurobiologic interactions make it extremely difficult for people with schizophrenia and other serious mental illnesses to quit</td>
<td></td>
</tr>
<tr>
<td>b) the stigma people with serious mental illnesses experience may make it difficult to attend and be accepted by people without similar illnesses in a Primary Care clinic</td>
<td></td>
</tr>
<tr>
<td>c) because of the difficulty of quitting for people with serious mental illnesses, support from practitioners they are familiar with can be helpful</td>
<td></td>
</tr>
<tr>
<td>d) all of the above</td>
<td>d is correct</td>
</tr>
<tr>
<td>e) none of the above</td>
<td></td>
</tr>
</tbody>
</table>

4. Research on the efficacy of early psychosis intervention programs has
shown that the longer the delay in providing services after psychosis appears, the poorer the ultimate outcome  

5. People with lived experience of serious mental illnesses rarely value services they receive from their peers due to confidentiality issues and the lack of evidence supporting their efficacy
Lecture Notes Citations


interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry, 77*, 3, 350–361.


**Additional Resources**

Citing the Curriculum

Citation for this Module:

Citation for the full Curriculum:

For additional information, contact:
Recovery to Practice initiative at the American Psychological Association, [www.apa.org/pi/rtp](http://www.apa.org/pi/rtp)
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