

March 2005

Show Me The Evidence!

Best practices, evidence-based practices, empirically-supported practices, promising practices, etc.

A myriad of terms are being used to describe those practices the field of mental health has determined are the most useful. Do these terms mean different things or are they just different ways of describing the same criteria for identifying which practices work best?

“Best practices” have been around for a long time and the term is usually used to designate a group of practices that an expert group has agreed represent the procedures that are most in agreement with professional consensus as to how practices should proceed. Best practices do not ordinarily focus on outcome results as the sole criterion for determining which practices to recommend. Instead, many process variables, such as being culturally sensitive, inclusive of diverse groups, meeting ethical criteria, etc. are included in qualifying as a best practice. As an example, the Association for Specialists in Group Work (ASGW) include practices related to planning, collaboration, ethics, evaluation, training and several other areas without ever citing any particular outcome results as indicating efficacy for their recommendations.

The American Psychological Association Division of Clinical Psychology has gone from using the term “empirically-validated” therapies to using the term, “empirically supported” therapies in response to criticism that their criteria did not constitute validation and, since new studies could lead to different conclusions about a therapy, it could be supported, but never truly validated. Meanwhile, in psychotherapy, mental health as a broader field, and medicine in general, the term “evidence-based” has caught on. In medicine, evidence-based has come to signify a style of practice that bases clinical decisions on the best available empirical evidence and which teaches clinicians how to find and evaluate such evidence and relate it to their clinical practice.

“Promising practices” are used by a number of national agencies and organizations (e.g. Centers for Effective Collaboration and Practice, Centers for Medicare and Medicaid Services) to identify practices that have empirical support in terms of positive outcomes, but do not necessarily meet strict criteria (e.g. controlled randomized studies) for the evidence-based designation (though some do) or to identify practices that are innovative and have some support for their efficacy. Criteria for promising practices differ widely, depending upon the agency listing them and do not necessarily include strong empirical support.

The bottom line with regard to the terms used to designate evidence-based practices is that the consumer needs to read with care the criteria used to designate programs and not assume that they are so designated because of empirical evidence that they work.

QRTips

This section provides monthly critical reminders in relation to documentation standards.

1) PROGRESS NOTES

The following examples are activities that **cannot** be billed to Medi-Cal:

- a) “13 yr old Hispanic male diagnosed with Dysthymia. His symptoms include sadness, withdrawal and suicidal thoughts. Received phone call from clt’s father informing this clinician that he would be canceling today’s collateral appt. Clt’s father reported that his son had a crisis, has been hospitalized and he wants to visit his son while in the hospital. Talked to father about the incident that led up to the hospitalization. Validated clt’s father’s feelings of helplessness and sadness. Assessed clt’s father’s current state of mind. Clt’s father reported that he wants to come to his session but will wait until next week’s appt. Will meet with client’s father next week for collateral session. **This is clearly a service that cannot be billed to Medi-Cal. The note indicates that the client is currently hospitalized. Medi-Cal cannot be billed for any kind of services while the consumer is hospitalized except for that which specifically and clearly documents discharge planning (within the last 30 days).**
- b) “Met for an assessment session with this 15 yr. old Caucasian female with the Provisional Diagnosis of 995.52. Client presents with no symptoms at this time. Plan is to continue to meet with client to complete assessment” **This is clearly a service provided for a consumer with no medical necessity. Medi-Cal billing requires medical necessity. A NOA-A (Notice of Action-A must be given).**
- c.) **Travel time cannot be billed for travel between provider sites or from a staff member’s residence to a provider site. A “provider site” is defined as a site with a provider number, including affiliated satellite and school site operations.** For example: “Clinician drove from CYS Mission Viejo to CYS Costa Mesa to co-lead a group/to meet with clt’s MD/or to meet with clt’s mother for a collateral session.....”. **The clinician in this example cannot bill travel time to Medi-Cal. At this time (subject to change) the travel time needs to be documented as “case mgmt-no fee” on a separate note/ED.**

Your Culture and Mine: A Monthly Column About Culture and Mental Health

Consumer Involvement

Consumer involvement in the provision of mental health services is a recent focus of many mental health efforts, though many professionals are unsure just what this means. In fact the whole shift from referring to those who receive mental health services as first, patients, then clients and now consumers reflects an emphasis upon a less paternalistic approach to providing services and an increase in recognition of both the dignity of recipients of services and their rights as consumers of those services. Most recently the focus has been on the benefits that accrue from viewing consumers as the possessors of expertise as both persons or families of persons with mental illness and as persons who have navigated the mental health system.

From the perspective of viewing consumers as experts, the following roles have been occupied by consumers in various mental health systems: board members, advisors, quality reviewers, liaison to community groups, administrative staff, and consumer recruitment specialists. In these roles, consumers have been involved in activities such as the review and design of written materials for consumers, designing of outreach strategies, training of clinical staff, identifying barriers within the system, and carrying out quality improvement projects.

What about a more direct role for consumers as service providers? According to the 1999 Surgeon General's Report on Mental Health, consumers have run services "such as drop-in centers, case management programs, outreach programs, businesses, employment and housing programs, and crisis services, among others." Consumers have also been employed as peer counselors and job coaches. Evaluation of the outcome of using consumers versus professional, non-consumer staff as case managers in Assertive Community Treatment with adults found no differences between the two groups. Within the child mental health field, The Incredible Years program has successfully incorporated parent graduates of their parent training program as co-leaders with professionals of parent groups. The 1999 Surgeon General's report goes on to say that, "the rationale for consumer roles in service delivery is that consumer staff, clients, and the mental health system can benefit. Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders. Clients are thought to gain from being served by staff who are more empathic and more capable of engaging them in mental health services."

Our current focus in mental health is to recognize that the consumer (and in the case of children, this includes the family) needs to be in a collaborative position with regard to assessing problems and impairment, choosing goals, and designing interventions in their own case. Much recent thinking also suggests that consumers can take a more active role in all aspects of the provision of mental health care to the community.

Spousal and Partner Abuse

Presenter: Roseanne Kotzer, M.S.W. Children and Youth Services
Date: March 03, 2005
Time: 9: 00 a.m. – 5:00 p.m.
Place: 10 Civic Center Dr., Santa Ana **Planning Room**

Beginning January 1, 2004, state law mandated training in spousal and partner abuse in order for psychologists, MFTs and LCSWs to renew their licenses. This seven-hour course meets this requirement and will cover detection, assessment, and treatment as well as risk factors, cultural factors and causes of abuse. The presenter, Roseanne Kotzer, MSW, is an experienced clinician and teacher in this area.

Objectives:

1. To become aware of risk factors, cultural factors and signs in the detection of spousal and partner abuse
2. To be able to assess the likelihood of spousal or partner abuse
3. To learn about the treatment options for abusers and victims
4. To learn what to do when faced with an instance of partner or spousal abuse

Target audience: Mental health professionals

7 CE credits applied for Psychologists, LCSW's and MFT's

Acculturation and Ethnic Identity Development

Presenter: Alfonso Bustamante, Psy.D., CHOC, Santiago Canyon College
Time: March 15, 2005 8:30 a.m.-12:30 p.m.
Place: 744 N. Eckhoff, Orange Ca Auditorium

This course will explore the manner and extent to which ethnic, racial, and class membership bears upon the work of the psychotherapist. It will enable the attendee to identify, understand, and critically review major acculturation and ethnic identity models and extrapolate as to how these theories might affect one's knowledge and understanding of individual diversity

Target Audience: Licensed and pre-licensed mental health clinicians

Attendees will accomplish the following objectives:

1. Identify major acculturation and ethnic identity models
2. Identify how ethnicity, culture, gender, social class, religion, sexual orientation and age can be barriers to effective psychotherapy
3. Demonstrate increased sensitivity of one's own culture, ethnicity, etc. and how that might impact countertransference toward the client.

4 CE credits applied for Psychologists, LCSW's and MFT's.

Treating Substance Abusing Family Environments

Presenter: Gary Lawson, Ph.D. Alliant International University
Time: March 16, 2005 9:00 a.m.-1:00 p.m.
Place: 744 N. Eckhoff, Orange Ca Auditorium

Alcoholism and other substance abuse is not only devastating to the abuser, it has negative effects on family members. There are many unanswered questions in the field of substance abuse treatment, but we know one thing for certain: Substance abuse is a multigenerational family problem. Although there is a biological component to this transmission, the important focus for therapists, presented in this workshop, is the environmental components that promote and maintain substance abuse and the family. These will be discussed in relation to treatment and prevention and the role of the therapist. The presenter, Dr. Gary Lawson is co-author, with his wife, Ann of Alcoholism and the Family: A Guide to Treatment and Prevention (Aspen, 1998), and Adolescent Substance Abuse: Etiology, Treatment, and Prevention (Aspen,1992).

Objectives: At the end of this workshop, attendees will be able to

- 1) Describe recent research on families and substance abuse
- 2) Describe clinical techniques related to treating families with substance abuse problems.

Target Audience: Mental health professionals who work with children and families

4 CE credits will be available for Psychologists, LCSWs and MFTs

IMPORTANT!

All CYS and Contract Agency Staff

TAKE THE CO- OCCURRING DISORDERS SURVEY

Click on the following url or copy it into your web address box. This is a survey to help us determine the level of knowledge and training needs in the area of co-occurring mental health and substance abuse disorders. The survey is anonymous, but when you are done, please print your results before submitting them so you can compare them to the answer sheet that will appear after you submit your responses. You may use these results to determine your own training needs and we will use them to design further trainings in co-occurring disorders.

Thank You,
QRT Staff

Click on the url below or type it into your web address box on your computer

www.ohealthinfo.com/behavioral/cod_survey/

PLEASE REMEMBER TO CALL AND CANCEL IF YOU HAVE SIGNED UP FOR A WORKSHOP AND YOU ARE UNABLE TO ATTEND. NO PHONE SIGNUP PLEASE!!

❖ Introducing- The Quality Review and Training Team

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All staff may be reached via county email as well.

The County of Orange Health Care Agency is an approved provider of continuing education credits for the California Board of Behavioral Sciences (provider no. PCE389). OCHCA is approved by the American Psychological Association to offer Continuing Education for psychologists. The OCHCA maintains responsibility for the programs.