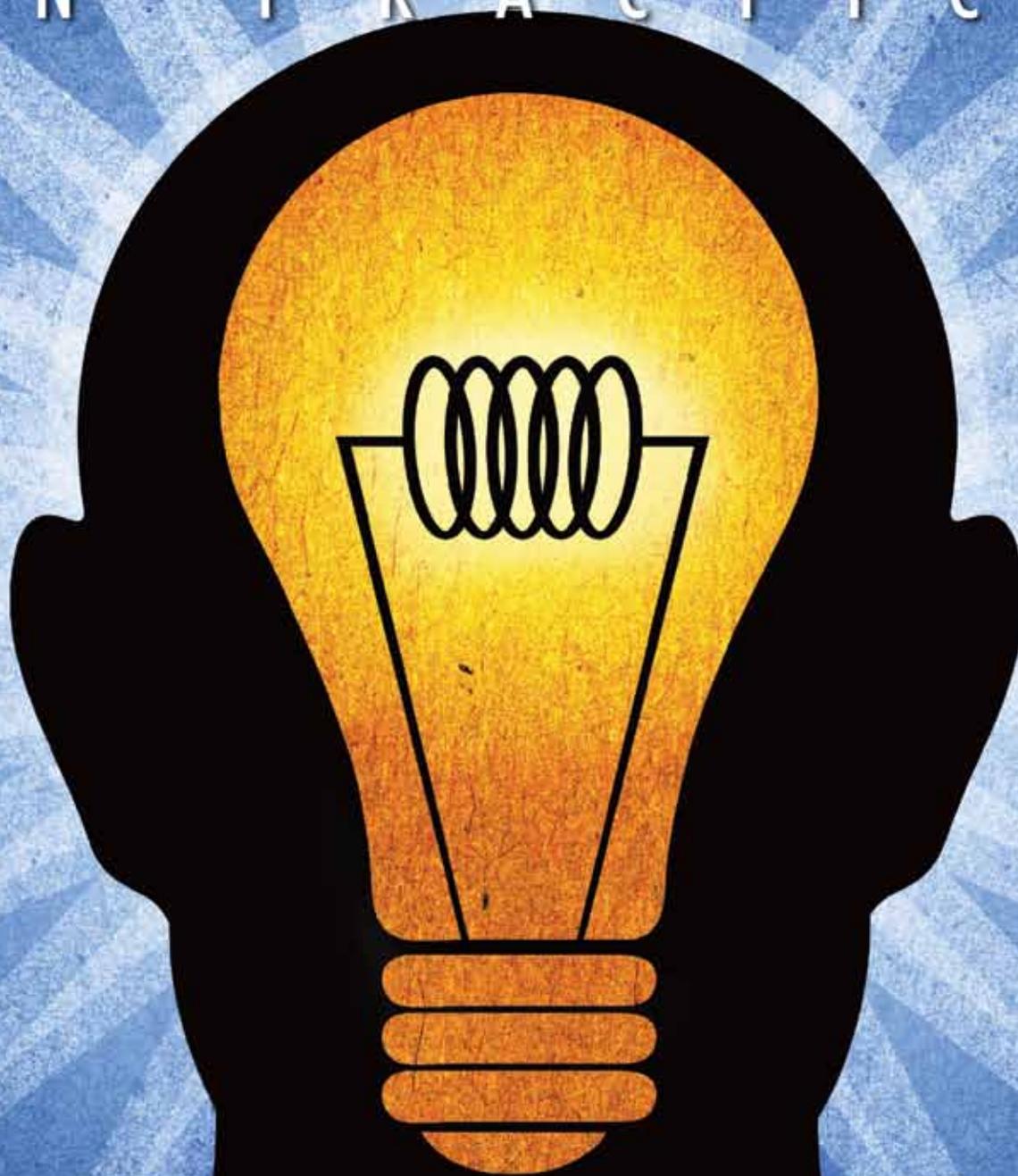a Misssissippi Department of Mental Health Newsletter

INNOVATIONS
IN PRACTICE

SUMMER 2012

Supporting a Better Tomorrow...Today

DMH

Using Evidence Based Programs for Alcohol and Substance Abuse Prevention and Treatment

BY STEPHANIE SMITH, DEPARTMENT OF MENTAL HEALTH, BUREAU OF ALCOHOL AND DRUG SERVICES

In the last decade, there has been immense pressure from funding agencies and federal, state and local governments for greater effectiveness and accountability of prevention and intervention programs. This mounting demand for program quality, and evidence of that quality, ignited a growing interest and improvements to evidence-based programs (EBPs).

Evidence-based practices refers to applying the best available research evidence in the provision of health, behavior, and educational services to enhance outcomes. As a result of rigorous data gathering and evaluation, evidence based programs have been proven to be effective in delivering desired behavior modifications. Evidence- based programs allude to organized and typically multi-component interventions with clearly identified linkage between core components and predicted outcomes for a distinguished target population and customary organizational supports for implementation.

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The Department of Mental Health Bureau of Alcohol and Drug Services (BADS) recognizes NREPP as a resource for providing valid programming to those seeking to implement evidence-based practices into their communities.

The purpose of this registry is to assist the public in identifying scientifically-based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field. NREPP is one way the Substance Abuse and Mental Health Services Administration (SAMHSA) is working to improve access to information on tested interventions, thereby reducing the lag time between the creation of scientific knowledge and its practical application in the field.

The Bureau of Alcohol and Drug Services promotes the highest standards of practice and the continuing development of evidence-based practices tailored to substance abuse prevention and treatment. Through the use of the State Prevention Enhance-ment grant that facilitates the infusion of the Strategic Prevention Framework model into every facet of state and community programming, BADS requires all organizations it certifies to dedicate at least 20% of their time to providing evidence based prevention programming. According to current dialogue between the federal government and BADS, the percentage for EBP's in the state of Mississippi is expected to increase. Presently BADS funds 29 programs in the state of Mississippi to which the prevention services are responsible for providing the required EBP hours. The 20% requirement is measured using a tool known as Data Gadget, which is a valuable online data resource that permits the state of Mississippi to track the activities associated with all the prevention programs it funds. Data Gadget allows programs to capture a broad set of outcome data that can be used to determine the effectiveness and impact of their programs. A primary focus of BADS is to emphasize the importance of integrating evidenced-based practices and data-driven decision making into alcohol and substance abuse prevention and treatment programs across the state of Mississippi.

EBP's implemented in Mississippi for tobacco and substance abuse prevention & treatment:

PROGRAM	PRIMARY FOCUS	SETTING	OUTCOMES
Life Skills Training	Prevention of substance use and violence	School-based	Reduction of use Increased knowledge Improved drug refusal skills
Matrix Model	Treatment	Outpatient	Treatment retention; Treatment completion; Drug use during treatment
Class Action/Project Northland	Prevention of substance use	School-based	Decreased likelihood of alcohol use; Decreased binge drinking
Living in Balance (LIB)	Treatment	Outpatient	Treatment retention; Treatment exposure; Regular cocaine use; Regular alcohol use; Regular use of other drugs; Illegal activities; Drug sales
Project ALERT	Prevention of substance use	School-based	Decreased likelihood of substance use; Behavior change, attitude, resistance and skill building

Where can I find evidence-based programs?

SOURCE	SPONSOR	HEALTH TOPIC/ RISK BEHAVIOR ADDRESSED
National Registry of Evidence-Based Programs and Practices www.nrepp.samhsa.gov/	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services	Alcohol/tobacco; juvenile justice; environmental strategies; HIV/AIDS; homelessness; aging; suicide/violence
Exemplary and Promising: Safe, Disciplined, and Drug-Free Schools www.ed.gov/admins/lead/safety/exelkmplary01/report_pg3.html	Office of Safe and Drug Free Schools, U.S. Department of Education	Alcohol/tobacco/drug/violence prevention, building social competencies
Guide to Effective Programs for Children and Youth http://childtrends.org/lifecourse/programs_ages.htm	Child Trends	Education/cognitive development; social/emotional/mental health; life skills; teen pregnancy/reproductive health
ETR Associates http://pub.etr.org/pages.aspx?docid=135	ETR Associates	Pregnancy/HIV/STI prevention, tobacco/drug abuse prevention
Diffusion of Effective Behavioral Interventions www.effectiveinterventions.org/	Centers for Disease Control and Prevention, Center on AIDS and Community Health	HIV/STD prevention, substance abuse Prevention
The Community Guide to Preventive Services www.thecommunityguide.org/index.html	Centers for Disease Control and Prevention, U.S. Department of Health and Human Services	Adolescent health; alcohol; asthma; birth defects; cancer; diabetes, HIV/AIDS/pregnancy prevention; mental health; motor vehicle; obesity; oral health; physical activity; social environment; tobacco; vaccines; violence; workplace

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1. National Registry of Evidence-Based Programs and Practices. www.nrepp.samhsa.gov/
2. A Guide To Evidence-Based Practices (EBP) on The Web. The Substance Abuse and Health Services Administration. http://www.samhsa.gov/ebpwebguide/

3. Miller, W. R, Sorensen, J., Selzer, J.A., Brigham, G.S. Disseminating evidence-based practices in substance abuse treatment:
A review with suggestions. Journal of Substance Abuse Treatment, Volume 31 (2007) page

Evidenced Based and Best Practice Models at the Specialized Treatment Facility

BY STACY MILLER, STF FACILITY DIRECTOR

The Specialized Treatment Facility is the Department of Mental Health's only residential mental health facility for youth. Clinical programming at the STF is based on evidence-based and best practices in the mental health field. It is well known that mental health facilities must be accredited and certified to ensure that a high standard of care is provided. However, in these dire times, public funds such as Medicaid are in higher demand and there is a higher expectation for scientifically-proven care.

Realizing that it will eventually be required that all mental health programs use evidence-based and best practices in order to become reimbursed and to guarantee quality care provided, the STF began early on to implement evidence-based and best-practice treatment. The service models at the STF focus on care for traumatized youth who may also be in need of alcohol and drug treatment.

Evidence-Based and Best Practices used at the STF:

• The Mandt System (implemented July, 2008)
• Trauma Focused-Cognitive Behavior Therapy (implemented November, 2008)
• Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (implemented February, 2010)
• The Matrix Model for Teens (implemented March, 2010)

The Mandt System
The Mandt System was implemented in July, 2008 as the behavioral intervention model to de-escalate and, if necessary, restrain aggressive residents. The Mandt System changes the way people relate to each other having a profound and lasting impact on all aspects of service delivery. The people served in organizations breathe the relational exhaust of staff-to-staff interactions. When the relation-

ships staff members have with each other are negative, the air residents breathe is toxic and this has a negative effect on their behavior. When the relationships between staff change, the entire environment is changed in healthy, positive ways. STF tracks and trends data to work towards a seclusion and restraint-free environment. Preliminary data does support that since the implementation of The Mandt System, interventions have decreased and have resulted in fewer injuries to staff and youth. STF benchmarks data against the National Association of State Mental Health Program Directors Research Institute, Inc.

Trauma Focused-Cognitive Behavior Therapy (TF-CBT)
The TF-CBT was implemented in November, 2008 as an individual and family therapy model. TF-CBT is a psychosocial treatment model designed to treat post-traumatic stress and related emotional and behavioral

problems in children and adolescents. According to SAMHSA's National Registry of Evidence-based Programs and Practices, TF-CBT outcomes include: 1) fewer behavior problems, 2) fewer symptoms of post-traumatic stress disorder (PTSD), 3) less depression, 3) fewer feelings of shame, and 4) an improvement of the parental emotional reaction to a child's experience of sexual abuse. TF-CBT outcomes indicate that the model decreases the severity of post-traumatic stress disorder symptoms for youth.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

The SPARCS was implemented in February, 2010 as a group therapy model. SPARCS is endorsed by The National Child Traumatic Stress Network (NTCSN). SPARCS was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning. Overall goals of the program are to help teens cope more effectively in the moment, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning. The NCTSN reports that pilot data indicates significant improvement in overall functioning with changes noted more specifically in level of behavioral dys-

function and interpersonal relationships. Improvements were also noted in interpersonal coping with a significant increase in support-seeking behavior. SPARCS outcomes indicate that the model decreases the severity of post-traumatic stress disorder symptoms for the resident.

The Matrix Model for Teens

The Matrix Model for Teens has been implemented since March, 2010 as STF's alcohol and drug prevention and treatment method. Although STF provides primary mental health services, it is necessary to recognize that statistics display that 80% of adolescents with a diagnosis of a mental illness also have a diagnosis of substance abuse. The Matrix Model for Teens and Young Adults, like the matrix model for adults, is a comprehensive, organized set of evidence-based therapeutic interventions. The Matrix Model for Teens and Young Adults consists of research-based techniques integrated into an approach that includes individual sessions, family sessions, group sessions, Twelve Step programs, and separate parent and adolescent substance-education groups. The complex social environment of the adolescent – including family, school, community, peers, and juvenile justice involvement – is an important consideration in developing appropriate treatment, as is the developmental stage of the adolescent. The model

recognizes that many teens entering treatment need programming that falls toward the middle of the prevention-treatment continuum. The material in the Matrix Model for Teens was selected, organized, and designed to be delivered while taking all of these issues into account.

The STF continues to track all clinical models to ensure that staff continue to implement the models as they were designed to ensure fidelity. Choosing, implementing, and ensuring fidelity of evidence-based and best practice models is important to mental health programs. Minimal resources will only be awarded to programs that can prove they are doing some good for not only youth, but to all ages of citizens in need of public programs. For a listing of evidence-based mental health models, view the SAMHSA National Registry at http://nrepp.samhsa.gov/

References:
1. http://www.mandtsystem.com/

2. Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices http://nrepp.samhsa.gov/ViewIntervention.aspx?id=135

3. National Child Traumatic Stress Network. http://www.nctsn.org/

4. Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices. http://nrepp.samhsa.gov/ViewIntervention.aspx?id=87

Social Skills Training: An Evidence-Based, Recovery-Oriented Intervention at MSH

WRITTEN BY KATHERINE MURPHY-PENRY, MSH PSYCHOLOGY RESIDENT, DOCTORAL CANDIDATE IN CLINICAL PSYCHOLOGY

Several articles from the last Innovations newsletter referenced Evidence Based Practices (EBPs) as the gold standard for mental health practice. This is especially true when the EBPs fall in line with the highly regarded standards of the Recovery Model.

In the APA Endorsement of the Concept of Recovery (2009), recovery is described as, "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as

one grows beyond the catastrophic effects of mental illness."

Quite a bit of effort has been directed toward defining or standardizing the concept of "recovery" and its core components. Much like EBPs, recovery-oriented interventions share several standards that are essential to its classification. Recovery-oriented interventions should include and/or encourage peer support, respect, empowerment, hope, and personal responsibility. They should be person-centered, holistic, strengths-based, and non-linear.

Mississippi State Hospital (MSH), in its

steady movement to enhance consumer welfare, fulfillment, and growth, has begun implementing one such EBP on its female and male receiving units. Social Skills Training for Schizophrenia has met the demands of scientific rigor while improving important recovery outcomes such as social functioning, vocational functioning, self-care, independent living skills, and enjoyment of life. The method goes beyond symptom reduction to address the improvement of quality of life and functional recovery. It also seeks to meet the needs that consumers identify as unmet. These include intimacy, company, and coping with psychological distress. Along with their symptomology, individu-

als with schizophrenia often struggle with significant impairments in social role functioning that keep them from meaningful work, meaningful relationships, and most importantly, a meaningful and fulfilled life.

When considering the diagnostic criteria for schizophrenia, it is the prototypical symptoms – delusions and hallucinations – that usually come to mind. However, to actually know a person with the disease, to have the experience of being with an individual with schizophrenia, provides a very different perspective than can be obtained from mere review of the DSM-IV categories and criteria.

What often stands out is the struggle to communicate, the flat effect, the inexpressive facial posturing, and simply feeling alienated or disconnected from the individual. All of these things fall under the rubric of Social Skills, and it is these challenges that many people with schizophrenia report as their most significant obstacles in the pursuit of happiness. The recovery movement recognizes the importance of addressing individual life goals as well as the deficits caused by positive and negative symptomology. Although symptom reduction is crucial, the recovery model encourages us to advocate for the humanity, dignity, and relational needs of our patients.

In recognizing the importance of EBPs for teaching skills and competencies to enhance successful community integration and goal fulfillment, MSH has taken its cue from the Schizophrenia Patient Outcomes Research Team, or PORT. Funded by the Agency for Health Care Policy and Research and the National Institute of Mental Health, PORT (2009) is an intensive meta-analytic review of interventions with the most empirical support for the treatment of schizophrenia. PORT generated a list of 16 psychopharmacologic and 8 psychosocial treatments for schizophrenia. Skills Training is third on the PORT list of psychosocial recommendations, right behind Assertive Community Treatment and Supported Employment.

Specifically, PORT recommends that "individuals with schizophrenia who have deficits in skills that are needed for everyday activities should be offered skills training in order to improve social interactions, independent living, and other outcomes that have clear relevance to community functioning." According to PORT, these rehabilitation efforts should include several key elements:

Social Skills Training for Schizophrenia conforms to all of these guidelines. Drawing on the five principles derived from Bandura's Social Learning Theory (Modeling, Reinforcement, Shaping, Overlearning, and Generalization), MSH's newest EBP seeks to join with the consumer to build socially appropriate behavior that can help them achieve self-identified goals. It is very important that we give all group participants the opportunity to reinforce their strengths and set achievable, behavioral goals.

A key component of the process is the individual meeting with the client to determine his or her specific future goals, which then guide the curriculum. For example, a consumer may say that his or her primary goal for the group is to be able to effectively date. An attainable behavioral goal that is necessary for the achievement of the larger goal "dating" might be "expressing positive emotions." The latter behavioral goal is something that can be achieved through incremental scaffolding, modeling, and reinforcement.

After achieving the skill of expressing positive emotions, the group leader may focus on building other conversation or friendship skills, all with the hope of helping the consumer navigate future interpersonal encounters and celebrate successes. Enhanced self-efficacy and recognition of goal attainment are vital to us all, and their importance cannot be over-emphasized in work with individuals experiencing chronic, severe mental illness. Social Skills Training hopes to do its part to close this gap and provide a highly rewarding experience for group participants.

For those who may be unable to meet the fidelity requirements of this specific group method, the Surgeon General lists several suggestions for successful psychosocial intervention. In his most recent publication on the topic, he reminds us that "the most potent rehabilitation programs" establish direct, behavioral goals, are oriented to specific effects on related outcomes, focus on long-term interventions, occur within or close to clients' naturally preferred settings, and combine skills training with an array of social and environmental supports. Combined with the take away points from Social Skills Training for Schizophrenia and the values from the Recovery Model, the Surgeon General's suggestions provide a framework for efficacious interventions for those with severe and persistent mental illness.

MSH is committed to generating individu-

- Behaviorally-based instruction
- Role modeling
- Rehearsal
- Corrective feedback
- Positive reinforcement.

alized, evidence-based interventions that align with the recovery mode, and we are hopeful Social Skills Training will be a welcome and effective step in the right direction. For those interested in a more in-depth look at the details of Social Skills Training for Schizophrenia, there are some excellent resources on the Veteran Affairs website at www.mirecc.va.gov/visn5/training/social_skills.asp.

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http://www.surgeongeneral.gov/library/mentalhealth

For more information on The Recovery Model visit SAMHSA's website at smahsa.gov. The APA Task on Serious Mental Illness and Severe Emotional Disturbance has published a catalog of Best Practices for Recovery and Improved Outcomes on the APA website. It can be found at apa.org/practice/resources

Catholic Charities' Trauma Recovery for Youth Works with Mississippi Department of Mental Health

WRITTEN BY BEN GARROTT, COMMUNITY LIAISON, CATHOLIC CHARITIES OF JACKSON

More than one in four youth in Mississippi experience a traumatic event by the age of 16, and are at subsequent risk of developing child traumatic stress. This statistic alone underscores the importance of effective treatments for a population of children and adolescents who, left untreated, will experience problems with daily life that affect behavior, school performance, attention, self-perception, and emotional regulation.

The U.S. Department of Health and Human Services has identified Trauma-Focused Cognitive Behavioral Therapy as an effective treatment for child traumatic stress and Post-Traumatic Stress Disorder. HHS findings indicate that children aged 3 to 18 will experience significantly fewer intrusive thoughts and avoidance behaviors; be able to cope with trauma reminders and emotions associated with them; show a reduction in depression, anxiety, disassociation, behavior problems, sexualized behavior, and trauma-related shame; and demonstrate improved interpersonal trust and social competence following 12-16 sessions of 60-90 minutes each.

In 2001, The Donald J. Cohen National Child Traumatic Stress Initiative was established to improve access to care, treatment, and services for children and adolescents exposed to traumatic events and to encourage and promote collaboration between service providers in the field, through a series of grants totaling more than $30 million. Grants were awarded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Admin-istration (SAMSHA), and U.S. Department of Health & Human Services to create the National Child Traumatic Stress Network (NCTSN). Catholic Charities, Inc. of Jackson, Mississippi established the Trauma Recovery for Youth Project (TRY) as a member site of the NCTSN in 2003.

Since its inception in 2003, TRY has worked to institute a trauma-informed system of care—focusing on Community Mental Health Centers (CMHC's) and other providers serving youth and families who are underserved or are least likely to have access to quality, trauma-informed care. Working with the Mississippi Department of Mental Health (DMH), TRY has disseminated TF-CBT and an evidence-informed adolescent group model, known as Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), to Mississippi's CMHC's. TRY employs the Learning Collaborative Model, which enables participants to share and learn from their collective experiences while stressing fidelity to the treatment model by combining face-to-face learning sessions, monthly consultation calls, on-site clinical assignments, and monthly metrics tracking to ensure comfortable, effective uptake of TF-CBT and SPARCS over a year-long process.

Using this method, TRY has trained more than 200 Mississippi therapists in TF-CBT and/or SPARCS. Collectively, all sites receiving training comprise a coverage area encompassing 61 of Mississippi's 82 counties. TRY is offering TF-CBT training in the remaining 21 counties in 2012, focusing on the resource-strapped Mississippi Delta.

TRY's influence extends beyond Mississippi's borders. It is working closely on an advisory and training level with the National Children's Advocacy Center, including presenting at the 27th National Symposium on Child Abuse in Huntsville, Alabama. TRY's original mentoring relationship with Catholic Charities Hawaii has evolved into a TF-CBT Learning Collaborative, being conducted through September 2012 in Honolulu, Hawaii. As word of its expertise in trauma-informed services has spread across the country, TRY has negotiated with sites in Florida, Louisiana, North Carolina, and Texas to provide TF-CBT training at their sites as well.

In 2008, TRY merged with the Solomon Counseling Center (SCC) at Catholic Charities, Inc. of Jackson, MS (www.solomon-counselingcenter.org) to form an outpatient therapy clinic specializing in child trauma interventions. The Solomon Counseling Center has since established itself as a leader in treating child traumatic stress in the Jackson metro area, a claim supported by the number of local organizations that trust SCC as a referral for care following exposure to a traumatic event.

For more information about TRY, SCC, TF-CBT, SPARCS, and/or the Learning Collaborative Model, please contact Ben Garrott, Community Liaison, at 601-326-3774 or ben.garrott@ccjackson.org.

References:
www.hhs.gov

Friends By Any Other Name

BY JAMES L. DICKERSON, CASE MANAGER, HUDSPETH REGIONAL CENTER

What's a friend worth?

Plenty if you have an emergency—or simply need a shoulder to cry on.

If you are like most people, you probably take your friends for granted.

Imagine what a friend would be worth to someone who never had one.

That was the issue raised by an innovative new socialization program initially funded by a 2009 grant from the Mississippi Council on Developmental Disabilities and later taken over by Hudspeth Regional Center. Named "You've Got a Friend," the program recruits individuals with disabilities from the community to work with individuals with disabilities on the campus. The recruits are paid an hourly wage and given the title of Friendship Mentor.

Under the supervision of social workers, the mentors work with individuals with a wide range of disabilities. Some are sight and hearing impaired. Some use wheelchairs. Some experience behavioral difficulties. Others are nonverbal, autistic or suffer bouts of depression.

What all have in common is a history of social isolation. Many of the individuals selected for the program have never known friendship. Some have been in institutions for 20-30 years without ever having a single personal friend or family member as a visitor.

Also benefiting from the program are the Mentors, who learn practical employment skills as well as friendship skills that can be applied to their advantage in the community.

"You've Got a Friend' operates on the belief that peers can affect positive social change to a degree that is not possible in authority figure/client relationships. When it comes to an IDD population, individuals with disabilities do not see parents or mental health personnel as friends. Indeed, they often see them as authority figures that control—or at-

tempt to control—their behavior. As a result, parents and mental health personnel cannot influence the behavior of individuals with disabilities to the extent that peers can.

What we know about peer interaction that is non-evaluative and nondirective is that it can be beneficial by reducing an individual's physiological load. According to research studies, peer support promotes good health by reducing physical reactivity to stress, thus providing protection against a wide range of stress-related illnesses, including social contact and the common cold (Cohen, Doyle, Turner, Alper & Skoner, 2003), social contact and heart disease (Seeman & Syme, 1987) social contact and cancer (Fawzy et al, 1993), social contact and aggressive behavior (Zilboorg, 1938), and social contact and depression (Gotlib and Hammen, 1992).

However, it is in the area of depression that "You've Got a Friend" can have one of its most important and measurable impacts. Concludes Dr. Alton Barbour, a University of Denver professor (see references) who has done research in this area:

"Interpersonal difficulties" are a common correlate of depression in both youth and adults. If you are lacking friends or an intimate or both, it is easy to be depressed. If you don't have much social skill, it is understandable that you might be without friends or an intimate . . . it is sufficient to say that as these "interpersonal difficulties" increase in either number or intensity, depression also increases. There is a clear and direct relationship between one and the other.

One of the most interesting areas of IDD research in recent years has been on the association between increased socialization skills and success in the community, especially in the workplace. Interpersonal skill deficits, as opposed to disruptive or psychopathological behaviors, seem to be the most prevalent reason for termination of employment among individuals with intellectual and developmental disabilities (Greenspan & Shoultz, 1981). In fact, such individuals have been found to be more likely to be terminated from employment for social response de-

ficiencies than for nonsocial reasons such as production deficits or health problems (Greenspan & Shoultz, 1981). More recently, a study (P. Schloss & C. Schloss, 1984) concluded that interventions that promote social competence are more likely to have an impact on the "quality of life" of IDD individuals than traditional or vocational skill development efforts.

Research data is clear: Loneliness causes behavioral problems and diseases that require mental health consumers to be prescribed medications in ever-increasing dosages. The "You've Got a Friend" program is a behavioral intervention designed to slow—and eventually reverse—that insidious progression.

One of the surprising things learned during the first two years of the Friends program was that the population from which the Mentors were drawn is more closed than previously thought. Most of the Mentors brought in from the community reported having few close friends of their own. In some ways, they were even more socially isolated than the Friends they mentored. They had more opportunities for social interaction within their respective communities than their Friends, but those opportunities did not always yield beneficial results because of the stigma with which the communities viewed the Mentors and because of the difficulty they have making friends in a non-disability population.

One of the first HRC participants in the Friends program was a woman in her mid-fifties who was being treated for depression with Prozac. She seldom interacted with other residents and often fled from social situations by retreating to her room. Sometimes, when frustrated by the inability of others to understand her needs, she exhibited aggressive behavior that resulted in shoving encounters with other residents.

Once enrolled in the program she immediately established a rapport with her Mentor, who visited her twice weekly and accompanied her to music classes, various outings, a

sensory room, and trips to the cafeteria for snacks. The impact of the Friends program on this individual was in many ways predictable in that they followed the conclusions of various research projects that preceded the

- Six months into the program she was taken off Prozac.
- One year into the program she was taken off a special behavior modification program.
- Today she lives her life without psychotropic medications and behavior modification programs. She carries herself with new confidence and she seeks out resident friends, often choosing to eat with them in the dining room. Her eye contact is almost always strong.
- The quality of her life has been greatly enhanced by the Friends program.

creation of the program:

The same level of progress was reported by the Mentors in the Friends program. Job satisfaction surveys based on interviews disclosed that 83 percent said it was the best job they ever had. All but one said that they would like to return next year, with one individual saying she was not sure (a talk with family members disclosed that she works a second job that exhausts her).

When asked what they have learned working with their Friends, the Mentors' responses went to the heart of the program. They reported learning how to better talk to others, how to better speak their own mind, how to work with other people, and how to better talk with people in other places.

In summary, they are learning those skills that will most help them succeed in the community, especially in the workplace where communication is critical to holding a job over the long term.

Improving socialization skills, along with decreasing aggressive behaviors and boosting overall health, are commendable goals for any program that targets individuals with disabilities. But with the current focus on transitioning residents from institutions into the community, the program's potential value is heightened by a pressing need for new approaches to old problems.

James L. Dickerson is a case manager at Hudspeth Regional Center and author or co-author of 35 books, including four titles that focus on parenting issues.

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EVENTS BOX

August 15-17, 2012
13th Annual Conference on Alzheimer's Disease and Psychiatric Disorders in the Elderly
Whispering Woods Conference Center
Olive Branch, MS
Registration Link: www.regonline.com/msalzconference2012
Continuing Ed. Contact: DMH, Division of Professional Development 601.359.1288

Sept. 24-26, 2012 OR Dec. 4-6, 2012
Wraparound 101
Medicaid Office
Jackson, MS
Registration Contact: Jackie Chatmon 601.359.6216
Continuing Ed. Contact: DMH, Division of Professional Development 601.359.1288

October 24-26, 2012
Community Integration: Common Challenges, Common Goals, Common Ground
IP Hotel and Casino, Biloxi, MS
Contact Scott Sumrall at scott.sumrall@dmh.state.ms.us for more information

Changes and/or additions to educational opportunities may occur frequently. Please check the DMH website, Upcoming Events Calendar at www.dmh.state.ms.us for updated information. For questions about any of the events listed contact the DMH Office of Professional Development at 601-359-6246.

HOW TO SUBMIT

Submissions to Innovations in Practice should be emailed in a Microsoft Word format (.doc). To submit a story, please send it to Mardi Allen, Mardi.Allen@dmh.state.ms.us, for any editing that may be needed. Mississippi State Hospital Public Relations staff members are assisting in some editing and layout, but as this newsletter is clinical in nature, they will make only slight edits for spelling, grammar, or format. Accordingly, please make sure articles are proofread and ready for publishing upon submission. Please keep articles no more than 1,000 – 1,200 words.

Please do your best to include at least one photograph with each article. Remember that signed consent forms will be needed for any patients or clients in the photographs. Those are to be faxed to Adam Moore at 601-351-8364 before publication, and the senders should keep copies for their records as well. Authors are also encouraged to include a headshot with their submissions. All photos should be emailed as a .jpeg file and sent as a separate attachment. Do not embed any photographs in Word files, and please send them at their original, unedited size, which will be adjusted as needed for the layout.