Silver and Bronze Achievement Awards

Silver Award: Thresholds' Grais Apartments, Chicago, Illinois—Residential Treatment for Adults With Severe Mental Illness and Co-occurring Substance Use Disorders

Consumers with co-occurring disorders face an arduous process of dual recovery that involves controlling two disorders while simultaneously constructing a meaningful life. Relapse prevention therefore involves not only avoiding alcohol and drugs and taking medicines but also developing the strategies, skills, and supports needed to create a satisfying life without alcohol and drugs. Most consumers with co-occurring disorders need treatment as well as decent housing, new friendships with non–substance abusers, and a daily meaningful activity. Although research shows that outpatient dual diagnosis programs benefit many consumers, at least a third of consumers need something more intensive to achieve recovery.

Thresholds is a private nonprofit psychiatric rehabilitation center in Chicago that serves about 6,000 "members" each year at 25 service locations and 75 housing developments. In 1999 Thresholds opened a long-term residential program, Grais Apartments, to serve persons with severe mental illness and a co-occurring substance use disorder who have a history of homelessness. The Grais model applies principles of integrated dual disorders treatment, an evidence-based practice for persons with co-occurring disorders, to a long-term residential treatment setting. In the five years that Grais has been open, 107 persons have been served by the program.

In recognition of exemplary success in the provision of residential treatment for adults with severe mental illness and co-occurring substance use disorders, the Thresholds' Grais Apartments have been awarded one of APA's Silver Achievement Awards for 2004.

Grais Apartments is an innovative program model, combining both the goals of traditional residential programs (to decrease alcohol and drug use, maintain and stabilize symptoms of mental illness, increase self-esteem, and create more independence and a higher quality of life) and newer integrated treatment concepts (education, harm reduction, and motivation to change). A resident lives in his or her own furnished studio apartment with a full-sized kitchen and a private bathroom. The 44 apartments are housed in a renovated building in the Rogers Park neighborhood of Chicago. All the apartments are subsidized by the Department of Housing and Urban Development. Residents pay approximately one-third of their income to live in the apartments. In this supportive environment, residents have privacy, security, and safety while working on their recovery goals. And residents can stay at the apartments as long as they feel they need the program.

Relapse prevention activities, stagewise motivational approaches, and maintenance of a supportive milieu are the heart of the program. Intensive mental health and substance abuse services and support are offered 24 hours a day, seven days a week, by residential staff members who follow a case management approach similar to assertive community treatment. The staff-resident ratio at Grais Apartments is 1:5 (lower than the 1:10 ratio for an assertive community treatment program). Each staff member works a five-day workweek that covers one weekend day to ensure continuity of programming during the times of highest risk of relapse.

Group and individual services are offered daily, with an average of 20 to 24 groups per week and an average of two outreach visits per week for each resident by nonresidential case management staff. Both group and individual work focus on illness management, substance-related issues, social skills, and activities of daily living. Additional monitoring activities include assistance with money management, medication supervision, and random alcohol and drug use tests.

The program includes a psychiatrist, a registered nurse, and a vocational coordinator, in addition to the program director, two team leaders, and seven bachelor's- and master's-level clinicians from a range of social work, psychology, and addictions backgrounds. The psychiatrist is a central team member at Grais and serves consumers at Grais and at other Thresholds locations. For a minority of residents who see other psychiatrists, the Grais team offers to accompany them to visits or to schedule periodic meetings with their psychiatrists to stay in close communication about the residents' progress and treatment planning. The vocational coordinator helps each resident find and maintain community employment. Twenty-five to 40 percent of the residents are working at any given time; upon program entry, less than 5 percent of residents have jobs. To better serve several residents with hearing impairments, one clinician is fluent in American Sign Language (ASL); other staff members have developed basic ASL skills as well.

In 2001 the program hired a nurse to address the comorbid physical illnesses that are experienced by this population, such as diabetes, chronic obstructive pulmonary disease, heart problems, asthma, tuberculosis, HIV,

hepatitis, and cancer. The nurse takes the lead on setting up medical appointments and follow-up care as well as running a medication education group to help residents learn how to communicate more effectively about their symptoms and side effects with their psychiatrist and other physicians. Grais has also taken other steps toward improving residents' physical well-being. Two smoking cessation groups are offered each week. During fiscal year 2003 half the residents attended these cessation groups at least once, with many residents reporting reductions in smoking habits. Also, Grais offers three walking groups each week along the lakefront (typically two miles per walk) and a weekly trip to the YMCA. The program also offers a healthy eating group in which the residents and staff prepare an easy, healthy meal together.

Unlike many traditional residential facilities that focus exclusively on 12-step approaches and emphasize punitive consequences when consumers relapse or violate rules, the Grais program has very few rules for residents. In 2002, through consultation with agency leadership and experts in the field of integrated treatment, Grais staff began to recognize that their zero-tolerance policy on in-house substance use could be a barrier to some residents' recovery. After much discussion, the policy was revised in January 2003 so that each episode of substance use would be evaluated on a case-by-case basis, rather than resulting in an absolute expulsion from the program. Now staff concentrate on improving the quality of everyday life for residents within a culture of recovery, based on mutual respect. Instead of punishing residents for relapses, staff and residents now work together to learn from these experiences and prevent them from happening in the future. To this end, each resident now has an individualized personal recovery plan, developed in consultation with staff at intake. If residents relapse, the relapse intervention plan is used to provide structure for learning from the situations, events, or moods that triggered the relapse and to build the lessons into the member's evolving personal recovery plan.

A peer intervention committee was established by recruiting a group of residents who have not relapsed for at least one year. Members of the committee serve with staff on an intervention team and meet with relapsed residents. Staff offer suggestions and facilitate discussion between the peers with the aim of helping relapsed residents gain insight into their own substance use disorder and the impact that substance use has, not just on residents who are using alcohol or drugs but also on the full-recovery community at Grais Apartments. In most cases the residents have reported that this process has been helpful to them.

For both clinical process and consumer outcomes measures, Grais staff complete standardized assessments of residents' progress over time, in six-month increments. Program directors and team leaders receive semiannual outcomes reports on these measures and share the results with direct care staff. The Thresholds integrated dual disorders treatment manager conducts annual fidelity assessments of Grais to ensure that the program maintains fidelity to the integrated dual disorders treatment model. Grais staff also attend an annual retreat where they discuss what has gone well or poorly over the previous year and form strategies for quality improvement.

Evidence for the Grais program's effectiveness comes from a retrospective, 18-month follow-up study of 38 original residents (1). All residents had histories of homelessness and multiple hospitalizations before residence at Grais. A majority had a diagnosis of a schizophrenia-spectrum disorder (30 residents, or 79 percent) and substance dependence (36 residents, or 95 percent). Outcomes showed that the program has helped residents to reduce substance use, manage dual illnesses, and advance their stages of treatment and recovery.

During the study, the program retention rate was 71 percent (27 of 38 residents remained at Grais at the 18-month follow-up). Compared with rates during the 12 months before Grais residence, more residents at the 12-month follow-up held jobs (nine of 29 consumers, or 31 percent, after residence, compared with two of 38 consumers, or 5 percent, before residence). Employment rates at the 24-month follow-up were even higher (14 of 27 consumers, or 52 percent). Compared with hospitalization rates in the 12 months before Grais residence, more residents were hospitalized at the 12-month follow-up (ten of 29 consumers, or 34 percent after residence, compared with ten of 38 consumers, or 26 percent, before residence). However, at the 12-month follow-up the number of hospitalization episodes and the number of overall days hospitalized per customer decreased (.41 episodes after residence compared with .5 episodes before residence; 2.9 days after residence compared with 5.16 days before residence). Hospitalization rates also decreased substantially at the 24-month follow-up (three of 27 consumers, or 11 percent, after residence compared with ten of 38 consumers, or 26 percent, before residence). For consumers who remained in the program, a significant advancement in stage of treatment was noted from baseline to follow-up, as well as significant reductions in alcohol and drug use. Although this was an uncontrolled study with limited information on treatment dropout, the overall evaluation was positive and compares favorably with all evaluations of residential programs in the literature.

The Grais Apartments program is now thriving. Its residents are reclaiming and reconstructing new lives. They have more hope and have virtually eliminated the use of alcohol or drugs. The effectiveness of the program is founded on a residential, integrated treatment model with several critical components: pleasant, secure housing; interventions informed by motivational techniques; individualized services that are available 24 hours a day, seven days a week, and are matched to the needs and treatment stage of the member; educational and supportive one-to-one or group sessions; random drug and alcohol testing; and reliance on an approach that allows for close monitoring (for exam-

ple, keeping track of money management and medication adherence). Most important, the program helps create holistic and healthy relationships both between staff and residents and among residents. In sum, the Grais Apartments program has matured and become a highly effective, extremely innovative approach for consumers with co-occurring disorders.

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Reference

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Silver Award: TennCare Centers of Excellence for Children in State Custody—A Successful Partnership for Serving a Population With Complex Needs

Children in state custody—or at risk of entering state custody—are highly likely to have special health care needs, including behavioral health care, medical, and developmental needs. In Tennessee, such children had been sorely underserved until TennCare's Centers of Excellence for Children in State Custody (COEs) were created to augment existing capacity to provide direct and ancillary medical and behavioral health services to this special population.

The COE concept grew from Tennessee's efforts to respond to two class-action lawsuits against TennCare—Tennessee's expanded Medicaid program—and the Tennessee Department of Children's Services, one in March 1998 and the other in May 2001. The lawsuits involved the adequacy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; the provision of medically necessary services to children in state custody; and the permanency process for children in state custody. The COEs were established in 2002.

In recognition of their response in addressing this service gap and their ability to coordinate treatment and other services for this previously neglected population, the TennCare Centers of Excellence for Children in State Custody in Tennessee have been awarded one of APA's Silver Achievement Awards for 2004.

The initial planning of the COEs called for five centers located in pediatric tertiary care centers to serve various regions in Tennessee. Currently, three COEs are contracted and operational: East Tennessee State University, Vanderbilt University Medical College, and the University of Tennessee–Memphis. The Knoxville and Chattanooga areas do not have direct access to COE services at this time. There is current planning to extend the coverage of the COEs statewide, including to the east region (surrounding Knoxville) and the southeast region (surrounding Chattanooga). The size and capacity of each COE were determined by the state on the basis of estimations of need in each region served by a given COE. Each COE was charged to create the operational infrastructure and recruit staff with the medical and behavioral health expertise to serve its target population. As of March 2004, the total number of children served since the COEs' inception was 1,478 statewide, with 77 percent of these in custody and 23 percent at risk of custody. The estimated total served to date is 1,800.

Access to the COEs is reserved for complex cases that the existing service system cannot address, or for instances in which no appropriate community providers are available. The primary service goal is to develop a care plan that provides a definitive diagnosis and a recommendation for treatment or placement and to consult with providers to ensure that the care plan is successfully implemented. Success depends on the working relationship and trust established between the centers themselves and the Department of Children's Services, community providers, and state-contracted agencies and facilities. The centers accept referrals from the Department of Children's Services and health units of the Community Service Agency as well as the provider community.

Services provided by the COEs include psychiatric evaluations, psychiatric medication management services, psychological evaluations, case consultation, case triage, case coordination, high-level case management, training and education, and network development (assistance with the recruitment of providers for managed care and behavioral health organizations in areas where the network is inadequate, especially for pediatric specialty providers).

The complex cases referred to the COEs often involve substantial medical histories characterized by multiple evaluations, multiple diagnoses, multiple providers, and multiple attempts at placement and treatment. The children range in age from infancy to 18 years; some youths up to the age of 20 who have developmental disabilities or mental retardation are seen at the centers. The COEs are capable of coordinating and arranging various services that are often unobtainable by the typical case manager or community provider. The main guiding principle for the COEs is a community-based system-of-care philosophy, with the goal of maintaining the youth in his or her community as much as possible and promoting community intervention.

The COEs' staff are multidisciplinary professionals in the fields of pediatrics, child psychiatry, and child psychology, with nursing, and social work represented at the University of Tennessee and Vanderbilt centers. The staffing of the COEs varies according to the size and needs of the regions they cover. For the most part, the staff are university staff devoted part-time to the mission of the COEs, including psychiatry and psychology trainees at all three COEs.

The child psychiatrists provide psychiatric evaluations, diagnoses, and recommendations for children who do not have access to a child psychiatrist in their community or for whom a second opinion may be needed. The child psychiatrists provide limited

medication management services, particularly for the purposes of stabilizing patients and then helping them to make the transition back to available providers in the community. The psychiatrists are available to community pediatricians and family physicians for telephone consultations about complex diagnoses and medication management needs. The COE at the University of Tennessee has provided telemedicine psychiatric consultation to juvenile detention centers across the state. The COE at East Tennessee State University has provided this service on a limited basis and is about to expand its capacity in this regard. The centers also provide comprehensive psychological evaluations or more targeted assessments for children when psychological assessment services cannot be obtained in the community. Finally, COE staff provide expert testimony in legal proceedings as needed.

The centers also have access to academic experts within their respective universities for input on relevant topics, such as attachment, developmental disabilities, psychopharmacology, functional behavior analysis, psychotherapy, child maltreatment, and various pediatric medical specialties.

The COEs provide training and education to improve the knowledge and skills of those who serve this client population. They undertake training and in-service activities with the Best Practice Network (a provider network of primary care physicians under TennCare that serves children who have special needs, including those in custody or at risk of custody), providers and staff from the Department of Children's Services, foster parents, and other professionals. Training areas include best practice guidelines, disease identification and management, behavioral health issues, and specialized behavioral treatment techniques. Through a "Lunch and Learn" program, COE child psychiatrists, child psychologists, and pediatricians travel to the Department of Children's Services and offices of the Community Service Agency and present information on topics such as symptoms of common behavioral problems, positive discipline, conduct disorder, attention-deficit hyperactivity disorder, and bipolar disorder among children. The centers have also partnered across regions to present workshops.

The COEs are directly funded by grants through TennCare to cover the costs of all services. They bill TennCare managed care organizations and behavioral health organizations for covered services provided to children and reduce invoices to the state by the amount of the collected fees. However, many of the services provided by the COEs are not covered.

When the COEs were created, state planners intentionally omitted evaluation plans so that the focus of the start-up would be on providing services to the target population of children in state custody or at risk of state custody. However, it has always been recognized that outcome data would be useful for long-term planning purposes. The COEs currently collect follow-up data on services to determine the extent to which recommendations have been implemented and the extent to which individual recommendations are helpful as well as to identify barriers that limit implementation. Data from the referral source are also gathered, to determine whether improvement has been noted since COE involvement, and satisfaction with COE services is rated. Overall compliance with COE recommendations on care plans has been good, with an average of 71 percent to 83 percent of recommendations being implemented. Ratings of success in outcomes have corresponded closely with the extent to which providers have followed through on the agreed interventions and plans. A peer-review process is also being initiated.

In summary, the TennCare Centers of Excellence have proven their expertise in effectively identifying and addressing obstacles to treatment and services for children in state custody and their families. The COEs are working to improve access to care for children and adolescents in custody or at risk of custody and are ensuring that this formerly neglected population receives effective community-based treatment.

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Bronze Award: Senior Outreach Program of the New York Service Program for Older People, Inc (SPOP)—An Innovative Approach to Alleviating Stigma in the Mental Health Treatment of Older Adults

Stigma associated with the receipt of mental health treatment is common among older persons. Seniors are often reluctant to seek help at traditional mental health facilities or from private therapists and often face geographic obstacles to receiving mental health care. However, when mental health services are offered in a familiar environment, seniors are much more likely to accept such services.

With these realities is mind, in June 1997 the New York Service Program for Older People (SPOP) initiated its Senior Outreach Program in four senior organizations in Manhattan. The program has progressively expanded and now provides services at 14 sites frequented by seniors.

SPOP's mission is to enhance the quality of life of older adults and to foster their independent living through the delivery of comprehensive mental health and supportive services, advocacy, and education. SPOP helps older people to cope both with their mental health problems and with the everyday challenges of aging by providing the emotional support, counseling, and connections they need so that they may

continue to live full and healthy lives in the community. In addition to its Senior Outreach Program, SPOP's programs and services include a continuing day treatment program, an adult day center, a clinic, a geriatric peer advocacy program, a geriatric outreach assessment linkage program, and a widowed persons service.

The Senior Outreach Program, which was selected as one of two winners of an APA Bronze Achievement Award for 2004, is the first of its kind in New York City. The program's success rests on its ability to effectively bridge the gap between social service and mental health care providers. Although local senior organizations have skilled and dedicated staff members, most lack the time and resources necessary to assist this client population. Signs of mental health problems may be mistaken for side effects of medications or for normal effects of aging. Unfortunately, it is only when the client has developed a severe mental health problem that the need is recognized and attended to.

By utilizing existing facilities that serve a large senior population, the Senior Outreach Program maximizes the resources of both SPOP and the partner site. Through this collaboration, older adults who would not normally receive mental health care can receive prompt intervention and the requisite mental health services, which means that further isolation and deterioration can be prevented.

One day each week, each of the participating sites is visited by one of the program's social workers, who provide individual and group counseling as well as home visits to seniors who live near the sites but, because of physical or psychological limitations, are homebound. (More than 60 percent of the program's clients are homebound as a result of physical or psychological limitations and receive counseling at home.) At full program capacity, Senior Outreach Program social workers provide mental health counseling to approximately 100 older adults each week. The program has a total of five social workers and a supervising social worker. While at the site, the social worker spends approximately one hour coordinating mental health services with the various other services provided either by site staff or by other agencies in the vicinity. A psychiatrist, of which the program has two, participates in the initial evaluation and periodic assessments and is available on an ongoing basis for consultation with the staff at the various sites. A clinic director oversees the psychiatrists and the supervising social worker, who maintains relationships with site case managers, social workers, and supervisory staff.

The social worker informally functions as the mental health expert on the team of people who are concerned about the older individual. The social worker plays an important role in treating the person while taking the environment and other involved clinicians into account. The social workers help clients "normalize" the many difficult transitions that accompany aging—physical, emotional, and social. They help clients make sense of their lives and make decisions with an awareness that, although loss is an inevitable part of aging, it is still possible to lead a more healthful and fulfilling—and less emotionally painful—life. Specific treatment goals and time frames are established at intake. The goals are reviewed every three months to determine the need for continued service.

The fact that the program utilizes multiple outreach sites creates substantial supervisory, clinical, and administrative demands on staff. Each site has its own culture, staffing patterns, and referral mechanisms, and the staff at each site have varying levels of mental health training. Each site has a different degree of experience in working with other agencies and identifying mental health problems, which requires substantial time and flexibility from staff of the Senior Outreach Program. Managing these disparate elements and establishing and maintaining a close collaboration with each outreach site is crucial to the program's success.

Staff of the Senior Outreach Program provide the necessary assistance to the designated sites to ensure that the case managers and social workers at the sites understand how the program works. Information is provided on the role of the Senior Outreach Program social worker, how to initiate a conversation with a potential client about the need for mental health counseling, and how to refer a client. When necessary, program staff will help the site create or refine its referral system to help the social workers prioritize referrals.

As a licensed mental health clinic, SPOP is able to bill Medicaid, Medicare, and third-party insurance for the mental health services it provides. Thus SPOP can fund program expansions with one-year foundation grants as each expansion becomes self-supporting after the first year. Foundation support for 2003–2004 included support from the Isaac H. Tuttle Fund and the Fan Fox and Leslie R. Samuels Foundation.

Typical client outcomes achieved through the program are a decrease in the symptoms of depression and anxiety, improved socialization, reduced isolation, and a decrease in psychiatric hospitalizations. The effectiveness of the program is assessed with annual, confidential client satisfaction surveys, and the numbers of clients seen individually and in groups are monitored. In addition, ongoing feedback is elicited from staff at each site to determine whether the program has served the clients' needs and helped maintain the clients in the community.

The continuing success of the program has created ongoing demand. As a result, SPOP has a waiting list of senior centers and sites wishing to establish relationships with the Senior Outreach Program. In addition, sites that are already being served by the program often request more service hours.

The Senior Outreach Program has proven to be a model project that can be replicated in communities with significant elderly populations that are currently served by senior centers and similar organizations. The program was recently selected by the Aging in New York Fund, Inc. (the nonprofit arm of the New York City Department for the Aging) to provide mental health counseling at five sites as part of a model program designed to demonstrate the effectiveness of this type of service. The program received the New York State Coalition for the Aging's 2003 Senior Services Achievement Award and was the fo-

cus of a workshop presentation at the National Council on Aging's 50th annual conference, where it was described as a model for providing mental health services in senior centers and other senior organizations.

In summary, SPOP's Senior Outreach Program exemplifies a cost-effective, innovative approach to providing much-needed mental health services to older adults in the community who most likely would not otherwise receive mental health counseling. Through its unique efforts to reach older persons at home and in other community settings, it is overcoming the stigma associated with mental health treatment among older adults.

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Bronze Award: Youth and Family Centers, Dallas Independent School District— Providing Comprehensive Mental Health Care to School-Age Children and Their Families

Youths cannot be successful in school without being in good physical and mental health. Until the school-based Youth and Family Centers program was established in Dallas, Texas, youths in these areas did not have access to a comprehensive school-based mental health program.

The Youth and Family Centers program is the first comprehensive, culturally competent, school-based program in mental health care in the nation. Since its inception in 1993 the program has provided mental health care to more than 15,000 students. Annually, the program serves the physical and mental health care needs of more than 14,000 low-income children and their families.

In recognition of its commitment to providing culturally competent mental health care in the school environment, promoting accessibility, and ensuring the involvement of families, the Youth and Family Centers, Dallas Independent School District, have been awarded one of APA's Bronze Achievement Awards for 2004.

The program was first developed in the summer of 1993, when Glen Pearson, M.D., child and adolescent psychiatrist and director of the county mental health authority, met both a middle school principal and Jenni Jennings, M.A., a school psychology staffer, at a Dallas County mental health meeting. All had been searching for answers to school mental health issues: recent school violence, suicides, and student and community stress. The principal was convinced that these mental health issues were negatively affecting school success, especially on standardized state and national tests. At this brief encounter it was agreed by the three that a school-based mental health program serving two campuses would be established in the new school year in cooperation with the Dallas Mental Health/Mental Retardation Center (MHMR).

In the new school year, Pearson and Jennings volunteered their time to the program in the early afternoon and evening hours. The program was started simply because these two individuals were determined to create a new model of care for children that used the resources of the school. No funding was provided from either education or mental health funds until the program expanded to additional campuses. At that time, school principals contributed their local education funds to the program and Pearson offered additional psychiatrists and pharmacy services through the county mental health system.

The experimental program was so successful that word spread rapidly throughout the district. Within six months, the program operated out of six sites and served 14 campuses. In 1995 the Dallas Independent School District invited both the Parkland Health and Hospital System, which had operated school primary care health clinics for more than 20 years, and MHMR (now known as Dallas Metrocare) to provide services together under the title of the Youth and Family Centers. By 1995 the school district was able to provide infrastructure funding for the project, including facilities, management, support, and supplies as well as a staff of mental health professionals to direct each newly established center.

Currently, nine Youth and Family Centers serve 218 schools throughout the Dallas Independent School District. The centers are located at either a middle school or high school campus and serve youths in preschool through grade 12. Each center has a modular building with a waiting room, four therapy rooms, four medical examination rooms, a medical laboratory, a Class D pharmacy, a kitchen, and a community room.

Part of the program's success is due to the fact that youths and families who will not seek services from a public or private clinic will accept them gladly if they are offered in a setting that is familiar, user-friendly, and close to home. The program overcomes stigma and inadequate access to care for underserved minority populations. The population that the centers serve is more than 90 percent Latino and African American, and the staff reflect the racial and ethnic composition of this population.

Each center has a mental health team that is led by a child and adolescent psychiatrist. Forty-five full-time and more than 50 part-time staff members work in the centers—including school psychologists, social workers, counselors, nurses, marriage and family therapists, and parent educators. Health team members include pediatricians, nurse practitioners, physician assistants, and social workers. Other staff include predoctoral interns in psychology and social work and residents in general and child and adolescent psychiatry.

Common reasons for a student to be referred for mental health services include behavioral issues, emotional problems, and family issues. Behavioral issues include hyperactivity, impulsivity, aggressive behavior, conflict

with teachers, and peer relationship difficulties. Emotional issues include depression, anxiety, social withdrawal, and somatic complaints. Family and home referrals may reflect issues about divorce, separation, marital conflict, death of a relative, and abuse or neglect.

Program staff train school nurses, counselors, and principals to identify problems and create solutions that are tailored to meet each child's needs. Services at the centers are provided immediately upon referral from the school staff or families. The resiliency-based model used by the centers embraces the belief that all families and communities have the ability to generate solutions. In fact, family participation and teacher involvement are required as key components of the program. The voices and visions of family members are highly valued; often families find immediate solutions to some of their pressing problems. Therapeutic interventions are provided by mental health staff and include individual therapy, group therapy, family therapy, play therapy, and adjunctive psychopharmacology. Each year, in 17 to 25 percent of the cases, a psychiatrist prescribes one or more drugs as an adjunct to other treatment. Care is provided year round, and the centers operate five days a week with extended hours until 8:00 p.m.

The program was the nation's first school-based health program to track educational outcomes, and it can point to solid statistically significant improvements in attendance, behavior, grades, and national test scores. The school district's Division of Evaluation, Accountability, and Information Systems collects data on all students and families and tracks educational outcomes and satisfaction measures of school personnel, principals, parents, and students. This information is integrated with data on students who receive services from the Youth and Family Centers. Indicators of school success for each student are tracked each school year, and aggregate data on these indicators are reported as feedback to center staff and to the school board of trustees. On the basis of these educational outcomes, the Texas comptroller of public accounts gave the program a commendation as an exemplary program of the Dallas Independent School District.

The program has been recognized for leadership in the field of youth mental health care. Numerous school districts now use the program as a model for their services. In fact, the central administration office receives at least one call a week from school districts, local governments, and state agencies asking how to establish a similar program in their community. The centers have also been recognized nationally as a "best practice model" for school-based mental health care services. Most recently, the report by President Bush's New Freedom Commission on Mental Health cited the program as "the outstanding model" for delivering culturally competent care.

An integrated, holistic approach to addressing youths' needs—particularly those of at-risk youths—requires coordinated, family-focused, prevention-oriented, community-centered programming that is developed in response to the self-identified needs of local school communities. School-based health centers provide accessible, affordable health care for a large number of previously underserved youths. The Youth and Family Centers staff members believe, and have shown, that valuing and empowering families produce positive changes for the student, school, and community and create opportunities for parents and families to participate fully in their children's education.

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