

Evidence-Based Practice: What It Is and Why It's Important to Family Advocates

Webcast Transcript

(Sita: Welcome, review of webcast topics, why EBP is relevant to families – 10 minutes)

(slide 1-Diehl)

Hello! And welcome to our web cast on Evidence-Based Practice: What It Is and Why It's Important to Family Advocates. My name is Sita Diehl, and I'm the Executive Director of NAMI-Tennessee. NAMI stands for National Alliance on Mental Illness, and I run the statewide organization of NAMI affiliates in Tennessee. We are a grassroots organization of families and individuals with mental illness who provide mutual support, education and advocacy.

(slide 2-Diehl)

With me today is Dr. Judith Cook, who directs the National Research and Training Center on Psychiatric Disability at the University of Illinois in Chicago. Also joining us on today's webcast is Dr. Sue Pickett who is Research Director at the Center.

Today's program is one in a series of ongoing web casts offered by the Center. Previous ones have been archived on the web, and are available for viewing at no cost. All have handouts that you can view and download if you wish. Additional information regarding upcoming web cast programs will be provided at the conclusion of today's web cast.

(slide 3-Diehl)

Next, I'd like review the topics we'll be covering in today's webcast. We'll begin with a look at why evidence-based practice is important to relatives of someone with a mental illness. Then we'll discuss what evidence-based practice is, how it differs from promising practice, and why some interventions are considered evidence-based, while others are not. Then we'll learn about the research evidence supporting the effectiveness of different family-led education programs. After that we'll learn what Intervention Science is, and why we need more of it. Finally, we'll discuss what members of NAMI can do to support evidence-based practices and promising practices.

(slide 4-Diehl)

So let's begin by looking at why evidence-based practice is important to families. Evidence based practice might seem like rather abstract academic concept. And you might be wondering why families should care about it. After all, we are just trying to get through life. So what does science have to offer us in the real world?

(slide 5-Diehl)

These days, families and individuals with mental illness hear a lot of talk about Evidence Based Practice, or EBP. Many mental health agencies claim to use EBP, but we might want to ask ourselves - Do they really? Most providers keep records and report outcomes to the government and managed care companies. We might ask ourselves, whatever happens to all that data? Shouldn't the compiled reports of interventions and outcomes be public information? Shouldn't researchers use some of that service outcome data to investigate which treatments are effective and which are not?

As individuals and families living with mental illness, we often find it to be an uphill climb to get to that first mental health appointment. First we have to become aware that what is wrong might be due to mental illness. Then we have to get through the stigma surrounding mental illness to acknowledge that treatment might be a good idea. Finally we have to find a provider, come up with payment or insurance coverage and actually show up to the first appointment.

After all of that, we expect effective treatment, but many common mental health practices have yet to be put to the test in rigorous scientific research. The result is a lot of trial and error, which might discourage us from pursuing treatment. Evidence based practices, or EBPs, HAVE been subjected to research that tells us when and how they are most effective in terms of, diagnoses and level of severity, kinds of people such as age groups, gender, race and ethnicity; and conditions under which they are most effective such as rural or urban communities or different socio economic levels. EBPs have a seal of approval to say that IF the provider is qualified to provide the treatment AND provides the treatment as specified, THEN the treatment is likely to work. When treatment is effective from the start the individual and family are more likely to follow through to recovery.

(slide 7-Diehl)

The third reason evidence-based practice is important to families is because we need the most bang for the buck with our scarce tax dollars and high insurance costs. Evidence based practices can help the public and policy makers gain confidence in mental health treatment by assuring them that what we are paying for actually works. But beyond this, promoting widespread availability of evidence-based practice requires that providers be educated about the latest service interventions and how to implement them. This also means that some providers need continuing education in order to switch from old or ineffective practices to those that actually make a difference in people's lives.

Once providers understand what evidence-based practices are and why they're important, they're sometimes encouraged to gather evidence about their services as a matter of course. As we'll see in a minute, all evidence-based practices start out as promising practices. When service providers routinely keep track of therapeutic procedures and outcomes, there will be information on new and promising practices as they emerge. That information can then serve as the basis for beginning research on new evidence based practice.

Now that I've discussed why families should care about evidence-based practice, I'd like to turn it over to Judith Cook, who will tell us more about what makes an intervention an evidence-based practice.

(Cook-What is EBP and how is evidence graded? – 15 minutes)

(Slide 8-Cook)

Thank you Sita. Let's look closer at how we define evidence-based practice.

(Slide 9-Cook)

There is more than one definition for the term evidence-based practice. The one we're going to use in today's web cast is that an evidence-based practice is an intervention that has been tested in a randomized controlled trial research study and shown to cause pre-defined positive outcomes in people's lives.

(Slide 10-Cook)

When deciding whether something is an evidence-based practice, our central question is - how confident we can be that an intervention or treatment causes positive changes in the lives of people who receive it?

(Slide 11-Cook)

I mentioned a randomized controlled trial or RCT. That's a research design in which participants are randomly assigned to either an experimental or control group. Those in the experimental group receive the intervention while those in the control group do not. The process of random assignment creates two equal groups at the beginning of the research study. If we compare those two groups before and after the intervention is delivered to the experimental group, we expect to see two things. First, we expect the experimental group to be significantly different from the control group at the end of the study. Second, we expect to see that the experimental group members' outcomes improved significantly from where they were before the intervention, while we expect to see little or no change among members of the control group. If the experimental group changes significantly and positively, and the control group does not, we can assume with confidence that any changes in peoples' outcomes are due to the intervention.

(Slide 12-Cook)

RCTs are not the only kind of research design we can use to study an intervention. Other designs can produce useful information, especially in earlier stages of intervention development when treatments look promising. For example, there's the pre-test/post-test design, where we study a group of people before and then after they receive an intervention, to see if they change. There's also a comparison group design, where we compare people who received an intervention to a highly similar group (but not one that was created through random assignment) to see if the two groups differ. There's the case study design, where we conduct an in-depth, descriptive study of intervention participants, the types of services they receive, and the different changes they experience during the intervention. Finally, there's something called a correlational study, where we collect data about intervention participants and examine statistical

relationships, such as between the participants' personal characteristics (like their age and gender) and certain changes they experience, or between different services and related changes in participant outcomes.

(Slide 13-Cook)

There are a number of steps in an RCT study. First you need to create a detailed, “how-to” manual for delivering the intervention. Often, this is called the “manualized” version of the intervention. You also need to develop a fidelity assessment. This is a way of measuring the extent to which the intervention is delivered exactly as intended, using high standards of quality. Next, you need to train experienced providers of the intervention to deliver it exactly according to the manualized version you've developed. Then, you must recruit an appropriate number of people into the study, interview them, and then randomly assign them to either the experimental or control conditions. Next, you deliver the intervention to the experimental group while maintaining high levels of fidelity to the version you're studying. During this time, you are collecting data from participants at multiple time-points, analyzing it, and interpreting and disseminating the study's results.

(Slide 14-Cook)

The quality of evidence supporting an intervention determines its “grade” or the rating we give to our level of confidence that the intervention produces positive change in participants. People often classify the strength of the evidence and the amount of evidence supporting an intervention's effectiveness. This is referred to as "grading" the evidence, much like when you assign a grade to a student or score the performance of an athlete.

(Slide 15-Cook)

While all types of well-conducted research are valuable, not all types of research are equally rigorous. By rigor, we're referring to how much trust we can place in the study's results. To be an evidence-based practice, interventions must be supported by rigorous research that proves their effectiveness. That means randomized controlled trials.

(Slide 16-Cook)

In this workshop, we're going to use the evidence grading system of the Agency for Health Care Policy and Research. In 1992, this agency published evidence rating guidelines and these range from a low of Level 4 to a high of Level 1. Let's take a look at these levels and what they mean.

Scientists feel that the most rigorous research involves random assignment, where people are assigned to one of two groups, strictly by chance. The fact that chance alone is used to assign people to the E or C group means that the two groups are identical before the start of the research. That way, at the end of the study, scientists can be pretty sure that any difference between the two groups is due to what was tested and not pre-existing differences between people who did and did not receive the intervention. In the evidence grading system, evidence from an RCT qualifies an intervention to be graded at Level 1b, which is the second highest level of evidence.

Evidence from many RCT studies can be combined and analyzed statistically. This is called a "meta-analysis," and interventions supported by a meta-analysis are graded at Level 1a. Level 1a is the highest level of evidence for an intervention.

At the next level down – Level 2 – we are referring to studies that do not involve randomization. But in this case, the rigor comes from one of two things. First, the research might include a comparison group that was not randomly assigned but instead occurred naturally. An example of this is two programs that are located close to each other geographically, and have similar size and population characteristics. Here, people in one program receive the intervention while those in the other do not, and their outcomes are compared to see if there is any difference. Because we cannot be sure that people in the two programs were identical before the study began, research using this design is classified as level 2a. The second and slightly lower level of 2b is assigned when no comparison group is used but people are carefully measured before and after the intervention is delivered, sometimes at multiple time points throughout the study. This is called a longitudinal pretest/posttest research design because people are assessed several times before the intervention (pre) and after (post) receiving the treatment.

Level 3 is used to grade well-designed studies where there is no comparison group, requiring researchers to use other means to determine whether a treatment was effective. For example, complex statistical procedures may be used to see if the intervention had an effect by examining peoples' scores to look for patterns that support the intervention's success. For example, you might look to see if those who got more of the treatment improved more than those who got less of the treatment. Or you might test to see whether some people improved more than others. Here, researchers need to test whether personal characteristics are the real reason for any observed improvement. In other cases, research evidence graded at Level 3 might involve a study conducted by gathering in-depth descriptive information over a long period of time, using multiple trained observers who note what is occurring in an objective, systematic way.

Finally, Level 4 refers to evidence based on the experience of experts who have spent a lot of time administering the intervention. Sometimes evidence at this level consists of the opinions of an expert panel of respected authorities who come together to discuss their experiences using a treatment or intervention. This is the least rigorous level of evidence, but it still has value compared to no evidence at all.

Like all grading systems, this one is not perfect. It is simply a tool that allows us to summarize how much confidence we might have in what we learn from the research. So let's keep that in mind as we see what levels of evidence characterize the research on family-led education programs. The presenter for this part of our web cast is Dr. Sue Pickett.

(Pickett: The level of evidence for NAMI family-led education and support – 15 minutes)

(Slide 17-Pickett)

Thank you Judith. In this segment of our web cast, I'm going to talk about the current level of evidence for NAMI family education programs. We know that families need information about the causes and treatment of mental illness, help on how to solve problems related to their relative's illness, and ongoing support. Family-led programs where family members are trained to provide this education and support to other families are a growing resource. The research on these programs also is growing. Let's look at the results of some of this research.

(Slide 18-Pickett)

One of the first RCTs of a family-led education program was conducted in the early 1990s by Phyllis Solomon and her colleagues. She studied the effectiveness of two family education programs in helping family members cope with their relative's illness. The first program, called brief individual consultation, provides educational technical assistance to a family unit or individual family members. Consultants specially trained to work with families conduct a one-on-one assessment to help families determine their educational needs, and then work with the family in subsequent sessions to develop and enact a plan that meets those needs. Consultation sessions include taking a brief history of the relative's illness; providing empathy and support; assessing family strengths; defining problems and developing strategies to address those problems; and helping families find and use community resources. The second program, called brief family education, is a 10 session educational workshop taught by a family member and a professional. During these sessions, families receive information about mental illness and its treatment, and learn coping skills. The family member instructor shares examples from his or her own life in order to help participants understand that other families share similar feelings and experiences. In Dr. Solomon's study, family members were randomly assigned to 1 of 3 groups: brief individual consultation, brief family education, or a 9-month waiting list control group. Dr. Solomon found that, compared to families in the control group, families who received either brief consultation or education reported significantly increased their confidence in their ability to both manage their relative's illness and reduce their own stress and burden. These improvements in self-efficacy occurred both at the end of the education program and 6 months later. Since, to date, this is the only RCT of these programs, the current evidence grade for brief consultation and brief family education in increasing self-efficacy for families is Level 1b.

(Slide 19-Pickett)

My colleagues and I conducted an RCT of the Journey of Hope family education program. Journey of Hope is an 8 week program where trained family members teach other families about the causes and treatment of mental illness, provide problem-solving skills training, and offer support. The curriculum was co-written by family members, consumers, and professionals, and uses scripted lectures, videotapes, group exercises and other resource materials. Topics include brain biology; symptoms and treatments; problem-solving and communication skills training; community resources; improving collaborations with professionals; substance use; consumer recovery; and self-care. The course also gives families an understanding of the predictable emotions they experience as they cope with their relatives' illness, and teaches families that their

emotions are normal reactions to illness-related problems. In our RCT, we examined the effectiveness of JOH in improving families' ability to cope with their relatives' mental illness. We randomly assigned families to either the Journey of Hope course—which served as the experimental group—or to a 9-month course waiting list—which was the control group. Our results showed that, compared to families assigned to the control group, families who received Journey of Hope had significant increases in their knowledge of the causes and treatment of mental illness and knowledge of problem-solving skills; fewer needs for information about mental illness; decreased depressive symptoms; improved views about their relationships with their ill relatives; and greater caregiving satisfaction. The improvement in these outcomes occurred at the end of the course, and were maintained 6 months after the course ended. Similar to Dr. Solomon's study, our study is the only RCT to date of the Journey of Hope program, so its current evidence grade is also Level 1b.

(Slide 20-Pickett)

I'm sure that many of you are familiar with NAMI's Family-to-Family education program, and perhaps have taken the course or teach it yourself. Family-to-Family is a 12-week family-led education program. Like Journey of Hope, all instructors are trained family members who are graduates of the Family-to-Family course. The goal of this program is to help families cope with the trauma related to their relative's illness. The course encourages families to regain their own lives, and to express their feelings of anger and grief. Topics include brain functioning and medications; problem-solving and communication skills; self-care; rehabilitation and recovery; stigma; and advocacy. Dr. Lisa Dixon has conducted two pilot studies of Family-to-Family that examined changes in coping outcomes. In the first study, families were assessed before taking the course, immediately after, and 6 months later. In the second study, families who were on a 3-month waiting list for the course were interviewed at the time they were placed on the waiting list; again, right before their first Family-to-Family class; again, at the end of the course; and finally, 6 months later. In both studies, Dr. Dixon and her colleagues found that families had significantly increased feelings of empowerment and decreased feelings of worry and displeasure. In the second study, families also had significant improvements in problem-solving, self-care, their understanding of mental illness, and knowledge of the mental health service system. These improved outcomes occurred at the end of the Family-to-Family course, and were maintained 6 months later. Dr. Dixon currently is conducting an RCT of the Family-to-Family course. Until those results are available, the current level of evidence for this program is IIa.

(Slide 21-Pickett)

SAMHSA - the Substance Abuse and Mental Health Services Administration - currently recognizes and promotes 6 evidence-based practices. Each of these EBPs are backed by two or more RCTs showing that participation in these interventions results in improved outcomes for consumers. These 6 EBPs include supported employment; family psychoeducation; assertive community treatment; integrated treatment for co-occurring substance use disorders and mental illness; medication management; and illness management and recovery. I'll briefly describe each of these EBPs. Supported employment helps people with mental illness find and keep competitive employment

within their communities. Supported employment programs are staffed by employment specialists who work with treatment providers, so consumers receive both integrated employment and mental health services. Family psychoeducation programs teach families about the causes and treatment of mental illness, provides problem-solving skills training, support, and reduce stress within the family. It is important to note, however, that family psychoeducation refers to professionally-led programs that focus on improving consumer outcomes, such as reducing relapse rates and improving their social functioning. Family-led programs, like Journey of Hope and Family-to-Family, focus on improving families' ability to cope with their relative's illness, and currently are not SAMHSA-recognized evidence-based practices. Assertive community treatment, or ACT programs help consumers develop skills to stay in the community and out of the hospital. ACT services are delivered by a diverse team of providers that include case managers, nurses, and often substance use treatment specialists. Services are tailored to the individual and address his or her housing needs, finances, medication management, and daily living activities. Integrated dual diagnosis treatment is for people who have both co-occurring substance use disorders and mental illness. Substance use and mental health treatment are provided to these consumers at the same time, in the same setting. Medication management involves using medications in a systematic and effective way as part of an individual's overall mental health treatment. Finally, illness management and recovery programs help consumers set and pursue personal goals. These programs teach consumers strategies to manage their illness and avoid relapse, build social support, and cope with problems and symptoms.

(Slide 22-Pickett)

SAMHSA offers resource toolkits to help promote the use of these evidence-based practices. These toolkits include DVDs, videos, manuals, and information sheets that you can use to implement the EBP in your community. The toolkits not only help you promote these EBPs, but can also help you determine whether programs offered in your community meet the guidelines established by SAMHSA. For example, the fidelity assessment in the ACT toolkit can help you learn whether your local ACT program adheres to the model's critical ingredients, as outlined by SAMHSA and other ACT experts. Printed versions of the toolkits can be downloaded for free at SAMHSA's website.

Now I'd like to turn it over to Judith, who will tell us about a new type of science called intervention science.

(Cook: The need for Intervention Science – 10 minutes)

(Slide 23-Cook)

Thank you Sue. In this segment of our web cast, I'd like to introduce the idea of intervention science as something that is critically important to our field. This is especially the case now that we have identified what mental health interventions are evidence-based, and want to disseminate them more widely.

(Slide 24-Cook)

One of the challenges we face in doing this is bridging the gap between science and advocacy. It's only recently that scientists and advocates have tried to work hand in hand, and it hasn't been easy. Even though the two groups may be working toward similar goals, they operate from very different perspectives. This means that they can benefit from having a model that shows them how to work better together.

(Slide 25-Cook)

To get started, advocates and researchers also need to address a set of questions designed to help them collaborate. First, they need to consider why states continue to fund treatments and services that are not evidence-based. They also need to consider whose participation is necessary in order to widely implement evidence-based practices in this era of scarce resources. This requires advocates and scientists to help states develop ways to create incentives for existing providers to change their clinical practice. It also requires advocacy focused on convincing provider organizations to alter their organizational structures so that they can provide evidence-based interventions. Advocacy organizations like NAMI need to develop ways to promote evidence-based practice by doing what they do best – which is advocate with funders and policy makers. And scientists need to engage in a different type of science in order to tackle issues that go beyond deciding what is and is not an evidence-based practice.

(Slide 26-Cook)

In other words, we need a different type of science, where the emphasis isn't solely on conducting clinical trials research. We need to have more of an emphasis on funding and conducting intervention science.

(Slide 27-Cook)

Intervention science is interdisciplinary, which means that researchers working in different scientific fields come together in a coordinated effort. This effort involves working with communities that want to use evidence-based practices efficiently and effectively in a system-wide manner. This type of science operates in phases, and it requires that stakeholders participate in every phase. By stakeholders we mean consumers, families, and other advocates. Most importantly, the community members take the lead while the researchers provide the evidence and scientific expertise that helps the entire effort move forward. As intervention scientist Dr. Stephen Leff puts it, in intervention science, "Stakeholders steer, scientists row."

(Slide 28-Cook)

One way to think about this is to picture a ladder where each higher rung involves having more and more rigorous evidence supporting large-scale use of an evidence-based practice. The lowest rung is discovery, when clinicians try something new and it seems to be working. The second rung is development, when they begin to refine and improve a promising practice that seems to be working. The third rung is effectiveness when there is RCT evidence supporting the success of an intervention. The next rung – generalizability – involves learning whether the intervention works for a number of different populations in different areas of the country and in different organizational settings. If something only works in one state or region of the country, or only for men or

only for highly educated people, then it's not generalizable. The next rung is disseminability, which involves knowing whether it's possible to teach others to deliver the intervention on a wide scale, with a high level of fidelity and quality. Finally, the top rung is monitoring, where you are looking for evidence that the intervention can be tracked and its quality can be assessed within whole service delivery systems, county-wide or state-wide or nationally. The higher up you go on the ladder of intervention science, the greater the evidence supporting the intervention's usefulness in a large-scale, system-wide manner.

(Slide 29-Cook)

Right now, we don't really know whether many of the evidence-based practices we have identified are generalizable to a wide variety of populations in different areas of the country. We also don't have very good information about what these practices cost, especially when they are implemented in different kinds of organizational settings and in resource-poor versus research-rich regions of the country. We also lack knowledge about how to do the kinds of research that will help an evidence-based practice move up from level 3 to levels 4, 5, and 6. That's why we need more intervention science and need to get everyone involved in conducting projects that use this approach.

For the final segment of our web cast, Sita Diel will be talking about ways in which NAMI can support evidence-based and promising practices. Sita?

(Sita: What NAMI members can do to promote and support EBP and promising practices- 10 minutes)

(slide 30-Diehl)

Next, I'd like to talk about the how NAMI can support Evidence-Based and Promising Practices.

(slide 31-Diehl)

As individuals and families living with mental illness, we have the burning questions that need to be answered by research. Our lives will become easier and more fulfilling as knowledge is gained about how to help us. We look forward to the day when mental illness no longer disables us or throws our families into chaos. But it will take a lot of work to get to that day.

To influence the scientific process we must continue to demand that researchers investigate "real world" needs of individuals with mental illness, test what works, with whom and under what conditions. We also want researchers to focus on gaps in knowledge about commonly used interventions and promising practices that have not yet been researched. We want researchers to look at population subgroups for whom current EBPs have not yet proven effective, to determine what adaptations might be necessary or what promising practices may need further study. We also need to push federal and state governments to fund intervention research in addition to basic brain science and clinical trials. Further, we want governments to promote the use of EBPs and promising practice through policy, regulation and contracts.

(slide 32-Diehl)

What can we do to support EBP? Many family and consumer advocates serve on mental health planning councils and other stakeholder policy advisory groups. State budgets and mental health block grant applications are public documents that must be reviewed annually by planning councils. Federal Block Grant applications describe how the state spends tax dollars on services. My advice to you is to take a close look at those reports and budgets. Ask: Which of these agencies use EBP? What EBPs do they use? What promising practices do they use? What do they do that has not been proven effective? How can governments pressure providers to change to Evidence Based and Promising Practice?

Most community mental health practice is funded by Medicaid. Federal Medicaid law has trended toward limiting mental health practice to “medical” interventions like office based clinical practice and medications. Mental health EBPs have a large social service component that does not fit well into Medicaid funding criteria. What can be done to shift dollars toward EBP and promising practice? What sources of funding can be used in combination with Medicaid to enable providers to deliver EBP and promising practices? Ask your state mental health authority how they use Vocational Rehabilitation, mental health and substance abuse block grants, and state mental health dollars to promote Evidence Based Practice.

(slide 33-Diehl)

Many evidence-based practices are collections of different kinds of services. For example, integrated dual diagnosis treatment combines mental health with substance abuse treatment services. But providing different kinds of services can be complicated if the services have to be paid for by different funding sources. This often requires something referred to as “braided funding.”

In braided funding, monies from different sources are blended together to pay for a particular program or intervention. The different sources of funding might be state general revenue that comes from our state tax dollars, Medicaid funds that come from our federal taxes, state vocational rehabilitation dollars that consist of a blend of state and federal dollars, and other sources like the federal Mental Health Block Grant.

Remember, evidence-based practices often work so well because they are comprehensive. But being comprehensive can be expensive and complicated, even though we know it’s what works best as shown by the research evidence.

(slide 34-Diehl)

A good example of this is the evidence based practice called supported employment that Sue described earlier. I’m going to illustrate my point about braided funding by talking about how the state of Maryland makes this evidence-based practice available to its citizens. In Maryland, supported employment involves 6 different types of services, and these services are required by law to be paid for by a total of three different funding sources!

Pre-job placement services include assistance like vocational assessment and career counseling, and that is paid for by state general funds. Next comes job development or the process of helping individuals look for a job, which is paid for by state VR funding. Then comes job placement or helping the person get hired and trained for the job, which is covered by state general funds. Job coaching involves ongoing support and problem solving for people after they've begun working, and this is paid for by Maryland's state VR agency. While all this is going on, people are also receiving psychiatric rehabilitation services such as case management and skills training, for which the state bills Medicaid. Finally, clinical coordination involves medication management and clinical counseling, which is covered by state general revenue. Working something like this out takes a lot of time and effort on the part of state officials and advocates. Maryland is to be commended for creating an agreement between all these different funding sources and service providers. If you'd like to learn more about this agreement, you can visit the state's website.

(slide 35-Diehl)

We also need to demand that our treating professionals engage in both Evidence Based and Promising Practice. To maintain their license to practice, they are required to stay current on best practices through continuing education. EBPs are frequently offered as topics for continuing education workshops. When we as family members and consumers find out about new EBPs, we need to ask treating professionals how much they know about these EBPs and encourage them to find out more.

We also need to demand that universities and colleges teach EBP in all mental health disciplines such as psychiatry, clinical psychology, social work, nursing, occupational therapy, and counseling.

Contracts between states and managed care companies must require EBP methodologies and outcome accountability. Managed care companies will, in turn, hold providers accountable. We need to ask public mental health authorities to provide us with outcome reports from managed care companies. As we continue to hold the public mental health system accountable, EBPs and Promising Practices will become common practice. Then we will have confidence that when we are ready to access mental health treatment, the services we receive will actually help us recover and maintain balanced family life.

(slide 36-Diehl)

I'd like to encourage everyone who would like further information about this topic to visit the Center's website at www.psych.uic.edu/uicnrtc. This website also has information about previous Center web casts that you can access for free. I'd also like to invite you to visit NAMI-Tennessee's website to learn more about what we're doing in the areas of research and promotion of EBPs.

(slide 37-Diehl)

On behalf of the Center, we'd like to thank you for viewing our web cast and encourage you to complete the evaluation so that we use your feedback and suggestions to improve future web casts. And be sure to look for the Center's upcoming webcast on Financial Education & Asset Development for People in Recovery that will be available in early 2009.