MEETING NOTICE
INVITATION TO NEGOTIATE COMMITTEE
WEDNESDAY, SEPTEMBER 26, 2012
7:30 - 9:30 a.m.
COUNTY – CITY BUILDING – 555 S 10TH ST
ROOM 113

AGENDA

1. Approval of Minutes - September 12, 2012

2. Draft ITN

MINUTES
COMMUNITY MENTAL HEALTH CENTER (CMHC)
INVITATION TO NEGOTIATE (ITN) COMMITTEE
WEDNESDAY, SEPTEMBER 26, 2012
COUNTY-CITY BUILDING, ROOM 113
7:30 A.M.

Committee Members Present: Ron Sorensen, Community Mental Health Center (CMHC); C.J. Johnson, Region V Systems; Judy Halstead, Lincoln-Lancaster County Health Department (LLCHD); Lori Seibel, Community Health Endowment (CHE); Captain Joe Wright, Lincoln Police Department (LPD); Jane Raybould and Brent Smoyer, County Commissioners; Gary Lorenzen, Mental Health Foundation; Gail Anderson, CMHC Advisory Committee; J Rock Johnson, consumer advocate; Kerry Eagan, County Chief Administrative Officer (Ex-Officio); Vince Mejer, Purchasing Agent (Ex-Officio); Scott Etherton, CMHC (Ex-Officio); and Wendy Andorf, CMHC (Ex-Officio)

Others Present: Linda Wittmuss, Associate Regional Administrator, Region V Systems; Amanda Tyerman-Harper, Region V Systems; Topher Hansen, Director, CenterPointe, Inc.; and Ann Taylor, County Clerk's Office

Sorensen called the meeting to order at 7:30 a.m.

1 APPROVAL OF THE SEPTEMBER 12, 2012 MINUTES

MOTION: J Rock Johnson moved and Lorenzen seconded approval of the minutes. Sorensen, C.J. Johnson, Halstead, Wright, Lorenzen, Anderson and J Rock Johnson voted aye. Raybould, Smoyer and Seibel were absent from voting. Motion carried 7-0.

2 DRAFT INVITATION TO NEGOTIATE (ITN)

Discussion took place regarding the revised draft document (Exhibit A).

Lorenzen said one of his concerns is that the document accurately reflect what was spent on programs in the past. He said the document states that CMHC's operating budget in Fiscal Year (FY) 2011 was $10,148,301 (see Page 1) and said the figure that was presented to the CMHC Advisory Committee was $9,490,000. Lorenzen suggested that figure be used as a benchmark. Sorensen suggested the need for a more definitive description of the funding sources. Lorenzen noted Andorf had provided the Committee with information regarding CMHC sources of funding by program. He said those numbers total approximately $8,700,000, but said General Assistance (GA) could account for the difference. Andorf said her numbers were based on income data from the previous year. C.J. Johnson asked whether a formal audit of CMHC will be

required, noting an audit will separate revenues by funding streams. Andorf said an audit was recently performed. Lorenzen felt the ITN document should reflect the initial budget, before reductions were made. He said funding and staff reductions impacted revenues and, as a result, the revenues really don't reflect the need.

Etherton and Seibel arrived at the meeting at 7:36 a.m.

J Rock Johnson noted no revenue is associated with the van driver program, which serves an employment program and a service for clients, or the family education component. Lorenzen said the Mental Health Foundation purchased the van and leases it to CMHC for $1.00 per year. Funding of the van driver program is through a Community Health Endowment (CHE) grant that was transferred to the Lancaster County Medical Society (LCMS) because of the potential changes in CMHC's governance.

Lorenzen referred to Section 3: Financial Specifications, Subsection 3.2, Funding Amount, which states: *The estimated Regional funding available for this ITN for behavioral health services is $1,746,760*. He asked whether all the State funding comes through Region V. C.J. Johnson said all Program 38 (Behavioral Health Aid Program) funding does.

Smoyer arrived at 7:44 a.m.

Lorenzen said the budget information shows State's revenues of $3,800,000. C.J. Johnson explained that includes funding for the Crisis Center. **NOTE:** See introductory paragraph on Page 1 which states: *Region V currently contracts with CMHC for publicly funded behavioral health services in the amount of $3,201,565, approximately one third of the revenues for CMHC. $1,454,805 of those funds are allocated to the provision of services at the Lancaster County Crisis Center which will continue to be operated by Lancaster County; this portion of funds will remain with Lancaster County.* Sorensen noted there is some "interplay", or shifting of funds, between the two budgets. C.J. Johnson said funding of the Crisis Center will remain the priority and Region V will pull funds that are going to community-based services, if necessary, to fund that component.

Raybould arrived at 7:46 a.m.

Halstead noted there is another $2,000,000 related to GA (medical costs and support services) that could be freed up if there is expansion of Medicaid expansion.

C.J. Johnson asked that the definitions listed in Subsection 1.6, Definitions (see Page 4) mirror those in Legislative Bill (LB) 1083 (Nebraska's Behavioral Health Service Act) for consistency.

J Rock Johnson referred to Subsection 1.4,Target Population (see Page 3) and said the ITN should also recognize the serious mental illness (SMI) population, which needs more intensive services. She also asked that "psychiatric" be add to "rehabilitation" under Subsection 1.5, Scope of Service (see Page 1). J Rock Johnson also addressed capacity development and stressed the need for evaluation and consumer involvement as an outcome. She said education for staff and administrators about recovery-based services and recovery competencies is related to that and asked that "recovery-based" be added wherever "services" are mentioned in the document in order to reinforce that concept. J Rock Johnson said she will forward copies of the following documents to Committee members: 1) Behavioral Health System Design for Services for People with Severe and Disabling Mental Illness; 2) Best Practices, Nebraska Department of Health and Human Services, Division of Behavioral Health Services, Nebraska Behavior Health Reform; 3) A Crash Course in Peer Provided Service Research; 4) Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies; and 5) Consumer Outcome Monitoring Package (COMP) (Exhibits B-F).

Seibel asked that a definition of primary care integration be added to the Subsection 1.6, Definitions (see Page 4).

Discussion then focused on the ITN process. Sorensen reviewed the draft timeline (see August 22, 2012 ITN Committee Meeting minutes, Exhibit B). Seibel inquired about the Committee's role in the next step of the process. Halstead felt the Committee has essentially fulfilled the scope of its work although there are a few outlying projects that may interest the Committee, such as providing capacity in CMHC for primary care. Seibel felt the Committee should meet one additional time to review the input from the focus groups with consumers, providers and stakeholders, particularly if it will result in changes to the document. C.J. Johnson suggested Committee members make a commitment to be part of those focus groups. Raybould said she believes the Committee should also meet and receive an update after the award of the contract.

Wright asked when stakeholders will have an opportunity to provide input into system design. Halstead said she believes system design will be have to negotiated with Region V. C.J. Johnson said Region V plans to hold a series of focus groups over the next six to nine months to develop a strategic plan and said those will be opportunities to discuss system design.

Eagan said he will schedule a report on the ITN on the October 4, 2012 County Board Staff Meeting agenda and invited members of the Committee to attend.

3 ADJOURNMENT

There being no further business, the meeting was adjourned at 8:24 a.m.

Submitted by Ann Taylor, County Clerk's Office.

EXHIBIT
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DRAFT #3—September 25, 2012
Lancaster County & Region V Systems
Invitation to Negotiate (ITN) Response Package

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SECTION 1: INTRODUCTION AND PURPOSE

1.1 Introduction

Lancaster County Community Mental Health Center:
Lancaster County Community Mental Health Center (CMHC) was established by Lancaster County in 1976 through a federal grant under the Comprehensive Community Mental Health Centers Act for the purpose of treating persons with severe and persistent mental illness in the community rather than in state institutions. To date, CMHC continues to provide mental health treatment, rehabilitation, recovery supports and crisis services to approximately XXXX individuals in Lancaster County each year.

The current array of services offered by CMHC and the number of persons served within each of these services is summarized in Attachment A. CMHC's operating budget in FYXXXX was $10,148,301. CMHC revenues for FYXXXX are reflected in Attachment B. Revenue sources include Region V Systems, Medicaid, Medicare, Lancaster County and client fees.

Comment [AT1]: budgeted vs funded? Ron to follow up on FY and ensure accuracy of $ presented/time period in paragraph and attachments, include GA figures since not a line item in CMHC budget; what would GA pay out for intake, meds etc.?

Region V Systems:
Region V, a political subdivision of the state of Nebraska, has the statutory responsibility under Neb. Rev. Stat. 71-802-71-820 for organizing and supervising comprehensive mental health and substance abuse services in the Region V area, which includes 16 counties in southeast Nebraska. Region V, one of six regional behavioral health authorities in Nebraska, along with the state's three Regional Centers, make up the state's public mental health and substance abuse system, also known as the Nebraska Behavioral Health System. Region V currently contracts with CMHC for publicly funded behavioral health services in the amount of $3,201,565, approximately one third of the revenues for CMHC. $1,454,805 of those funds are allocated to the provision of services at the Lancaster County Crisis Center which will continue to be operated by Lancaster County; this portion of funds will remain with Lancaster County.

Region V is governed by a board of county commissioners, who are elected officials, one from each of the counties represented in the Regional geographic area. The Regional Governing Board (RGB) is under contract with the Nebraska Department of Health and Human Services, the designated authority for administration of mental health and substance abuse programs for the state.

Each RGB appoints a regional administrator (RA) to be the chief executive officer responsible to the RGB. The RGB also appoints an advisory committee for the purpose of advising the RGB regarding the provision of coordinated and comprehensive behavioral health services within the Region to best meet the needs of the general public. In Region V, the Behavioral Health Advisory Committee is comprised of 15-20 members including consumers, concerned citizens, and representatives from other community systems in the Region.

Region V's purpose is to provide coordination, program planning, financial and contractual management, and evaluation of all mental health and substance abuse services funded through a network of providers. Region V is responsible for the development and management of a provider network that services the behavioral health needs of southeast Nebraska. Currently, Region V has 13 providers in its network that have met the minimum standards required to be a

member of the network; each provider has a contract with Region V to deliver a variety of behavioral health services.

Region V, as payer of last resort, primarily serves financially eligible adults and youth with or at risk of serious mental illness, substance abuse, and/or substance dependence. Region V's geographical area includes Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York counties in southeast Nebraska.

1.2 Statement of Need

In June 2011 the Lancaster County Board of Commissioners established the Community Mental Health Center (CMHC) Planning Committee with the responsibility of advising the Board on the best model for providing services in the future and the proper role of the County in funding and providing these services. The goal of the Committee was to provide the County Board with an effective, sustainable long-term plan regarding how community-based mental health services should be provided in Lancaster County.

The CMHC Planning Committee submitted its final report to the Lancaster County Board in February 2012, recommending the creation of a new recovery-based service model, which integrates primary care and behavioral health services with extensive consumer involvement and emphasis on peer-supported programming. The Planning Committee further recommended the County Board work with Region V Systems to prepare specifications for the new service model to be used in soliciting collaborative and innovative proposals through an Invitation to Negotiate (ITN) process. The County Board accepted these recommendations, and the CMHC ITN Committee was established to assist the Board in defining the essential components of the new service model. This panel is charged with developing the process to transition CMHC from County governance to the private sector.

Recommendations relevant to this process and providing guidelines for development of the new service system are summarized in three different reports:

A. CMHC Planning Committee Report: The Lancaster County Board of Commissioners established the CMHC Planning Committee in June of 2011 for the purpose of reviewing how the County is providing behavioral health services at the CMHC; determining the best model for providing services in the future; and advising the Lancaster County Board as to the proper role of the County in funding and providing these services. The Report and Recommendations of the CMHC Planning Committee is provided in Attachment C.

B. Health Management Associates Report: Delivery and coordination of mental health services in the County was also addressed in a report prepared by the Health Management Associates (HMA) for the Community Health Endowment. The HMA report specifically addresses CMHC and provided the County Board with a recommendation on how to provide services in the future. A copy of the HMA report can be found at: http://www.chelincoln.org/images/pdfs/HMA_CHE_Report_1_30_2012.pdf.

C. The Recovery Project Report: Consumers of Lancaster County have a vested interest in the CMHC transition process and have provided input into this ITN in a set of standards and recommendations relating to recovery-based integrated services which can be found in Attachment D. The report is based on extensive research on recovery-based models of

behavioral healthcare. Vital information regarding standards and recommendations from over 40 white papers and federal publications help to operationalize a recovery-based model of care.

1.3 Statement of Purpose

Pursuant to the findings and recommendations of the Planning Committee and Lancaster County Board, Lancaster County (County) and Region V Systems (Region V) are seeking to identify prospective contractor(s) through an Invitation to Negotiate (ITN) process. Qualified candidates will be community-based organizations with demonstrated experience in behavioral health services that are interested in assuming a role in the provision of behavioral health services that will replace the current CMHC service system. The contracted service provider(s) will assume the responsibility of administering, managing and providing behavioral health services in Lancaster County to residents of counties within Region V's geographical service area.

Comment [AT2]: behavioral health or mental health; be consistent throughout document

Comment [AT3]: role of County? Parameters under these funds?

It is the intent of Region V Systems to contract for the administration, management and provision of Region funded behavioral health services and supports in Lancaster County. The primary goal of the service delivery system is to improve the mental health and lives of the residents of Lancaster County by making mental health crisis, treatment, rehabilitation, and recovery support services available through a comprehensive, integrated community-based system of care and to engage and encourage persons with mental illness to live, work, learn and participate fully in their community.

A formal Transition Plan for assuming responsibility for the administration, management, and provision of services will be mutually negotiated and developed with Region V and the Lancaster County Board.

Comment [AT4]: will Lancaster County Board play a role in negotiations?

1.4 Target Population

Subject to the availability of funds, the provider(s) will deliver a comprehensive array of behavioral health services to eligible individuals within the target population as defined below:

A. Persons over 19 years of age and over who reside within ~~Lancaster County and~~ the Region V geographic service area;
B. Adults with a risk of experiencing disruption in functioning or impairments due to
C. behavioral health issues, a majority of whom may have severe and persistent mental illness (SPMI);
D. Adults who meet financial guidelines (see Attachment E) and do not have coverage for services through other payer sources or who qualify for Medicaid; and,
E. Persons meeting the mental health community service priorities as defined by the Division of Behavioral Health and Region V including :
    1) Persons being treated in a Regional Center who are ready for discharge;
    2) Persons being treated in a community inpatient setting or crisis center and who are awaiting discharge;
    3) Persons committed to outpatient care by a Mental Health Board

Comment [AT5]: Lancaster County residents? What is the county's continued role, investment and how does it impact this? Will they have additional or conflicting requirements for their S?

1.5 Scope of Service

As can be seen in Attachment A., CMHC offers a wide variety of crisis, treatment, recovery support and rehabilitation services. At this time the Region is not prescribing services to be provided as part of the transition process and development of the new service system although it

does reserve the right to identify core services that must remain as part of the service system. Providers submitting a response to the ITN may apply for one or all services as described in Attachment A and currently comprising the CMHC service system. Providers may also submit a proposal separate from the services outlined because as indicated this is not intended to be prescriptive and alternative approaches are encouraged. The ITN process promotes innovative, collaborative proposals that provide for a recovery-based, evidence-based service model that integrates behavioral health and primary care.

Comment [AT6]: at what point are these core services defined? do we specify the amount of capacity that needs to be maintained in certain services and $ available for that purpose at release of ITN?

Over the past few years, the Nebraska Behavioral Health Division (NBHD) developed new service definitions designed to meet the needs of the population while promoting service delivery efficiency and effectiveness. NBHD service definitions can be found at: *http://dhhs.ne.gov/behavioral_health/Pages/beh_bhsvcdef.aspx*.

Behavioral health services shall include but are not limited to the services described on the Nebraska Behavioral Health Division's website. It is expected that the new recovery-based service delivery system will give consideration to all available service options in incorporating a full range of crisis, treatment, rehabilitation services and recovery supports in a variety of settings. A comprehensive menu of services and supports will best meet the needs of the target population. ITN respondents must identify the core behavioral health services they intend to offer and planned service locations. Locations must be convenient and accessible to persons served Preference will be given to service locations located on city bus routes.

Comment [AT7]: preference or requirement?

1.6 Definitions (needs work)

Behavioral Health Services: mental health services and substance abuse prevention and treatment services which are provided using state and Federal funds.

Community-based:

Consumer: User of behavioral health services.

Co-occurring Disorder: Most often defined as at least one mental illness disorder and one substance abuse disorder, where the mental disorder and substance abuse disorder can be diagnosed independently of each other.

Cultural and Linguistic Competence

Evidence Based Practices: for the purposes of the ITN, an evidence-based practice is one that is based on accepted practices in the behavioral health profession and is supported by research, field recognition, or published practice guidelines.

Individuals Served
Invitation to Negotiate (ITN)

Outcome: A measure of the quantified result, impact, or benefit of program tasks on the individuals served or user of the services.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA)

Proposal

Quality Improvement

Stakeholders

System of Care

1.7 Minimum Standards of Eligibility for Respondents

A. Minimum Standard Requirements**:** Eligible respondents may be a state, county, or community-based public; private not-for-profit; private for profit; or faith-based organization. Respondents must be a legal entity already established and functioning with paid personnel and demonstrable experience in working with the target population as evidenced by the following:

1. Region V Provider Network member or, if a new applicant, demonstrate how it meets all the minimum standard requirements including demonstration and primary source verification of facility licensure, fire inspections, professional licensure, and insurance to be enrolled as a member of Region V Systems' Provider Network.
2. Demonstration of fiscal viability; in operation and in good standing (based on a current independent audit) for at least 24 months;
3. Enrolled as a Nebraska Medicaid provider for identified behavioral health services or willingness/ability to obtain Nebraska Medicaid provider status;
4. Hold national accreditation in the provision of behavioral health services by a nationally recognized accreditation organization, i.e. CARF, COA, TJC, or have an accreditation development plan that outlines the agency's timeline (minimum 2 years) of achieving national accreditation;
5. Current applicable Nebraska behavioral health licensed clinicians and physicians on staff (including contracted personnel);
6. Have current license as a "Nebraska Mental Health Center" by the State of Nebraska or plan to obtain such license;
7. Ability to build the organizational capacity to serve the population within the chosen service category(s);
8. Ability to provide services within Region V's geographic area;
9. Able to initiate services effective XXX.
10. Willingness to accept Region V contract terms and conditions reflected in standard contract template (Attachment F-F.1)
11. Willingness to accept contracted rates for services as identified in Attachment G
12. Ability to serve the identified target population as defined in Section 1.4
13. Demonstrated competencies in provision of services and supports that are evidence-based and adhere to best practices in working with persons with serious mental illness
14. Demonstrated recovery competencies or a plan to develop recovery competencies

B. Minimum Programmatic Requirements**:** Provider(s) will be responsible for the development and management of a recovery-based service system. Behavioral health services will need to be coordinated and developed into an integrated network of recovery-based services accessible and directed to individuals in need of behavioral health services and community stakeholders. To accomplish this, providers will

implement evidence based and recovery based practices through participatory program development and design, training, and quality improvement activities. Recovery-based system of care development and management will include the following elements:

1. Demonstration of a collaborative approach to service delivery with diverse community stakeholders ensuring a community driven and supported system of care;
2. Implementation of a comprehensive, continuous integrated system of care model that provides behavioral health services and recovery supports for individuals to address their needs;
3. Recovery-based integration of behavioral health and primary care services;
4. Implementation of a system of care that supports the individual and the family and is recovery-based, person-centered, strengths-based and self determined, and builds empowering relationships and resiliency in the community;
5. Demonstrated commitment to maximize positive, meaningful program involvement by persons served and their family members in all phases of design, development, implementation, evaluation, operation and delivery of programming.
6. Provision of evidence-based practices in service delivery designed to meet the unique cultural and linguistic needs of the persons to be served.

Three key elements are required to be addressed in the development of the system of care including:

1. **Recovery-based Behavioral Health Integration with Primary Care:** A major component of the funded service system includes integrated behavioral/primary health care. This component must be based upon a recognized behavioral health/primary health care model. Various models of integrated behavioral/ primary healthcare exist and, based on the needs of the individual, different models are appropriate. A background document on integrated behavioral/primary healthcare, "Evolving Models of Behavioral Health into Primary Care," authored by the Millbank Foundation (2010), can be found at: http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf. Additionally SAMHSA and The Center for Medicaid Services (CMS) have developed a Guidance Document for states that provides key questions organized according to Health Home Service components (Attachment H). The document is intended to be useful, however not prescriptive, for providers responding to this ITN. Further information regarding health homes can be found on the SAMHSA website. http://www.samhsa.gov/healthreform/healthhomes/

   Although, integrated behavioral/primary healthcare is an essential component of the envisioned service system, it is anticipated that some behavioral health providers may not be offering primary care as a part of their service package, and some primary care providers may not be offering a complete package of behavioral health services (crisis, treatment, rehabilitation). However, in both scenarios, providers must address how they will ensure the behavioral and primary healthcare needs of those they serve.

   Partnerships and formal collaborations are highly recommended in the development and implementation of integrated services. Collaborative

relationships with local organizations inside and outside of the provider network that can enrich the lives of those served is expected.

2. **Adherence to Recovery-Based Principles**: In 2011, as part of its Recovery Support Strategic Initiative, SAMHSA announced a working definition of recovery from mental health and substance abuse disorders. The definition of recovery as defined by SAMHSA is, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." SAMHSA also delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one's disease(s) as well as living in a physically and emotionally health way;
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love and hope.

Provider(s) shall, at a minimum, identify how their proposed system of care design will support recovery in persons served and help persons served in achieving their potential in regards to health, home, purpose and community. To ensure that services are being delivered in a way that supports the recovery of behavioral health consumers, providers will:

A. Promote dignity and respect for all individuals served and their families, staff and all others;
B. Incorporate a broad array of recovery-based services and recovery supports to provide a continuum of care that supports many pathways to recovery;
C. Ensure recovery-based services are person-centered and that the individual's needs and strengths are elicited through informed choice and self-determination methods;
D. Ensure that services are provided throughout the community in the most integrated and least restrictive setting;
E. Ensure that services are available to persons regardless of ability to pay, accessible via different transportation means, and available at times convenient to persons served;
F. Ensure that services are coordinated across the recovery-based service system;
G. Ensure that intervention and treatment services focus on the whole person and promote improved health and wellness;
H. Ensure assessment and treatment is from a holistic approach which promotes the treatment of co-occurring physical health, substance abuse and mental health needs
I. Provide a recovery-based system of care that is participatory and provides services that are based on a partnership between consumer and provider where the provider serves in a consultant role focusing on collaboration and less on hierarchy; ensuring informed choice and self determination

J. Ensure that services approaches are strengths-based with emphasis on individual strengths, assets, and resilience;

K. Ensure that service will be person-centered focusing on increasing the individual's resiliency and self-determination skills and increasing their ability to successfully cope with life challenges;

L. Ensure that cultural and linguistic competence is provided throughout the system of care.

M. Ensure trauma informed competencies throughout the system of care.

N. Demonstrate commitment to foster meaningful consumer and family involvement in the program design, development and implementation, evaluation, operation, governance, training, evaluation and delivery of services and supports.

For further detailed information about the working recovery definition or the guiding principles of recovery visit: http://www.samhsa.gov/recovery/. The Recovery Project (Attachment D) also helps in providing an understanding of the principles of recovery-based systems.

3. **Relationship with Lancaster County**: Although Lancaster County–under this process will discontinue its status as a provider of community-based behavioral health services through CMHC, the County still has a vested interest in how effectively these services are delivered by the new provider(s). The new provider(s) will need to demonstrate the existence of a strong working relationship with the County or a plan to establish and maintain this type of relationship with the County. Areas of mutual interest include:

- Location of CMHC facility: To aid in a smooth transition, the new provider(s) will have the option of remaining at the existing location of 2201 S. 17th Street for a minimum two (2) years period. The County will consider proposals for the continued use of this property for this or other behavioral health services.
- Midtown Center: Lancaster County owns the Midtown Center at 2966 O Street, which houses CMHC programs for psychiatric rehabilitation and other related services. The County will consider proposals for the continued use of this property for this or other behavioral health services.
- CMHC Staff: All efforts should be made to retain as many of the current CMHC employees as possible. CMHC employees are highly trained and have years of experience providing specialized care, to consumers with severe and persistent mental illness. Retaining existing employees will also provide a continuity of care, which is essential to consumers.
- Crisis Center: The County will continue to operate the Crisis Center. For the immediate future, the Crisis Center will remain on the 2nd floor of the CMHC building. The new provider(s) will need to demonstrate the ability to work closely with the Crisis Center.
- General Assistance: Behavioral health services are provided by CMHC to consumers receiving County General Assistance. With the integration of behavioral health and primary health care, the new provider(s) will need to demonstrate how they will deliver both behavioral health and primary health care to consumers receiving General Assistance

Comment [AT8]: •(ITN Committee suggested additional information—do we need to include an attachment with a table showing costs, persons served etc'?)

SECTION 2: INVITATION TO NEGOTIATE PROCESS

This Invitation to Negotiate (ITN) is issued by Region V Systems for the purpose of soliciting collaborative and innovative proposals for the transition of the Lancaster County Mental Health Center (CMHC) service array to a behavioral health service model that is 1) recovery-based, 2) inclusive of peer supported programming which may include, but is not limited to, the operation of peer run programs and provision of peer recovery supports 3) inclusive of consumers in program design at all levels of development and implementation, 4) evidence-based, 5) trauma informed and 6) integrates behavioral health with primary health.

The ITN is intended to function as an open process for groups and organizations interested in submitting responses and is less rigid than a formal Request for Proposals (RFP). It provides an opportunity for interested parties to learn about Lancaster County and Region V's expectations and specifications and provide written documentation in response. Ideally, the ITN process will lead to further negotiations with qualified parties and subsequent contract awards with selected provider(s). The provider(s) selected through the ITN process will contract with Region V for the delivery of services.

The current array of services provided by CMHC includes an array of recovery supports and crisis, treatment, and rehabilitation services and does not include integration with primary care. Region V reserves the right to negotiate with more than one entity in order to develop a service system inclusive of recovery supports and crisis, treatment, rehabilitation, and primary care services that best fits the needs of the community and persons served. Collaboration among providers in the design of a mix of services (recovery support, crisis, treatment, rehabilitation and primary care) is strongly encouraged.

2.1 Posting

All notices, decisions, and intended decisions and other matters relating to the ITN process will be electronically posted on Region V System's website: www.region5systems.net.

Region V reserves the right to amend, modify, supplement or clarify this ITN at any time at its sole discretion. The electronic posting on www.region5systems.net is the official posting. It is the exclusive responsibility of the interested parties to check the website for the following:

A. Changes to the solicitation;
B. Other documents referenced by the solicitation (Attachments);
C. Written official responses to written inquiries;
D. Notice of Intent to Negotiate;
E. Notice of Intent to Award

2.2 Contact Person

The contact person for all communication regarding this ITN is:

Procurement Manager Name
Region V Systems
1645 N Street
Lincoln, NE 68508
(402) 441-4343
Email Address

2.3 Limits on Communications

Questions to the identified contact person regarding this ITN may be made either by fax, email, or written correspondence using the "*Request for Information*" form available electronically at www.region5systems.net. Written responses to questions will be made by Region V personnel within three business days and posted accordingly on the Region V website.

Under the parameters of the ITN process, with the exception of clarifying questions, prospective respondents are prohibited from contacting personnel of Region V Systems, the Department of Health and Human Services, Lancaster County and the Community Mental Health Center; members of Region V's Behavioral Health Advisory Committee (BHAC) or Regional Governing Board (RGB); Lancaster County Board members or members of the ITN Committee regarding this ITN solicitation during the period following the release of this ITN, after the release of available funding amounts, during the proposal evaluation period, and until a determination is made and announced regarding an invitation to submit further information. Violation of these provisions may be grounds for rejecting a reply to this ITN.

2.4 Schedule of Events and Deadlines

The County and Region V expect to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. In addition, the County and Region V reserve the right to issue a Request for Proposals if enough information is not gathered through the ITN responses received.

Activity		Date/Time
1.	ITN Process Announcement	1/31/13
2.	Notice of Intent to Submit a Proposal to be received by Region V (Submission is not mandatory)	2/15/13
3.	Pre-submission Conference	2/28/13
4.	Closing Date for Receipt of Proposals	3/31/13
5.	Evaluation of Replies	4/1/13
6.	BHAC	5/1/13
7.	Regional Governing Board	5/13/13
8.	Posting of Proposal Scores and Notice of Intent to Negotiate	5/14/13
9.	Negotiation Meetings	?????
10.	Posting of Notice of Intent to Award	
11.	Anticipated Effective Date of Contract(s)	

Comment [AT9]: will evaluated proposals go to BHAC/RGB prior to negotiations for approval?

2.5 Notice of Intent to Submit a Proposal

Prospective providers wishing to submit a *Notice of Intent to Submit a Proposal* may do so by sending the notice to the contact person specified in **Section 2.2**. This is not required, but preferred, prior to attendance at the Pre-submission Conference. The format for the *Notice of Intent to Submit a Proposal* will be electronically posted along with this solicitation documents at: *www.region5systems.net*. Submission of a *Notice of Intent to Submit a Proposal* does not bind the organization to submit a proposal.

2.6 Pre-submission Conference

All interested parties are required to attend the pre-submission conference to be held at the time and location as specified in **Section 2.4.** The purpose of the pre-submission conference is to review the contents of the ITN, to explore potential service model designs, and to identify interested providers that may wish to collaborate with other interested providers in developing and providing the services to be purchased. Interested parties will have the opportunity to present oral questions regarding this ITN. However, oral responses from Region V staff to questions asked at the pre-submission conference shall not be considered binding. Attendance at the pre-submission conference is a prerequisite for acceptance of proposals from interested parties/prospective providers or groups of providers.

2.7 Withdrawal of Proposals

The applicant may withdraw its proposal, with written notification, at any time in the process. In such instance, a letter of withdrawal with an original signature by an authorized officer/executive must be submitted to the Contact Person identified in **Section 2.2**, either by hand delivery or by certified mail.

2.8 Acceptance of Proposals

A. **Proposal Deadline:** No requests for extensions of the due date will be approved. All proposals must be received by the Contact Person identified in **Section 2.2** at the date, time and address specified in **Section 2.4** of this document. Changes, modifications or additions to submitted proposals will be not be accepted after the identified deadline for submission of proposals.

B. **Receipt Statement** Replies not received by the Contact Person at the specified place and by the specified date and time will be rejected as non-responsive and returned unopened to the provider by Region V. Region V will retain one (1) unopened original proposal for use in the event of a dispute. Region V/County accepts no responsibility for mislabeled/mis-sent mail.

2.9 Posting of Proposal Scores

The results of the proposal scoring shall be posted electronically in accordance with the Schedule of Events described in **Section 2.4** at: www.region5systems.net

2.10 Posting of Intent to Award

The results of the negotiation activities including posting of intended award shall be posted electronically in accordance with the Schedule of Events and Deadlines described in **Section 2.4** at: www.region5systems.net

SECTION 3: FINANCIAL SPECIFICATIONS

3.1 Funding Source

A. STATE GENERAL FUNDING. The contract amount includes funds contracted to the Region by the Nebraska Department of Health and Human Services. Funds are passed through the RBHA and subsequently passed from the RBHA to the Network Providers.

B. FEDERAL BLOCK GRANT FUNDING. The contract amount includes funds contracted to the Nebraska Department of Health and Human Services by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Mental Health Services (CMHS). Funds are passed through to the RBHA and subsequently passed through from the RBHA to the Network Providers.

C. COUNTY FUNDING including General Assistance Funding

Comment [AT10]: ADD fund amounts available, funding source (role of County, any $ from the County (GA $) that may be separate from Region funds), contract terms

Comment [AT11]: To be determined?

3.2 Funding Amount

A. TOTAL FUNDS AVAILABLE. The estimated Regional funding available for this ITN for behavioral health services is $1,746,760. The contract amount is subject to the availability of funds. At this point, the Region cannot determine the specific amounts available. The complete anticipated funding amounts will be finalized during the negotiation process.

Comment [AT12]: County contribution to be determined.

3.3 Reimbursement Methods

NON FEE FOR SERVICE (NFFS): Services are reimbursed based on actual monthly expenditures up to the designated amount specified in the contract; or

FEE FOR SERVICE (FFS): Services are reimbursed based on a unit of service up to the designated capacity specified in the contract.

The funding amounts are annualized based upon 12 months of service or upon units of service delivered during the fiscal year.

The cost proposal for the programs/services in this RFP should be based on a maximum one-year contract term. Region V Systems' fiscal year operates from July 1 to June 30.

Comment [AT13]: Any start up costs?

3.4. Use of Funds

The use of funds provided under Region V Systems' Network Provider Contract is limited to the employment of personnel, technical assistance, operation of programs, leasing, renting, maintenance of facilities, minor improvements, and for the initiation and continuation of programs and services. An agency may be reimbursed on a Non-Fee for Service status during the period of start up and move to a Fee for Service status later in the fiscal year. It will be Region V Systems' decision to reimburse the agency on a NFFS or FFS basis and will be finalized during the contract negotiation period.

Region V will not fund:

A. Financial contributions to individuals.

B. Fund-raising events.

C. Lobbying.
D. Abortion.
E. Laboratory or clinical research.
F. Projects which do not serve the Region V geographical area.
G. Purchase or improvement of land, purchase or permanent improvement for any building or other facility, or purchase major medical equipment.
H. Cash payments to intended recipients of health service.

3.5 Non-Transfer of Funding Award

Any contract awarded to a successful applicant may not be transferred or assigned by the applicant/contractor to any other organization or individual.

3.6 Use of Subcontractors

The chosen provider may be permitted to subcontract for the performance of certain required administrative or programmatic functions. Anticipated use of subcontractors must be clearly explained in the ITN Narrative identifying the proposed subcontractors and their proposed role. Use of treatment subcontractors and the terms and conditions of the subcontract must be approved by Region V in advance of execution of any subcontract. The successful applicant is fully responsible for all work performed by subcontractors. No subcontract into which the successful applicant enters with respect to performance under the contract will, in any way, relieve the successful applicant of any responsibility for performance of its duties.

SECTION 4: GENERAL INSTRUCTIONS ON SUBMISSION OF PROPOSALS TO THE ITN

4.1 Method of Delivery and Receipt of Proposals

Any proposal must be received by the Region according to the deadline set forth in the Schedule of Events and Deadlines, **Section 2.4**, of this document. The provider(s) may choose and is responsible for the method of delivery to the Region except that **facsimiles will not be accepted at any time; electronic transmission is required but does not replace the need to submit hard copies of the proposal**. An untimely reply will be rejected and returned. The Region will keep one copy for its records. **The Region is not responsible for any lost or misdirected submittal.**

All proposals received by the date and time specified in the, **Schedule of Events and Deadlines, Section 2.4,** become the property of Region V Systems. The Region shall have the right to use all ideas, or adaptation of ideas, contained in any reply received in response to this ITN. Selection or rejection of the proposal shall not affect this right.

All instructions, conditions, and requirements included in this document are considered mandatory unless otherwise stated. ITN responses that do not conform to the items provided in this document will not be considered. All applicants must adhere to the following guidelines.

Any costs incurred in the submission of proposals are the responsibility of the provider.

4.2 Submission Instructions

A. Respondents must submit one (1) original and fifty (50) copies of the ITN Response to the Contact Person specified in **Section 2.2** by the date, time and place specified in **Section 2.4**.

B. The provider must submit an electronic version of the proposal at the same time as the hard copies are received by the Region.

C. ITN responses must be clearly referenced as **ITN Response** on the outside of the envelope or package.

D. Responses must be typed in 10-point font or larger, submitted on standard 8 ½" by 11" paper, numbered consecutively on the bottom right-hand corner of each page, starting with the Cover Page through the last document, including required attachments.

E. Staple or clip the original and each copy of the response at the upper left-hand corner. Do not use covers or add unsolicited attachments to your proposal.

F. FAX copies will not be accepted.

G. Two-side copying is allowed but not required.

H. Designated information must be provided on Region V forms provided in the attachments of this document. Electronic versions are available on the Region V website.

4.3 ITN Proposal Format:

ITN Response Proposals must be organized in the following sections in the following order:

A. Cover Page

Complete the entire Cover Page (Attachment X) and obtain the signature of the chief executive officer, board chairperson, or other individual with the authority to commit the applicant to a contract for the proposed program/services.

B. Executive Summary

Complete the entire Executive Summary (Attachment X). The Executive Summary must summarize the three components of the Capacity Development Plan including Program Narrative, Development/Implementation Time Line Plan, and Budget Justification Narrative.

C. Capacity Development Plan:

A Capacity Development Plan for Behavioral Health Services following the format specified must be used in submission of ITN Response Proposals. Specific forms referenced are available at www.region5systems.net.

I. Program Narrative

The **Program Narrative** is a written plan that describes, in detail, the program to be funded. The applicant should provide the following information in as thorough and complete detail as possible.

A. **Name and address of the provider agency or agencies, if applicable,** with an explanation of why the provider(s) is capable of providing this program. Identify the specific amount of time (up to a maximum of 12 months) needed to develop the service and the dates of the service development period requested.

B. Describe the **purpose** of the program. Explain the reason for developing the program in terms of the result expected to meet the needs of consumers.

C. Thoroughly describe the **need** for the program using current, valid data to justify why this program should be developed at the agency applying, in this geographic area, and for the purpose detailed above. Report the source and time period for the data. Include an explanation of why this need would logically lead to the development of the program being proposed.

D. Describe the **target population** to be served and provide specific details about gender, ages, ethnicity, geographic location, school grades (if appropriate), mental illness(es) and/or substance abuse needs, and other relevant information about the persons to be served in this program.

E. Provide a general overview of **how the services will be organized**. Include information about how the provider's resources (facility space, personnel-current/new, equipment, other) and administrative structure are coordinated and directed to meet the needs of the consumers through the proposed program. Include information regarding network experience, capacity to work with Medicaid and other health insurance companies, health information technology including electronic medical records, health information exchange, etc., and financial management. Describe any partnerships and collaborations that will be employed in developing this service model. Describe the organization's relationship with Lancaster County; discuss plan to establish and/or maintain a strong working relationship with Lancaster County particularly in relation to the Crisis Center and the General Assistance. Describe the proposed model addressing how the organization(s) will integrate behavioral health and primary care.

F. List and explain the **goals of the program** which describe specific, measurable desired outcomes from a consumer's point of view. What will a consumer want to gain from this program? The goals should have a direct relation to the program purpose and should deal specifically with issues related to the services to be delivered in the program. The goals should address expected short and long term benefits for the target population. Program goals do not include organization management or program development goals. These goals are different than those identified on the **BH-5.**

G. Thoroughly describe **admission criteria** and procedures for consumers to access the program or how the Behavioral Health clinical criteria will be used in this program.

H. Describe the **assessment process** and procedures which will be used in the program. Include an explanation of what information will be gathered for each consumer and how consumers in this program will be screened for other problems (i.e., substance abuse problems, if developing a mental health program or mental illness, if developing a substance abuse

program). If more detailed procedures need to be developed, include this in the Program Development/ Implementation Schedule.

I. List and include complete explanations of the **specific services** to be provided directly to the consumer:
   1. How individual treatment or rehabilitation planning will be done with the consumer and what is included in this individual plan.
   2. What is involved in the services to be provided within this program.
   3. How the services will be coordinated with other programs.
   4. The provisions for periodic reassessment and individual plan revision.
   5. Discharge planning procedures, criteria, and follow-up.
   6. The projected average length of stay in the program for the consumer to successfully reach the desired results as specified in the goals (see F above).

J. Describe procedures for **direct consumer involvement** in the program. Include an explanation of:
   1. How potential consumers will be informed about the program and consumer rights.
   2. How meaningful participation of consumers will be incorporated into the development, evaluation, and ongoing modification of the program.
   3. Describe consumer and family members involvement in conceptualization of service model design, planning including identification of needs, goals and objectives; and budget development
   4. How the program adheres to recovery based principles and demonstrates recovery-based competencies
   5. Discuss any involvement of consumers and family members in staff training and development include description of any employment positions specific to consumers or family members i.e peer support positions
   6. Describe consumer and family member involvement in program administration, governance, policy determination and program evaluation.

K. Discuss the **capacity** anticipated for the program. Program capacity means the total number of individual consumers considered "active" in the program at any given time. Daily census means the number of individual consumers who can be served on a single business day. Estimate the total number of consumers who can be served during the capacity development period, and also, in a normal 12 month period (if the capacity development period is less than one year).

L. Discuss the **program staffing** proposed. Include an explanation of the qualifications and supervision of the positions which will provide any services (direct and indirect) in the program. (Job descriptions are optional but could be included here.)

The transition from the current CMHC system to a new service delivery system will be stressful for consumers receiving services from CMHC and CMHC employees. The ultimate goal is to reduce the stress of transition and retain as many consumers and staff as possible. To accomplish this goal, careful transition planning must be employed to ensure a smooth transition for both groups. In addition, a communication plan developed to assure transparency and to assist consumers, families, and employees with the transition is expected. Describe the employee retention, transition and communication plan that will be implemented to achieve this goal.

M. Describe the quality assurance plan which be used for this program and directed at desired outcomes for the consumer. Explain how information and data will be gathered to evaluate the program, anticipated outcomes and evaluation measures, how data will be used, and who will be involved in making this happen. Include the details of the quality improvement functions including data collection, analysis, and reporting the agency plans to use. Describe how meaningful involvement of individuals served will be achieved in the quality improvement and evaluation activities of the program. The quality assurance plan should address the following elements:

- Quality improvement goals and objectives including use of evidence-based practices;
- Reliable and valid performance measures;
- Measurement of performance in relation to performance outcomes established at the local, State and Federal level, as applicable;
- Plan for continuous and progressive improvements, and measuring the impacts of these improvements;
- Plan for reviewing the results of quality assurance reviews, critical incident reports, and the numbers and kinds of grievances and appeals and using this information to initiate system improvements;
- Plan for identifying service problems and improvement opportunities;
- Plan for measuring individuals served satisfaction and recovery measures and reviewing for improvement opportunities;
- Quantitative and qualitative indicators, outcomes and outputs that can be used by the payers and persons served and other community stakeholders to objectively measure a provider's performance and used to improve services.

N. Identify the specific facility needs of the program and explain how this program will meet those needs. Specify proposed service locations for services. Include an explanation of the relationship of this program within the operation of the provider agency or agencies, if applicable.

II. Development and Implementation Timeline Plan

1) **BH - 5** Goals and Objectives One form is completed for each goal.

The **Development/ Implementation Timeline Plan** will be developed on **Form BH-5.** The development plan includes an implementation schedule. The information will explain in detail the development process and show a clear step-by-step plan of how the program will be developed over a given period of time. The Program Development Plan will conclude with consumers receiving services and a formal evaluation of the program plan, the process, and the services provided.

The Development/Implementation Timeline Plan will have several **BH-5** forms that will identify the goals and objectives needed to develop and implement a service capacity. Use a separate form for each goal. Capacity development goals should include, at a minimum, the following:

1. Develop administrative structures and personnel for service.
2. Develop facility for providing service, if needed.
3. Develop program plan, program operating policies and procedures, operation plan, authorization/referral system for service.
4. Develop reporting, financing, and quality assurance systems.
5. Develop a plan to begin to serve people.
6. State certification development plan/time line and an infectious disease policy and disaster plan.

Instructions for completing **Form BH-5**.
Identify specific **goals** to address development issues (different from program goals for consumers as stated above).

Column A. Each goal should include several time-limited, measurable **objectives** (including specific measurement indicators) which will all work together to successfully attain the goal.

Column B. Each objective will need to have several specific **activities** that have to be accomplished in order to fulfill the objective.

Column C. Each activity must include the name of the **staff** person or the title of the position which will be primarily responsible for completing that activity.

Column D. Each activity must have a specific **beginning and ending time** identified. This time period must be within the proposed service development time period. Please be as specific as possible.

Column E. Each activity must identify the **expected outcome** that demonstrates that development activity has been accomplished. This will measure if the program is progressing toward full administrative, financial, and programmatic development through successful completion of each activity.

III. Budget and Narrative Budget Justification

1) **BH - 20a through BH - 20g** for annual ongoing budget
2) **BH - 20a through BH - 20g** for one-time budget (all expenses and revenues expected)

The budget section should include the following two sections:

a) Itemized Annual Operating Budget
b) One Time Development/Start-up Budget

Use **Forms BH-20a through BH-20g** to develop the detailed budget for the service. Also included is a list of the specific items that would be in that budget section.

BH-20a Revenue Summary [Ensure revenues expected for the service are reported from ALL other funding sources (i.e., Medicaid)]
BH-20b Expense Summary [Ensure that indirect administration is not more than 10% of total.]
BH-20c Personal Services Expenses [Ensure that all staff to be employed to provide the service are reported on this form.]
BH-20d Operations Expenses
BH-20e Travel Expenses
BH-20f Capital Expenses
BH-20g Other Expenses

Use **Forms BH-20a through BH-20g** to develop the one time start up budget for the service. These forms have a list on the back of the page that includes specific items for that budget section.

BH-20a Revenue Summary
BH-20b Expense Summary
BH-20c Personal Services Expenses
BH-20d Operations Expenses
BH-20e Travel Expenses
BH-20f Capital Expenses
BH-20g Other Expenses

Budget Justification Narrative: This narrative will explain in detail why the costs listed on the budget itemization forms for BOTH #1 and #2 above are necessary and how those costs were calculated. The applicant should review the Regulations for allowable and unallowable costs. Please address the following items separately in the narrative:

1. *Annual Operating Budget*. Explain and justify all items included in the annual operating budget including
   - Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately.
   - How ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined.
   - Describe the project's facility and space requirements and explain why the amount is needed.
   - Identify amounts and sources of any other revenues to be used or received with this project, in addition to the state and/or federal funds being requested with this proposal.

2. One Time Development/Start Up Budget. Explain and justify all items included in the start-up (one-time) cost budget.
   - Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately.
   - How long it will take to develop the service and why.
   - How ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined.
   - Describe the how the agency will procure the project's facility and space requirements, and explain why the amount is needed.
   - Identify amounts and sources of any other revenues to be used or received with this project, in addition to the state and/or federal funds being requested with this proposal.

3) Budget Narrative Justification that (1) explains the one-time expenses and why they are needed, and (2) explains the ongoing annual expenses and why they are needed.

IV. Minimum Standards Primary Source Documentation: The following supporting documents are required to be submitted with your ITN proposal:
   a) Financial Audit Summary
   b) Current Facility Licensure, Fire Inspections and Food Permits, as applicable
   c) Accreditation Certificate
   d) Most Recent Accreditation Report, and
   e) Number of Staff by Licensure including source documentation of licensure
   f) Insurance documents to include workers' compensation; motor vehicle liability, professional liability, directors/officer's liability, and general liability coverage

SECTION 5: CAPACITY DEVELOPMENT PROGRESS REPORTS

Capacity Development reports will be required for any service approved for capacity development. Depending on the individual situation, the report may be required monthly, bi-monthly or quarterly to communicate the details of the progress made toward completion of the goals, the progress in developing and providing the service, and the progress made toward moving the payment method from Non-Fee for Service (NFFS) funding to Fee for Service (FFS) funding.

Format for Progress Report: A BH-5 should be used to report progress and should include details and data on specific progress completed toward successfully meeting each goal, objective, and activity identified on the **BH-5**.

Due Dates for Progress Report: Due dates for progress reports will be identified in the contract.

SECTION 6: ITN EVALUATION METHODOLOGY

The Region shall identify at least XXX evaluators with a combination of appropriate financial, data, and programmatic expertise to evaluate the proposals. The team will be comprised of a minimum of X evaluators with financial expertise and a minimum of X evaluators with behavioral health expertise.

The maximum points available is 100. The evaluation will be performed using XXX evaluation tools (to be developed?). Evaluators will be instructed to provide ratings in X point increments on criterion items. Evaluators with financial expertise will score criterion items XXXX. Evaluators with behavioral health expertise will score criterion items XXXX. The average of all evaluators' scores for each criterion rated will be tabulated. The vendor's final score will be the sum of all average criterion scores.

The Region intends to extend an invitation to enter into negotiations with up to X highest ranked providers. The Region reserves the right to negotiate with a fewer number or greater number of provider in the best interest of the community. An invitation to a provider to enter into the negotiation phase of the schedule shall not be construed as a contract award.

The posting of Proposal Scores and the Notice of Intent to Negotiate will be posted in accordance with Section 2.

SECTION 7: REGION RIGHTS AND RESPONSIBILITIES

7.1 Right to Reject Any and All Proposals: The Region reserves the right to reject any and all proposals.

7.2 Right to Withdraw the ITN: The Region reserves the right to withdraw the ITN at any time, including after and award is made and by doing so assumes no liability to any provider.

7.3 Negotiation Methodology: The Region may negotiate with one or more providers simultaneously. The Region intends to extend an invitation to enter negotiations up to the three highest ranked providers based on the rating methodology outlined in Section 6. The Region reserves the right to negotiate with fewer or greater providers based on the best interest of the community. An invitation to a provider to enter the negotiation phase of the schedule shall not be construed as a contract award.

Comment [AT14]: The County purchasing act prevents county from negotiating with two entities at the same time. No bearing on Region V?

Providers selected to enter negotiations should be prepared to discuss and address any issue in the ITN or the provider's proposal to the ITN.

Each party to the negotiations will designate a lead negotiator. The lead negotiators will establish a communication protocol allowing for contact between parties as provided in Section 2.X. While there may be ad hoc workgroups assigned during the negotiations, all final decisions and agreements between the parties will be made at the negotiation meetings and agreed to by the lead negotiators. Negotiation meetings are scheduled as listed in Section 2.4. The Region will designate the Region's negotiation team. The Region's negotiation team will recommend a provider(s) for further negotiations or contract award based on consensus agreement.

EXHIBIT
tabbies
B

Behavioral heath system design for services for people with severe and disabling mental illness

Will Spaulding, Ph.D.
Professor of Psychology
University of Nebraska-Lincoln

This discussion specifically addresses the question of how the Region V service system should serve adults with *Serious Mental Illness* (SMI). On the way to answering the question, the discussion considers some basic principles and realities pertinent to behavioral health in general.

The extremely complex task of designing and regulating a region-wide behavioral health service system can be made rational and principled by separating out some related but different considerations:

What is Serious Mental Illness?

Serious Mental Illness (SMI) is formally recognized in various federal and state laws and regulations. SMI refers to chronic psychiatric conditions that cause extensive and persistent functional disability. Functional disability means impairment in one's ability to perform routine daily hygiene and self-care, manage one's personal affairs, maintain gainful employment and have social relationships. SMI is not the same as psychiatric diagnosis, but the diagnoses associated with SMI are those in the "schizophrenia spectrum."

There are important differences between jargon terms like SMI and others, most especially "severe and persistent mental illness" (SPMI). In Nebraska, SPMI refers more generally to any psychiatric illness that is not transitory, including chronic anxiety disorders and depression. *There are very important differences between people who have SMI and those who have SPMI but do not meet criteria for SMI, in terms of symptoms, types and severity of disabilities, and treatment needs.*

Most SPMI is treated with individual and group psychotherapy and/or antidepressant or anxiolytic medication. SMI generally requires more comprehensive psychiatric rehabilitation, including specialized psychotherapy, living skills and social skills training, and antipsychotic medication. When SMI co-occurs with substance abuse, specialized forms of substance abuse treatment are required. Materials for treating substance abuse specifically for people with schizophrenia-spectrum disorders are included in the SAMSHA Best Practices toolkit. In contrast, for people with SPMI standard forms of substance abuse treatment are usually appropriate, when delivered in conjunction with standard treatment for the co-occurring psychiatric disorder.

What is a behavioral health service system?

Behavioral health is an expansive category composed of importantly different sub-categories. Best practices and cost-effective operations are different across these sub-categories. A basic design task is to identify the sub-categories that require their own policies and regulations. There is some communication value in talking about "behavioral health" in broad, inclusive terms, e.g. for public education and advocacy. However, for the purposes of designing and running the system, "behavioral health" is best understood as a conglomeration of its sub-categories.

The sub-categories in behavioral health are created by multiple factors:

- Naturally-occurring commonalities among groups of people that distinguish them from other groups
- The psychiatric diagnostic system (this is not the same as naturally-occurring commonalities; psychiatric diagnosis is notoriously unreliable and unhelpful for making clinical decisions or designing or regulating systems, but for historical and political reasons the diagnostic system does influence how behavioral health gets sub-categorized)
- Service standards and regulations, especially "service definitions"
- Funding conduits and their associated regulations (e.g. Medicaid, private insurance, public institutions)
- License laws that specify which providers can do what for which recipients
- The different skill sets associated with different behavioral health disciplines (this is only loosely related to licensing laws)
- The evolving clinical technologies and related evidence-based practices
- Local socio-cultural values (e.g. tolerance for public deviant behavior, homelessness and dangerousness)

Not only are these factors multiple, they are fluid, changing over time, sometimes rapidly. As a result, there is no single formula or logic that can determine the best possible sub-categorization. Therefore, the principled approach to system design is to *recognize and accommodate* the way behavioral health is categorized by nature and society, not attempt to *control* how it is categorized.

Most people would probably agree about the major categories of behavioral health evident in Nebraska and everywhere else (except maybe for gambling) right now:

- Developmental disabilities and severe childhood psychiatric disorders
- Child/adolescent adjustment and family functioning problems
- Substance abuse and associated behavioral, psychological and social problems
- Gambling and associated behavioral, psychological and social problems
- Non-disabling psychiatric disorders
- Disabling psychiatric disorders ("serious mental illness," SMI)

There might be an argument about where sex offenders fall in this scheme. Sex offenders inhabit a gray area between the behavioral health and correctional systems. They can have

any of the problems listed above, or none of them. For 10 years sex offenders who do not have any other behavioral health problems have been placed in the behavioral health system for political reasons. Similarly, Medicaid reimbursement policy on treatment of conduct disorder shifts it from family and adolescent behavioral health into the correctional system - ironically, the reverse of adult sex offenders. For the purposes of this discussion, politicized policies do not create real behavioral health categories. Services for sex offenders who do have other behavioral health problems are appropriately categorized according to those problems, with the additional treatment and risk considerations that inappropriate sexual behavior creates. Accordingly, for system design purposes it is important to recognize that some people with SMI also have a legal status of sex offender.

When we talk about individuals "falling through the cracks" we usually mean people whose problems do not fit into existing categories and therefore don't have access to services within those categories. This can be partly fixed by simply revising regulations to include those people in a category, but that also means the regulations and services within the category will need revision to accommodate the new members. Examples with which we are currently struggling are "autism spectrum," which logically fits in the developmental disability category, "conduct disorder," which logically fits in the adolescent and family category, and "borderline personality disorder" which logically fits in either the disabling or non-disabling psychiatric category, depending on its severity. "Traumatic brain injury" is another example, but in that case there is no logical category to fit it into. In all cases, people in these groups are denied treatment because regulations "define them out." Unfunded means unavailable in most services systems, despite strong scientific support for effectiveness. Cost-effective treatments for these problems appear in the research literature, stimulating advocacy for making them available in some category of the behavioral health service system. This pressure is opposed by the bureaucratic/political perspective that we're not just adding treatments to the system, we're adding people with entitlements and therefore increasing costs. Instead, in this view, we should be eliminating people from categories, or better yet eliminating entire categories, from the behavioral health system.

In recent years the concept of co-occurring disorders has received much deserved attention. In large part this reflects a realization of the problems with psychiatric diagnosis, especially as a guide for system design (in technical terms, high co-morbidity rates compromise the construct validity of the separate diagnoses). However, the significance of co-occurring disorders does not greatly affect the major sub-categories of behavioral health. *Most* people with substance abuse have related behavioral, psychological and social problems. Services in the substance abuse (SA) category must be fully capable of addressing these problems when they are present. At the same time, there are many people with non-disabling psychiatric disorders who don't have SA problems. There are both differences and overlaps, in specific treatments and practices, for SA vs. the various non-disabling psychiatric disorders. It is therefore useful to have separate categories for SA and non-disabling psychiatric disorders, even though people with "co-occurring disorders" are principally served through the "SA/dual disorder" parts of the service system.

Similarly, the fact that a majority of people with SMI have substance abuse problems means SMI services must be able to effectively address those problems. However, the major behavioral health category of SMI is preserved by the research finding that the substance abuse treatment approaches beneficial for people with SMI are different from those for people *without* SMI. It would better fit reality to speak of "substance abuse complicated by other problems" or "SMI complicated by substance abuse" than to use terms like co-morbid or co-occurring, which are relics of an obsolete diagnostic system.

In Nebraska, the jargon term SPMI includes people with disabling and non-disabling psychiatric disorders. SMI is the more useful term because by definition all people with SMI are severely disabled. In this sense "SPMI not in the schizophrenia spectrum" is simply a poor synonym for "non-disabling psychiatric disorders." Of course, a person with SPMI not in the schizophrenia spectrum may still be disabled, but the disability is rarely caused by the psychiatric disorder. For people with substance abuse complicated by a non-disabling psychiatric disorder, the disability is caused most primarily by the substance abuse and its consequences.

The concept of using empirical statistical techniques, specifically cluster analysis, to influence system design has been much discussed recently in Region V. Such techniques are useful research tools when used with caution and circumspection. Cluster analysis is designed to identify naturally-occurring groups, and in that sense does not have the diagnostic system's problem of arbitrary categories with dubious validity. As such, it can be useful for informing the broadest levels of system design, i.e. the major categories. However, that is where the usefulness of such analyses end. Naturally-occurring groupings of people is only one of several factors in creation of behavioral health categories. Furthermore, the categories that are derived from any cluster analysis are dependent on the particular variables that are entered into the analysis. There are mathematical limitations in the number of variables one can enter and the number of clusters one can derive. There is no reason to expect that the same clusters would appear if a different set of variables were entered. If we are looking for the biggest clusters at the highest levels of the system, this is not a problem. We choose a limited set of variables that captures the range of variability that we want the clusters to cover. However, this also means that however stable and valid the clusters, each contains individuals who are very different from each other. You can't have it both ways. If you want to find the major clusters in a big chunk of behavioral health, e.g. "all recipients of psychiatric services," you will get very heterogeneous clusters. As the next part of the discussion indicates, this leads to the most serious mistake that can be made in planning SMI services in behavioral health systems.

How homogenous is the SMI category?

The most pervasive mistake made in design of SMI service system is the "one size fits all" fallacy. The most striking local example is the NDHHS notion that "all rehabilitation must occur in the community," as if all the people who need rehabilitation live in the community. This is a cruel disregard of the increasing numbers of people stuck in the institutions and

prisons, for whom the best hope for returning to the community is the psychiatric rehabilitation they now can't get.

Even limited exposure to the SMI subpopulation reveals that even though SMI is a clear and stable category, there is substantial heterogeneity within it, in terms of people's functional problems, needs and treatment indications. However, we still tend unreflectively to use stereotypes of the "average patient." We do it at the level of basic clinical practice. For example, research shows that about 20% of people with schizophrenia get no benefit from antipsychotic drugs, yet we insist that 100% "take their meds" because we don't bother to determine who is benefitting and who isn't. As the NDHHS example shows, we do it at high levels of administrative practice as well.

Ironically, a flawed understanding of "evidence-based practice" numbs us to the stereotype as well. We certainly want to use treatments that have withstood controlled trials, but controlled trials unavoidably include contrived, atypical groups of patients. Once a treatment is research-supported, the question remains as to what patients it will work for, and when. If we design an inflexible treatment array for the "average" patient, only "average" patients will derive optimal benefit. Very few fall right on the statistical mean; being "average" has no meaning at all in this context.

The heterogeneity of SMI does not mean it's a bad major category. Major categories evolve, influenced by multiple fluid factors. In a practical sense, the fittest categories survive. They appropriately reflect useful service provision conventions as well as naturally occurring groups of recipients. The cluster solutions of interest to Region V appear to support the existence of a naturally occurring group that reflects our general notion of SMI as a category of behavioral health. But the measures that reveal the cluster are not expected to be the measures that most helpfully inform us about individual differences within the cluster, and choosing personalized treatment regimens from our rapidly expanding armamentarium.

The one-size fallacy is bad enough when applied within the SMI cluster, but it's even worse when SMI is confused with SPMI. The group identified by the jargon term SPMI generates a cluster quite distinct from the SMI cluster, if it generates a distinct cluster at all. This is logical, in that the treatments associated with the various diagnoses within the SPMI group (anxiety, depression, etc.) are collectively distinct from psychiatric rehabilitation. In addition, the co-morbidity of anxiety, depression and substance abuse is so strong that it blurs the boundaries of the substance abuse and SPMI cluster boundaries. This is why programs that serve people with co-occurring SPMI and substance abuse can efficiently serve a broad spectrum of recipients, with treatments that are not substantially different from the respective treatments for SPMI and substance abuse alone. However, this is not the appropriate service configuration for programs serving the SMI group. This is why psychiatric rehabilitation programs remain quite distinct from programs that serve recipients with non-disabling psychiatric disorders *and* from programs that serve people with substance abuse complicated by non-disabling psychiatric disorders.

Confusion of SMI with SPMI usually results in the transfer of resources, from those intended for SMI to those not intended for SMI. There are several reasons for this. The familiar phenomenon of "cherry picking" is one of them. Providers who take funds to serve SMI are rationally motivated to select the least disabled, least risky recipients. This is especially true in the private sector, where providers have much greater control over who they serve than in the public sector. Expanding eligibility by using "SPMI" as the criterion, instead of "SMI," is an effective way of filling the roster with recipients with anxiety and depression instead of chronic disabling psychosis. A recent study in Nebraska commissioned by NDHHS provides a striking example. A federal grant was used to create a number of "supported employment" programs statewide. Supported employment is an evidence-based treatment whose effectiveness for SMI populations is well accepted. It should be part of any psychiatric rehabilitation service array. It was never intended for SPMI recipients outside the schizophrenia spectrum, and there is no evidence of effectiveness for that group. Nevertheless, in the Nebraska project regulations made people with SPMI eligible. With one exception, all the programs served *only* recipients with SPMI outside the schizophrenia spectrum, i.e. non-disabling psychiatric disorders. This is almost always what happens when "one size fits all" eligibility requirements are used in regulation of services intended for SMI recipients.

Does treatment really work?

A pernicious fellow traveler of the one-size-fits-all fallacy is the idea that SMI is incurable so it really doesn't matter what you do. The national recovery movement and the President's Commission report that inspires it are indictments of this idea. Today we all talk about "recovery" and "client choice," but neither has meaning in a Model-T service system (where you can have any color you want, as long as it's black). Recovery is possible, and it's substantially more possible to a larger number of people when they have access to treatment and rehabilitation tailored to their individual needs. Nevertheless, we fail to hold practitioners accountable for outcomes when they engage in "one size" practice, because at some level we buy their self-serving argument that recovery doesn't happen. We still waste a substantial proportion of resources providing treatments that don't work, and we pay dearly later for not using appropriate treatment today. A service system design that doesn't recognize and manage these realities is doomed to perpetuate the very problems we are trying to solve.

So what should guide design of SPMI service systems?

The principles are pretty much the same as in other categories, but they play themselves out uniquely in the SMI category:

- Evidence-based practice: The research literature provides the guide for what needs to be *available* in the treatment array, which is different from the assumption that everyone needs any one treatment to the same degree. Nebraska is fortunate to have an officially recognized Best Practices document, created by an ad hoc

committee of academic experts, focused on the needs of people with SMI. That document identifies a number of generally accepted principles, and 14 types of evidence-based treatments and services, that translate directly into the treatment array needed for a modern SMI service system. Although new treatments are rapidly proliferating, they still fit well into the basic types identified in the document, so it provides a stable and operational guide to developing the treatment array in a service system.

- Practice-based evidence: It's not enough to buy packaged treatments off the shelf. Evidenced-based treatments must be validated on a case-by-case basis. Providers must be expected to collect and present credible data showing that their treatment produces overall benefits. Such data must be available to practitioners and consumers for individualized clinical decision-making. Modern treatments generate such data. If the treatment isn't generating data, it's not truly evidence-based.
- Epidemiology: The cluster analyses of interest to Region V are essentially statistical approaches to epidemiology. They tell us how many people there are within certain subgroups within the broadest population served by the behavioral health system. However, quantitative epidemiology has a chicken-egg dimension that renders interpretation tricky. For example, are the people in a particular cluster there because of their stable characteristics, or because of the structure of the service system? If the latter, changing the system could actually change the cluster. This is not to say quantitative epidemiological data should not be collected. It is (or should be) an inexpensive tool, but only one of many key tools in the administrator's toolbox.
- Recovery principles: Many argue for this on humanitarian grounds, but there is also a hard-nosed pragmatic reason for incorporating recovery principles in service design. The one size fallacy and related stereotypes create the false design principle that people with SMI don't change. Even when systems include the right treatments, the administrative processes that organize them often reflect the presumption of treatment failure. The non-stereotypic presumption, that virtually everybody recovers to some degree given the right services, has a key fiscal implication: money spent on a person's treatment and rehabilitation today causes a reduction in money spent on that person's care in the near future. Design needs to recognize that capital investment yields returns, if the investments are the right ones.
- Cost relativity: Related to the recovery consideration is relative cost of services. This is another reason why cluster analysis should not directly drive system design – different clusters generate different costs per recipient, and again, those costs are also determined by the appropriateness of the services. It is penny-wise and pound-foolish to neglect the fact that some of the most expensive services in our system are the least effective. Technological "progress" makes this a fluid dimension too. For example, before the second generation antipsychotics (ca. 1990's), medication was a relatively minor cost in the SMI system. Now, because of presumably "safer" but no more effective drugs, medication is a major expense. Accordingly, the amount of money we waste paying for medications that have no benefit has exploded. Ironically, for all the effort spent regulating psychotherapy and other psychosocial

services, we make little or no effort to compel practitioners to validate the logic, much less the effectiveness, of the drugs they prescribe. This is a national problem but it's even worse locally. For example, the local rates of "polypharmacy" (dubious prescription of multiple drugs) appear to be substantially higher than national figures. Unless we believe that local prescribers are less competent that others, we can only attribute it to failure of the regulatory system.

- The regulatory infrastructure: Regions do not control NDHHS, and we must not pretend they can. We operate in a regulatory environment that evolves and mutates like the rest of behavioral health. However bad current regulations might be (and the consensus of the provider community seems to be that they are pretty bad), they provide opportunities for regional systems to develop cost-effective services, at least in some sectors (for the purposes of SMI, the worst part of the regulatory system is how it manages inpatient and secure residential services, but that is another discussion). Region V has shown considerable ability to pursue these opportunities. System design needs to recognize those parts of the policy structure that support services that will serve the system well, and minimize the damage caused by bad policy. Advocacy for better regulations is an important role for regional administrators and other policy makers, but we can't let better services be held hostage to regulatory reforms.
- Risk assessment in system design: At the clinical level, risk assessment and management are recognized as evidence-based best practices. There is also an administrative and policy level of risk management. Unlike diagnosis, assessed risk is a major factor in determining how and where people can be served. We struggle to recognize this reality, much less incorporate it into system design. In fact our irrational beliefs about SPMI appear as basic dimensions of the system infrastructure. For example, we inexplicably distinguish between "forensic" and "non-forensic" services, settings and populations, when the populations and needed treatment are no different. We presume that "NRRI" patients are a greater risk than "civil commitment" patients, when in fact risks can be much more reliably managed under a court order. We believe that judges are the problem in getting NRRI patients into less restrictive settings, when in fact the problem is the ineffectiveness (or lack) of treatment in more restrictive settings. We do too little to hold mental health boards accountable, and the mental health boards in turn do too little to hold providers accountable. System design must be explicit and precise about the nature and severity of risks the service system will manage, yet the level of risk is in turn dependent on the quality of risk assessment and management services in the system. As with the recovery dimension, risk changes over time and the most cost-effective system capitalizes on this to reduce overall costs.

How should these considerations affect behavioral health system design in Region V?

1. SMI should continue to be recognized as a stable major category for system design, with the expectation of significant differences from other categories, in treatment array and regulation.

2. Region V should systematically and quantitatively monitor the local epidemiology of SMI, using local research and evaluation resources to minimize costs. The analyses should address not only the boundaries of the SMI population cluster in terms relevant to policy, but also dimensions within the cluster of relevance to individual differences in treatment and service needs.

3. Decisions about deployment of regional resources should be based on a circumspect analysis that includes quantitative epidemiology along with all the other dimensions described to this point. These decisions must be universally understood to be administrative in nature, not simplistically driven by statistical analyses, and inevitably must accommodate local policy and social values. The key to credibility is not the statistical analysis, but the overall transparency and accountability of the policy-making process and the logical coherence of the policy makers.

And what should be the result?

When the policy process is credible, coherent, transparent, and accountable, all are more willing to let the chips fall where they may. However, a sound process will predictably produce solutions with key features:

1. The Region V system will include a complete array of the specific evidence-based treatments and related services known to benefit the SMI population.

2. Region V policy will explicitly identify the range of risk factors for which it accepts service responsibility, and the system will have resources sufficient for serving people with those risks. Concretely, this probably means an increase in the highest-intensity services now available (in the SMI category, "psychiatric residential rehabilitation"), stabilization of higher-intensity case management resources, and front-end resources for rapidly identifying high-risk and/or high service need cases and diverting them from emergency/crisis/triage into suitable intensive rehabilitation.

3. Region V policy will explicitly identify natural groupings within the SMI population and service system that match individual needs with cost-effective service organization. Concretely, this will probably mean stabilization of integrated rehabilitation programs (e.g. "residential rehabilitation" and "day rehabilitation") that provide intensive treatment with "one stop shopping" efficiency, and further development of higher-intensity case management-type services to provide effective in vivo skill training and related services, for people not needing or wanting day rehabilitation.

4. Region V will capitalize on state regulation opportunities to compel complete functional assessments and treatment plans, justifying all services in terms of measurable needs.

5. There will be a clear distinction between "support" services, not expected to produce further recovery or improvement in functioning, vs. "rehabilitation" services expected to yield greater independence and lower service costs.

6. All services, whether support or rehabilitation, medical or psychosocial, will be held accountable to show continuing clinical benefit, as measured objectively in terms of behavioral functioning and consumer satisfaction. Rehabilitation services will be required to document the assessment and planning activities necessary to achieve fully personalized, recovery-oriented treatment. This must include problem-oriented treatment and rehabilitation plans that identify specific evidence-based treatments applied to specific functional problem areas, implemented and coordinated by a supervising treatment team.

7. Risk assessment and management will be a core feature of SMI services. For consumers at elevated risk, plans for managing and reducing the risk will be integrated into the personalized treatment and rehabilitation plan. The plan will include evidence-based treatments and related procedures for resolving the problems that create the risk, plus coordination with law enforcement, the judiciary, emergency and respite services, and other entities involved in managing the risk.

EXHIBIT
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BEST PRACTICES

Nebraska Department of Health and Human Services
Division of Behavioral Health Services

Nebraska Behavioral Health Reform

Academic Support Work Group

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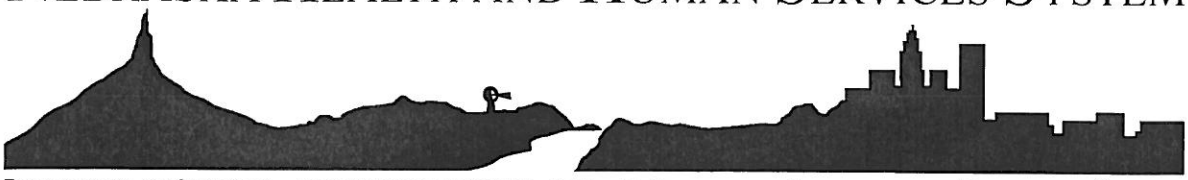
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

Best Practices

For serving people under civil commitment, court ordered or guardian petitioned treatment in Nebraska

The Academic Support Workgroup
Behavioral Health Reform Project

Executive summary. This document describes a "best practices model" for serving people who are under civil commitment, guardian-petitioned treatment and court-ordered treatment in Nebraska. Best practices include the social values, organizational and administrative principles and specific treatments and related services that most cost-effectively benefit the people served. Some aspects of best practice reflect community values, and are not subject to scientific evaluation. Others, especially specific types of treatment, are considered best practices because there is scientific evidence for their effectiveness. The values, principles and treatments included in the best practices model described in this document reflect a consensus of Nebraska's academic mental health community.

Best Practices

For serving people under civil commitment, court ordered or
guardian petitioned treatment in Nebraska

Introduction

Origin and purpose of this document

This document was developed by the Academic Support Workgroup of the Behavioral Health Reform Project in response to the Workgroup's charter. The purpose of the Workgroup is "To ensure academic support for excellence in behavioral health services for consumers in the state public behavioral health system." One goal specified in the Workgroup's charter is "to develop evidence based "best practices" to improve access to and delivery of behavioral health services in urban as well as rural/frontier areas of the state." This document is the "deliverable" associated with that goal.

What are Best Practice models?

Best Practices is a concept used extensively in industry, management, education and healthcare (for recent reviews and discussion pertinent to mental health, see Morrison, 2004; Drake, Rosenberg, Teague, Bartels, & Torrey, 2003; Essock, Goldman, Van Tosh et al., 2003; Hermann & Provost, 2003; Lehman, Buchanan, Dickerson, et al., 2003; Silverstein, Wilkniss, & Bloch, 2002; Stuart, Burland, Ganju, Levounis, & Kiosk, 2002; Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002; Drake, Goldman, Leff et al, 2001). Its basic principle is that communities can and should develop consensus about which of many alternative practices are considered the "best" ones within those communities. The dimensions upon which practices are judged "best" are many, and specific to particular communities and/or applications. These dimensions include broad ones, such as social values and general ethics, to more specific ones, such as administrative policy and professional ethics, to very specific ones, such as technological effectiveness. The "best practices" for any particular application or context is therefore expected to include a range of practices, from social policy to administrative practices to technological (or clinical) practices. Best practices are similar to "standards," the key difference being that standards provide general guidelines and effectiveness criteria, while Best Practices specify what approaches are to be taken toward realizing those guidelines and criteria.

Best Practices do not define a dimension of healthcare services that ranges from "sufficient" to "especially good." In policy vernacular, they do not distinguish between "Ford-quality" services and "Cadillac-quality" services. Best Practices describe practices that should be used in all service systems. Service systems that do not use any particular Best Practice are not simply lower quality or less complete than those who use exclusively Best Practices. They are deficient, and in need of repair. In all aspects of healthcare, including mental health, consumers have a right to expect complete and comprehensive observance of Best Practices, to be treated with dignity and respect and to make informed choices.

In healthcare in general, and mental health in particular, Best Practices incorporate global premises about the nature of mental illness, the nature of recovery from mental illness and the roles of consumers and providers. These premises follow partly from social values, and are in that sense not completely subject to scientific evaluation. Best Practices also incorporate more specific premises about the effectiveness and efficacy of specific clinical techniques. This sub-domain of Best Practices is often termed evidence based practice, and as the name implies, is subject to scientific evaluation.

Best Practices and mental health reform in Nebraska

The charge to the Academic Workgroup is to develop a Best Practices model for application in mental health system reform in Nebraska. There are 3 key considerations that set the parameters of the model:

1. Recent Nebraska Unicameral legislation (LB1083) directs that a new Division of Mental Health and Substance Abuse be created within NDHHS, and that administrative steps be taken to modernize Nebraska's mental health service system;
2. Within the larger context of system modernization, the consumer population of primary concern to the Academic Workgroup consists of *people who are civilly committed for treatment, or who would be committed absent a legal guardian who petitions for treatment, or are under court-ordered treatment* (in this document these individuals are hereafter collectively termed "the population of concern");
3. Two overall goals of system modernization, pertinent to the population of primary concern, are to *maximize use of community-based services as alternatives to institutionalization*, and to *maximize consumer involvement in all aspects of service planning, administration, research and provision.*

These considerations give focus to the Workgroup's task of developing a Best Practices model. At the same time, they clearly suggest that the Best Practices model for this particular population of concern include the values-based and science-based elements that are to be expected in Best Practices models. For that reason, the model described in this document is organized into sections that separately address pertinent social values, policy and administrative practices, and evidence-based clinical practices.

One important characteristic of the population of concern is that it is a subset of the population of people with "serious mental illness" (SMI). The term SMI also serves to identify a body of scientific research, clinical research and technology, legal scholarship and case law, first person narratives and public policy discourse highly pertinent to the population of primary concern to the Workgroup. The Best Practices model developed by the Workgroup draws heavily on this body of work. For many purposes, the population of concern is best understood as representative of people with SMI. For some purposes, the population of concern's legal status (committed, etc.) generates more specialized considerations.

Hereafter the model developed by the Academic Workgroup and described in this document will be termed the Workgroup Best Practices Model (WBPM).

The Workgroup Best Practices Model (WBPM)

Social values

There is considerable consensus nationally, across the consumer, advocacy, provider, policy and scientific communities, and in the general public, about the social values that should guide mental health services for people with SMI. A key force in development of this consensus has been organized activism on the part of people with SMI and that of their families. Consumer and family advocacy has included a robust discourse among consumers, families, the professional and scientific mental health community, and the social policy community, emphasizing the importance of consumer input in all aspects of research, service provision, evaluation and policy: "Representing the consumer's perspective on the meaning of

mental illness and the correlates of 'getting better,' the process of client involvement in evaluation design and implementation is not only realistic and feasible; it is, we feel, a professional necessity whose time is overdue (Prager & Tanaka, 1979, p. 51)." The U.S. Surgeon General articulated the national consensus in his 1999 report on mental health (U.S. Public Health Service, 1999). The most recent and comprehensive expression of the current consensus is the Report of the President's New Freedom Commission on Mental Health (President's New Freedom Commission, 2004).

Another important source for determining relevant values is legal scholarship and case law. The values enumerated in the WBPM reflect judicial findings and decisions regarding individuals' rights to treatment, and other rights of people with disabilities receiving involuntary treatment and/or housed in institutions (Stefan, 2001; see also Report of the President's New Freedom Commission, Goal 2.5).

The essential social values in the WBPM are:

1. The primary and overriding purpose of services for people with SMI, and people in the population of primary concern in particular, must be the benefit of those people;
2. Services for people in the population of concern must be appropriate to their individual needs, modern and high quality, guided by a Best Practices model that identifies relevant values, policies and evidence-based clinical practices, and provided in the least restrictive and most integrated settings appropriate to their needs and with necessary and sufficient supports (see especially the Report of the President's New Freedom Commission, Goal 2.4);
3. Mental health administrators and providers must be held directly accountable for the quality, appropriateness and effectiveness of the services they administer or provide;
4. People who are civilly committed, under guardianship or under court-ordered treatment must have the same access to appropriate, modern, quality services as people who are not;
5. The concept of *recovery* provides the best, most comprehensive integration of social values, scientific understanding of SMI and effective clinical practices, the most important domain of operational outcome measurement, and the best overall goal and outcome criterion for services (see especially the Surgeon General's report, U.S. Public Health Service, 1994, chapter 2, and the Report of the President's New Freedom Commission, Goal 2.2);
6. In the population of primary concern for the WBPM, a key aspect of recovery is regaining personal autonomy and resolving the circumstances that led to civil commitment, guardian-petitioned treatment or court-ordered treatment;
7. At any and every point in the recovery process, people in recovery must be supported in their self-determination and served with the least intrusive, least restrictive services possible, in the least restrictive and most integrated settings possible;
8. The experience and involvement of people with SMI is integral to and a priority in all aspects of the research, planning, administration and provision of mental health services (see Salzer, 2002);
9. Services provided to the population of concern should meet the criteria for trauma informed services and should be provided in environments that are trauma and coercion free (Blanch, 2003; Finklestein, et. al. 2004; Jennings, 2004a; Jennings, 2004b;)
10. Services provided to the population of concern should be delivered in a culturally competent manner within a culturally responsive environment.
11. In order to foster and promote the human dignity of people who live with SMI, mental health clinicians, researchers and providers should adopt the use of *person first language*, e.g., "persons diagnosed with mental illness, people who live with schizophrenia."

12. The above principles are incorporated into policy, planning, administrative practice and regulation at every level of the mental health service system.

Policy, administration and regulation

Policy, administrative practices and regulatory practices are highly variable, even for the specific population of primary concern to the Workgroup. This is because mental health systems must be tailored to state and local demographics, economics, politics and geography. Nevertheless, application of Best Practices social values and evidence-based clinical practices in Nebraska leads to general guidelines:

1. Policy, administrative practices and regulatory practices must all be congruent with the social values enumerated in the WBPM;
2. Policy, administrative practices and regulatory practices must all be congruent with generally accepted standards and accreditation criteria such as those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF), and must require relevant accreditation for facilities and services in the mental health system;
3. Policy, administrative practices and regulatory practices must effectively support provision of the best services and clinical practices enumerated in the WBPM, in particular those that most effectively support the process and goal of recovery from disabilities associated with severe mental illness;
4. Policy, administrative practices and regulatory practices must support effective collaboration among the consumer, the mental health system and the legal/judicial system, so that clinical decisions and legal/judicial decisions are optimally informed by each other and the first person narrative.
5. Policy, administrative practices and regulatory practices must support effective interdisciplinary collaboration and optimum use of professionals practicing within the full legal scope of their respective disciplines;
6. Policy, administrative practices and regulatory practices must be subjected to continuous data-based evaluation to ensure they effectively support the best services and clinical practices and generate the best possible outcomes;
7. Policy, administrative practices and regulatory practices must hold providers accountable for providing quality services at fair cost.

Clinical services: organization and administration

Best Practices for the organization and administration of clinical services derive from the nature of the services that must be organized and administered. For the purposes of the WBPM, there is too little empirical research to conclude that any particular organizational and/or administrative model is better than any other. Best Practices in this domain emerge primarily by logical inference that starts with the outcome research on specific clinical practices, and is informed by general principles of management and administration. The guidelines that emerge from this process are:

1. The organization and administration of clinical services must all be congruent with the social values enumerated in the WBPM;
2. The concept of *psychiatric rehabilitation* provides the best, most comprehensive approach to organizing the services and clinical practices that most effectively realize the goals of recovery for

people with SMI (for a definitive account of psychiatric rehabilitation, see Wallace, Liberman, Kopelowicz and Yaeger, 2001; for an account of the co-evolution of the rehabilitation and recovery movements, see Anthony, Cohen & Farkas, 1999);

3. Psychiatric rehabilitation is a collaboration of the person in recovery, family (where applicable), advocates, peers, service providers and substitute decision makers (where applicable), formally organized and working together as an interdisciplinary team;
4. Psychiatric rehabilitation is systematically provided according to a formal, documented treatment or rehabilitation plan, tailored to the individual needs and goals of the person in recovery (see especially the Report of the President's New Freedom Commission, Goal 2.1);
5. The treatment or rehabilitation plan is comprehensive, addressing all factors pertinent to the biological, psychological and social functioning of the person in recovery, and his or her environment, that are barriers to recovery (for this reason, psychiatric rehabilitation is also known as biopsychosocial rehabilitation);
6. The treatment or rehabilitation plan for each person who receives services is subjected to periodic, data-based review and evaluation, to ensure the person is making progress toward specified goals;
7. The professional members of the treatment or rehabilitation team are held directly accountable for their participation on the team and the quality of their services.

Clinical services: arrays, settings and packages

Clinical services for the population of primary concern are usually "bundled" for optimal provision by an agency or program. Often service packages include the setting in which they are provided, e.g. in a hospital, institution, residential facility, outpatient clinic or day program. The scientific literature provides some indications of the best ways to organize, or "bundle" combinations of services for the population of primary concern. However, it is equally clear that the population of primary concern is heterogeneous with respect to need for particular settings and/or services. A single "bundle" will not cost-effectively meet the recovery needs of all persons. Similarly, as recovery progresses, people's needs change, sometimes dramatically. Therefore, specific clinical services and "bundles" of services must all be considered part of a larger service array whose elements are available to people within the population according to their respective needs.

For most of the population of concern, at most points in time, a "wrap-around" model is the best way to ensure comprehensive access to appropriate and effective services. Wrap-around models provide a comprehensive package of services, often including general healthcare as well as mental health services, under a single administrative auspice. As people recover and require less intensive services, less comprehensive models of service provision sometimes become more cost-effective and/or less restrictive than wrap-around models (even while the individual remains civilly committed), so the former must be available in the service array. Various types of wrap-around models are used in health and human service systems. The models can be tailored to the specific needs of the population served, to characteristics of the service settings, and to the characteristics of the specific services themselves. Such tailoring is necessary for cost effectiveness.

It is critically important to distinguish between service arrays developed to serve specific populations in specific settings, vs. commercially developed bundles of services. The latter are developed in an entrepreneurial context, packaged, marketed and sold to service providers or service systems. Similar packages or "toolkits" are sometimes assembled by researchers or government agencies for the purposes of studying dissemination, use and effectiveness of the modalities contained in the bundles (e.g.

SAMHSA, 2004). The packages usually consist of procedure manuals, assessment instruments and related materials, staff training and program development consultation. Their commercial appeal is that they appear to offer a quick and straightforward way to reform or expand the capabilities of a service system. While such packages may have value, they are typically developed for particular sub-populations in specific settings. Their scope of generalization is unknown. They all include specific services and treatment approaches that are variants of services and approaches found in other packages. There is no evidence on the superiority of any such package over any other, except for the general finding that packages that include active treatment and rehabilitation are more beneficial and cost-effective than those that do not (Brekke, Long, Nesbitt & Soble, 1997; Mueser, et al, 1998). For the specific purposes of the WBPM, there is no commercially packaged service array with demonstrated superiority for people who are under commitment or guardian- or court-ordered treatment. Implementing a commercially packaged bundle of services is no substitute for developing a service array tailored to the needs, human resources and local characteristics of a mental health service system.

The value of least intrusive/least restrictive alternatives (social value #7 in the WBPM) generates another (but related) key consideration for Best Practices in this domain. The safety needs of individuals within the population of concern are highly variable. When appropriate services are available, a high security environment is not always (in fact, seldom) necessary for the safety of a person who has been judged "dangerous to oneself or others." As recovery progresses, people are expected to require decreasing levels of security, even while they would still be "dangerous" at even lower levels of security. Nevertheless, for some people at some points in time, treatment and rehabilitation must be provided in a high security setting. There is no legal, ethical, scientific nor technological reason for not providing treatment and rehabilitation in a high security setting. The social values of the WBPM require that psychiatric rehabilitation services be accessible to all people in the population of concern, regardless of their security needs at any particular time.

Maximizing community-based services generates yet another key consideration in this domain. All other things being equal, services and settings in the community are preferred over institutional settings.

The WBPM identifies the following guidelines for developing and maintaining an appropriate array of settings, service "packages" and individual services:

1. Clinical service arrays. settings and packages must all be congruent with the social values enumerated in the WBPM;
2. All people in the population of concern must have access to and be actively involved in the particular combination of treatment and rehabilitation services that best meets their self-identified recovery needs and those legally mandated at any particular time in the course of their recovery;
3. All people in the population of concern must have access to active treatment and rehabilitation regardless of the setting required by their safety needs and their legal status;
4. All people in the population of concern must be served in community settings to the maximum degree made possible by safety concerns and cost-effectiveness.

Clinical services: case management.

The diversity and complexity of rehabilitation technology and the need for "wrap-around" services requires systematic integration and coordination for cost-effective delivery. Interdisciplinary treatment teams typically use a case management model for this purpose (for overviews see Holloway, Oliver, Collins & Carson, 1995; Mueser, Bond, Drake, & Resnick, 1998). Case management models generally

assign one member of the treatment team the role of monitoring the progress of the rehabilitation plan, coordinating delivery of services, calling team meetings and implementing team decisions, and making sure relevant information on the progress of the person in recovery is disseminated to team members. Under the broad rubric of case management there are a number of specific models of service organization, specialized for people who have SMI, in which case management plays a central role. These will be discussed further as specific evidence-based service organization models.

Clinical services: peer involvement.

The involvement of *peers*, people who themselves are recovering from serious mental illness, is an increasingly important factor in all aspects of service provision. In fact, peer involvement goes beyond service provision, and provides an overriding support system and interpersonal context for recovery. A variety of models and approaches to peer involvement have been developed and implemented across the country. Controlled outcome research has not yet identified a particular model or approach as an evidence-based practice, although there is "promising" preliminary data on peer support and illness/wellness management groups and peer involvement in intensive case management (further discussed under evidence based practice #6, below). Meanwhile, the social values of the WBPM require that peer involvement be planned and implemented in all stages of mental health system reform and development. The state of New York includes "Self-Help and Peer Support Services" on its list of priority evidence-based practices, as "a complement to treatment and as a life-long support [that] promotes the process of recovery," with the expectation that "educating consumers about self-help, encouraging referral and attendance, and supporting participation in mutual aid fellowships will benefit people with limited social networks and those interested in sharing and participating in personally meaningful activities." As peer involvement programs with specific outcome benefits are identified by research, these should be added to the WBPM list of evidence-based practices.

The President's New Freedom Commission on Mental Health, in *Achieving the Promise: Transforming Mental Health Care in America* (2003), strongly advocates for consumers and family members to be involved fully in orienting the mental health system toward recovery. The Commission supports the need to increase opportunities for consumers to share their knowledge, skills and experiences of recovery. Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations and by consumers who work as providers in a variety of settings, including peer-support and psycho-social rehabilitation programs (Clay, 2005).

The President's Commission recognized the following benefits associated with consumer involvement:

1. Consumers who work as providers help expand the range and availability of services and supports that professionals offer.
2. Consumer run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with behavioral health conditions.
3. Consumers, because of their experiences, bring different attitudes, motivations, insights and behavioral qualities to behavioral health treatment.
4. Consumers, because of their experience, have an important perspective that requires their direct participation in treatment planning, evaluation and research activities.

5. Consumers have a key role in expanding the behavioral health care delivery workforce and in creating a system that focuses on recovery.

Finally, the President's Commission notes that emerging research has validated that having hope and opportunity for self-determination are important factors that contribute to recovery. In recent years, consumer knowledge has been translated into a growing understanding that people can recover and that peer support has an important role in the recovery process.

Clinical services: evidence-based practice

The professional and scientific literature identifies a number of specific treatment or rehabilitation modalities having known effectiveness for enhancing recovery in people living with SMI. The usual criterion for classifying a modality as "evidence-based" is that it has proven superior to a comparable alternative or "treatment as usual" in at least 2 randomized controlled clinical trials conducted by different research groups. In recent years, this has been amplified by *meta-analysis*, a quantitative technique for determining the collective results of multiple separate clinical trials. However, there is considerable debate about whether the "randomized controlled trial" criterion alone is sufficient to compile a list of evidence-based modalities. Consumers are concerned that an overriding emphasis on traditional evidence based practices will limit the opportunity for funding innovative consumer based practices that support consumers' goals of self determination and recovery (Marzilli, 2002; Kanapaux, 2003; Miller & Thompson, 2004; New York State Consumers, Survivors and Ex-Patients, 2004). Consumers question this standard and promote the value of the qualitative experiences of the individual narratives of people who have moved beyond the limitations of their diagnosis (Kanapaux, 2003). All aspects of research and evidence-based practice activities about people living with SMI have been vigorously criticized as lacking sufficient consumer input at all levels and stages (Prager, & Tanaka, 1979; Campbell & Schraiber, 1989; Campbell, Ralph & Glover, 1993; Scott, 1993; Fenton, Batavia & Roody; 1993; Ralph, 1994; Everett & Boydell, 1994; Campbell & Johnson, J. 1995; Campbell, 1996; Ralph, Lambric & Steele, 1996; Campbell, 1997; Campbell, 1999; Campbell & Zahira DuVall, 2001). Within the scientific community, there is concern that research studies are necessarily conducted in contrived circumstances where effectiveness may not generalize to natural environments. In some contexts, "no treatment" may be a more appropriate comparison condition than "treatment as usual" in a clinical trial (unfortunately, in the real world "no treatment" is sometimes indistinguishable from "treatment as usual"). There is no universal consensus about what outcome measures have ecological validity, i.e. are meaningful outside the laboratory with respect to a person's personal and social functioning and quality of life. The importance of some modalities or practices derives not from specific trials, but from their centrality to a larger approach having known or broadly accepted superiority. Separate subcategories of evidence-based practices have been proposed, ranging from "undisputed effectiveness" to "emerging practices" to "new modalities of considerable promise." Without a broad consensus about how to identify evidence-based modalities and practices, Best Practice models are compelled to consider multiple criteria, weighing evidence from controlled clinical trials along with other scientific and practical considerations (for recent discussions of evidence-based practice principles in mental health, see Leff, 2004; Lehman, Kreyenbuhl, Buchanan, Dickerson et al, 2004; Morrison, 2004; Drake et al., 2003; Lehman et al., 2003;).

The clinical modalities and practices in the WBPM are described below along with the scientific support for their effectiveness:

1. Collaborative Psychopharmacotherapy. There is a voluminous scientific literature on the effectiveness of psychotropic medication in suppressing psychotic symptoms, reducing hospital recidivism and "postponing" psychotic relapse in people who have SMI. Effectiveness on these specific outcome

dimensions is generally beyond dispute. However, concerns about the ecological validity of these effects remain. There is general agreement that psychotropic medications alone are usually not sufficient for a person's optimal recovery from SMI.

There is some recognition in the psychiatric literature that the complexity of SMI and the unpredictability of the person's response to treatment demand a somewhat unconventional but enlightened approach to pharmacotherapy (Kopelowicz & Liberman, 2003; Liberman, Corrigan & Schade, 1989; Liberman, Fallon & Wallace, 1984; Falloon & Liberman, 1983). There are two key principles in this approach: (1) although anti-psychotic drugs are a sine qua non in treating people diagnosed as having SMI, they are almost never sufficient by themselves, and so special attention must be given to coordinating pharmacological treatment with other treatments, including primary healthcare and rehabilitation efforts, and (2) nothing can be taken for granted about the effectiveness of any particular drug intervention, so each intervention must be systematically, comprehensively and objectively evaluated, in a hypothetico-deductive, trial-and-test approach to treatment.

Recent years have seen development of guidelines and algorithms for prescribing psychiatric medication and evaluating its effectiveness (American Psychiatric Association, 1997; Lehman et al., 1998; McEvoy, Scheifler, & Frances, 1999). There is some early evidence that adherence to such guidelines produces superior and cost-efficient outcome (Suppes et al., 2003; Schumacher, Makela, & Griffin, 2003), but the research does not yet meet "evidence-based" criteria. For present purposes, the guidelines and algorithms do represent the views of experts and leaders within the psychopharmacology community, and as such, familiarity with the guidelines and algorithms should be considered a component of best practices. If research continues to support superior outcome, the best practice criterion should become adherence to guidelines and algorithms.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2004) has produced a package for public dissemination, *Medication Management Approaches in Psychiatry*, intended to enhance collaborative pharmacotherapy. The package includes materials for all participants in treatment and rehabilitation process, including the person in recovery, medication prescriber, primary physician, other health care professionals, other providers, family and friends. For the purposes of the WBPM, adherence to the principles represented in that package reflects best practice in collaborative pharmacotherapy.

It is important to carefully monitor the general health of people who are taking antipsychotic medication (Meyer & Nasrallah, 2003).

2. Rehabilitation Counseling. Rehabilitation counseling, primarily associated with the work of William Anthony and his colleagues (Anthony, Cohen, & Farkas, 1990) represents a fusion of key concepts and principles from traditional physical rehabilitation and traditional client-centered psychotherapy. Rehabilitation counseling typically involves a periodic meeting between the person in recovery and at least one other member of the treatment and rehabilitation team. Both directive and nondirective psychotherapy techniques are employed to identify the problems that require treatment and rehabilitation, the person's desires and concerns, and resources to be applied. The initial objective is to reach consensus about the person's needs and what the team can do about them. A subsequent objective is to construct an individualized treatment and rehabilitation plan that integrates the team's goals and objectives with specific interventions and other services, bearing in mind that the person in recovery and/or substitute decision makers are key members of the team. All the pharmacological and psychosocial modalities to be employed in the treatment and rehabilitation of the person in recovery are included on this plan, and it thus takes on a key role in consolidating each team member's understanding of the purpose and importance of each modality and service. This is seen as crucial to maximally engaging the person in

recovery in his or her rehabilitation and ensuring high fidelity implementation of the treatment plan. As the treatment plan is implemented, the focus of counseling turns to appraisal and evaluation of progress, with the ongoing objective of reinforcing the person's experience of success and self-efficacy. Counseling continues until the treatment plan goals have been met and recovery is well underway.

There have been no controlled experimental analyses of the unique contribution of rehabilitation counseling to outcome. It plays such a central role that comprehensive psychiatric rehabilitation would be difficult to provide, if not impossible, without it. Similarly, it is doubtful that treatment planning standards such as those of JCAHO or CARF could be met without some form of rehabilitation counseling integrated into the treatment planning and review process. Also, some form of rehabilitation counseling is demanded by the overriding necessity of the - maximum involvement of the person in recovery in treatment and rehabilitation (Social values #1 and Clinical services guideline #3) including identification of recovery goals. Rehabilitation counseling represents a communication conduit between the recovering person and the rest of the treatment team that is prerequisite to implementation of the rehabilitation and recovery approach. In the population of concern, disagreements among the person in recovery, family and other treatment team members are almost always a problem, and rehabilitation counseling is a key part of the solution.

For the purposes of the WBPM, best practices require that assessment, treatment planning and rehabilitation include an ongoing counseling process that identifies and documents the desires and goals of the person in recovery, and clear representation of these desires and goals in the comprehensive treatment and rehabilitation plan.

3. Social Skills Training. This modality is familiar to many mental health professionals, having been widely applied to a diversity of recipient populations. There are highly developed and manualized versions designed specifically for people who live with schizophrenia and related SMI conditions. The most widely researched and used are disseminated by the UCLA Center for Research on Treatment and Rehabilitation of Psychosis, along with related therapist training materials. Original research studies and a meta-analysis of 27 controlled trials (Benton & Schroeder, 1990) are consistent in showing that formal social skills training improves personal and social functioning, reduces hospital recidivism and moderates symptoms in people who live with schizophrenia.

Social skills training of the type known to be effective for people who live with SMI is an energetic, highly structured, highly interactive modality. It involves almost continuous use of role playing exercises, with all group members serving as observers and assistants when not actually role-playing. It is necessary for the therapist to engage the people participating in training and facilitate their active participation throughout treatment. Unfortunately, "social skills groups" in mental health settings are often quite a bit less than this. The availability of therapist training materials and related resources make it possible for most mental health settings to be able to provide high quality services, but only if the training is actually done and high fidelity to training precepts is assured by quality assurance mechanisms.

For the purposes of the WBPM, best practice requires that social skills training be accessible to people who need it, at the particular level (basic to advanced) appropriate to the person's current functioning, and that the skill training be provided by specifically trained therapists, with ongoing mechanisms to ensure fidelity to training procedures and treatment manuals.

4. Independent Living Skills Training. This modality is also familiar to professionals who have experience working with people who have SMI . People who live with schizophrenia and related disorders often lose or fail to develop skills associated with routine daily living, such as basic personal healthcare, grooming and hygiene, keeping a daily schedule, housekeeping, cooking, management of

personal funds, and using public resources (transportation, libraries, etc). Acquisition of these skills contributes heavily to the ability to live safely and comfortably as members of the community.

People who participate in independent living skills training receive classroom instruction and in vivo coaching to establish the knowledge base and performance ability necessary to use specific skills. The required therapist skills are often in the professional training of psychiatric nurses, occupational therapists, social workers, psychologists and other mental health professionals. Empirical verification of the effectiveness of independent living skill training is provided by separate controlled trials (e.g Liberman et al., 1998; Michie, Lindsay, & Smith, 1998), but is more commonly incorporated in assessments of more comprehensive rehabilitation programs that include or emphasize living skill training (e.g. Burns & Santos, 1995; Wallace & Liberman, 1985).

For the purposes of the WBPM, best practice requires that living skills training be accessible to people who need it, in the particular domain appropriate to the person's current functioning (cooking, housekeeping, personal financial management, etc.), and that the skill training be provided by specifically trained therapists, with ongoing mechanisms to ensure fidelity to training procedures and treatment manuals.

5. Occupational Skills Training. Occupational functioning incorporates both "work and play." In the "work" domain, occupational skills are generally understood to be those that are important for any work-related activity, e.g., punctuality, proper workplace grooming, staying on task, following instructions, managing relationships with coworkers and supervisors. These should not be confused with vocational skills, which are more specific to particular kinds of work. Leisure and recreational skills, including identifying interests and planning activities, are as important to stable functioning and a decent quality of life as work skills. Occupational skills training is more specific than occupational therapy, a range of services provided by certified occupational therapists, although occupational skills training can be provided under the auspices of occupational therapy. Research generally supports the effectiveness of occupational skill training for increasing work-related performance (reviewed by Durham, 1997) and enhancing leisure/recreational functioning (Pestle, Card, & Menditto, 1998), in people with SMI.

Vocational functioning is a subset of occupational functioning. A variety of basic interpersonal skills are prerequisites to vocational functioning, and these are addressed by social, occupational and independent living skills training. In addition, skill training focused specifically on working has shown effectiveness in helping recovering people get and keep jobs (Drake, Becker, Biesanz, Wyzik, & Torrey, 1996; Drake, Becker, Clark, & Mueser, 1999; Marwaha & Johnson, 2004; Twamley, Jeste, & Lehman, 2003). *Supported employment programs* have been shown to be effective in helping people make the final step into stable employment (Drake et al, 1996; Twamley, Jeste & Lehman, 2003). In supported employment, the person in recovery works at a competitive job with gradually diminishing help, coaching and support from a rehabilitation professional.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has produced a package for public dissemination that falls under this category, *Supported Employment*. The packages includes manuals and related materials for developing a supported employment program in conjunction with a comprehensive psychiatric rehabilitation service array. The package represents a best practices exemplar for supported employment services.

For the purposes of the WBPM, best practices requires availability of a range of occupational rehabilitation opportunities, from basic work skills training to supported employment, capable of addressing the occupational needs of people as they progress through recovery.

6. Illness/wellness Management Skill Training. Gaining the ability to manage one's own psychiatric illness is central to the rehabilitation and recovery perspective (Mueser, Corrigan, Hilton, Tanzman, Schaub, Gingerich, Essock, Tarrier, Morey, Vogel-Scibilia & Herz, 2002). In the rehabilitation literature, skill training in illness/wellness management has gradually differentiated itself from related social and living skills approaches, reflecting a growing recognition that specialized skills are needed to self-manage psychiatric disorders, comparable to skills needed to self-manage severe and persistent physical conditions such as diabetes. People learn about the episodic and persistent symptoms of their illness, the relationship between these symptoms and functional impairments, pharmacological and other techniques (e.g., relaxation and stress management) for controlling the symptoms, drug side effects, identification of "warning signs" of an impending relapse, and various other aspects of their disorder and its management. Behavioral skills indirectly relevant to disorder management are included, for example, the assertive skills necessary for dealing with the doctor and the doctor's receptionist in getting an appointment for a medication review.

Illness/wellness management skill training materials have been packaged for testing and dissemination by several developer groups. A number of original studies and reviews confirm the effectiveness of skill training focused on illness/wellness management for improving adherence to treatment in people who live with severe mental illness (Conley & Kelly, 2001; Dolder, Lacro, Leckband, & Jeste, 2003; Eckman et al., 1992; Heinssen, 2002; Ikebuchi & Anzai, 1995; Liberman, Glynn, Blair, Ross, & Marder, 2002; Siddle & Kingdon, 2000; Velligan, Lam, Ereshefsky, & Miller, 2003; Young, Spitz, Hillbrand, & Daneri, 1999; Zygmunt, Olfson, Boyer, & Mechanic, 2002). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2004) has produced two packages for public dissemination that fall under this category, *Illness Management and Recovery*, and *Medication Management Approaches in Psychiatry*. Both packages include materials for all participants in the illness/wellness management process, including the person in recovery, medication prescriber, other service providers, family and friends. Together the two packages are exemplars of best practice in illness management skill training.

Illness/wellness management training for people who live with schizophrenia benefits from relapse prevention and related techniques (e.g. Birchwood, 1995; Bradshaw, 1996; O'Connor, 1991). Well known for its application in substance abuse, many of the techniques of relapse prevention are well suited to the episodic nature of the lived experience of people who have SMI, the role of stress in precipitating episodes and the important role of the recovering person in managing those episodes. The original application of relapse prevention is also of interest, as people with SMI often have substance abuse problems as well. So far there have been no controlled trials of the unique contribution of relapse prevention techniques to disorder management in schizophrenia, although it is frequently incorporated in psychiatric rehabilitation programs.

For the purposes of the WBMP model, a service array should include formal skill training modalities in illness/wellness management, provided by qualified therapists with quality assurance monitoring.

Peer involvement is especially relevant to illness/wellness management. *Peer support and self-help groups* have been associated with the recovery movement throughout its recent history. One exemplar is Recovery, Inc., for which there is some research evidence of benefit (Gallenter, 1988). Some versions of Assertive Community Treatment (e.g. Allness & Knoedler, 2003, discussed under item 13 below) include Peer Specialists. A controlled trial of a peer support and self-help group approach for people with severe affective disorders showed benefits in numerous domains of illness/wellness management and general well-being (Powell, Hill, Warner, Yeaton & Silk, 2000). A partially controlled quasi-experimental trial found similar benefits by adding "peer specialists" to an intensive case management team (Felton, Stastny, Shern, Blanch, Donahue, Knight & Brown, 1995). Although the data is promising, there is also evidence that the benefits of peer support and self-help approaches are heavily moderated by the "fit"

between the person in recovery and the rest of the group (Luke, Roberts & Rappaport, 1994). The outcome data do not yet to meet the criteria for evidence-based practice, but research is ongoing and such data are expected to be forthcoming. In this sense, peer support and self-help approaches are "promising practices." Promising practices should be considered and anticipated in the course of service planning and system development. In addition, the social values of the rehabilitation and recovery perspective require that peer involvement be considered in all aspects of system development.

It is important to note that peer support and self-help reflect more than a specific approach to illness/wellness management. In the rehabilitation and recovery perspective, peer involvement, social support and non-professional help are important in most, if not all services and domains. As models for peer involvement continue to evolve, they may fit under a number of evidence-based practice rubrics in addition to illness/wellness Management.

7. Family Consultation, Education and Therapy. A broad spectrum of family processes and therapies have long been of interest in schizophrenia research. In the 1950s many believed that families, and parents in particular, have a causal role in the etiology of the disorder. This view was never empirically supported and today is largely discredited. Nevertheless, family members often experience guilt and/or distress in this regard. Clinicians should always be vigilant for this possibility and intervene with corrective information when indicated.

In a number of controlled outcome trials, family services that include psychoeducation, reduction of expressed emotion, behavioral management and social support have been found to reduce relapse and recidivism rates (reviewed by Pilling, Bebbington, Kuipers, & Garety, 2002; Lam, 1991)

A variant of this approach to family services uses multi-family psychoeducational groups to build supportive social networks (McFarlane, Lukens, Link, Dushay, & al, 1995). In controlled comparative studies the multi-family format has been superior to a single-family format in reducing relapse (McFarlane, Link, Dushay, Marchal, et al, 1995).

Controlled trials of briefer family education and support modalities, ranging from one to eight sessions, have been found to increase family members' sense of support from the treatment team, increase their knowledge about schizophrenia and its treatment and rehabilitation, improve their coping, reduce distress and self-blame, and increase satisfaction with services (Abramowitz & Coursey, 1989 (Posner, Wilson, Kral, Lander, & &al, 1992). However, the briefer modalities have not been shown to reduce relapse or hospital recidivism. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2004) has produced a package for public dissemination that falls under this category, *Family Psychoeducation*. The package provides materials for general family education and support programs.

For the purposes of the WBPM, best practices requires that a range of family services, provided by specifically trained clinicians, be available in the service array. The array should include basic familiarization and education about the nature of SMI, the experiences of people diagnosed with SMI, multi-family groups and intensive family therapy for those who need it. Best practice requires that family therapy include the specific behavioral techniques known to reduce expressed emotion, manage problem behavior and enhance family problem solving.

8. Contingency Management. Contingency management is a genre of techniques that evolved from learning and social-learning theories in the 1960s. They are especially important in psychiatric inpatient settings (see Corrigan & Liberman, 1994). As community-based programs for people with SMI have proliferated, relevance of contingency management to such programs has generalized. Nevertheless, contingency management is one of the most underutilized technologies in adult mental health services.

Implementation is complicated by the need for administrative mechanisms to review and approve individual treatment plans, because of the potentially restrictive nature of the approach and the fact that it is often used to address problems with people who are involuntary patients.

The earliest applications of contingency management for schizophrenia, in the form of token economies in psychiatric hospitals, provided strong empirical evidence of effectiveness in promoting adaptive behavior (Ayllon & Azrin, 1968). In a 7 year controlled clinical outcome trial (Paul & Lentz, 1977), described at the time as "the largest outcome trial in the history of psychiatry," a rehabilitation program that included contingency management was vastly superior to psychiatric treatment as usual. Replication studies and an accumulation of case studies and institutional experience continues to support its effectiveness in suppressing inappropriate behavior (including "symptoms"), increasing adaptive behavior and increasing participation in treatment and rehabilitation (e.g., Paul & Menditto, 1992; Wong, Massel, Mosk, & Liberman, 1986). In addition to general effects on maladaptive and adaptive behavior, when combined with other social-learning modalities, contingency management has been shown to be effective with two of the most troublesome and drug-resistant problems encountered in inpatient settings, aggression (Beck et al., 1997; Beck, Menditto, Baldwin, Angelone, et al, 1991) and polydipsia (Baldwin, Beck, Menditto, Arms, et al, 1992). As psychiatric rehabilitation has evolved, the role of contingency management in enhancing engagement in rehabilitation activities has become increasingly important (Heinssen, 2002).

For the purposes of the WBPM, best practices require that contingency management be available in all settings in which the population of concern is served, provided by specifically trained staff, under the supervision of a qualified professional, with all the data collection, documentation and oversight practices necessary for ethical and effective use of this approach.

9. Individual psychotherapy. *Cognitive behavioral therapy* (CBT) is a type of psychotherapy, based on principles of conditioning, learning and cognition. It is effective for a variety of mental illnesses and behavior problems, including anxiety disorders, depression and personality disorders. These problems are common among people with SMI. CBT has also proven effective in the residual phase of schizophrenia for improving psychophysiological self-regulation and stress tolerance, reducing drug-resistant symptoms (positive and negative), improving problem solving skills, increasing medication adherence and reducing relapse (Garety, Kuipers, Fowler, Chamberlain, et al, 1994; Haddock et al., 1998; Lecompte & Pelc, 1996; Tarrier et al., 1988; Tarrier, Beckett, Harwood, & Baker, 1993). A controlled trial (Drury, Birchwood, Cochrane, & MacMillan, 1996a; Drury, Birchwood, Cochrane, & MacMillan, 1996b) has shown that people with acute psychosis in acute inpatient settings, receiving standard pharmacological and psychosocial treatment, experience a faster and more complete remission if they also receive CBT.

A widely used social skills training format, developed and disseminated by the UCLA Center for Research On Treatment and Rehabilitation of Psychosis (Wallace, Liberman, MacKain, Blackwell & Eckman, 1992), uses the familiar interpersonal problem-solving technique (D'Zurilla, 1986, 1988; D'Zurrila & Goldfried, 1971), a classic CBT approach. The approach uses a heuristic model of problem-solving. The model has five stages: detection and identification of the problem, generation of possible solution scenarios, selection of a solution, implementation of the solution and evaluation of the results. People who participate in therapy learn this model, and then apply it to problems they have identified in their own lives. The cognitive and behavioral skills relevant to each stage are specifically rehearsed. It is generally accepted that cognitive behavioral problem solving is a key component of social skills training.

There is some overlap between CBT and related techniques that address functioning at a more neurocognitive level (discussed under #10 below). Both overlap with social skills training (discussed under # 3 above). Integrated packages sometimes include evidence-based techniques from all 3 domains.

An evidence-based exemplar is *Integrated Psychological Therapy* (Brenner, Roder, Hodel, Kienzle, Reed & Liberman, 1994).

Until recently, almost all the research on CBT for SMI was conducted in England. A recent meta-analysis of the English research (reviewed by Pilling, Bebbington, Kuipers, & Garety, 2002) confirms its effectiveness across specific modalities and applications. Large scale NIH-funded trials in the U.S. are currently underway.

In addition to problems uniquely associated with psychotic disorders, various forms of CBT are effective for addressing generalized anxiety, panic, social anxiety, depression and obsessive-compulsive symptoms. These problems often co-occur with chronic psychotic disorders, and there is no reason to believe they are any less effective in the population of concern than the general population. For the purposes of the WBPM, specialized forms of CBT should be available to all individuals in the population of concern who have problems or symptoms known to be responsive to CBT.

Similarly, psychodynamic principles may usefully inform assessment, rehabilitation counseling and psychotherapy for people with SMI. Psychodynamic therapy, strictly defined as interpretation of unconscious material, e.g. transference and regression, should not be used to treat psychotic disorders. However, a psychodynamic perspective may be useful in helping the recovering person engage, resolve conflicts and identify recovery goals. For the purposes of the WBPM, this perspective should be provided by professional practitioners specifically trained in psychodynamic understanding of SMI.

Personal therapy (Hogarty, 2003; Hogarty, Greenwald, Kornblith, DiBarry, Cooley, Carter & Flesher, 1997) is another evidence-based individual psychotherapy for chronic psychotic disorders. Its focus on cognition is similar to CBT, but its overall emphasis is more on personal and social functioning rather than specific symptoms and behaviors. Although the Hogarty group has produced compelling evidence for effectiveness, controlled trials have not been replicated by other research groups. In that sense, personal therapy is therefore best described as a "promising" practice. However, personal therapy is very similar to CBT for persons who have SMI, and in this sense it can be considered a variant of an evidence-based practice.

For the purposes of the WBPM, best practice requires that specialized forms of CBT, having known effectiveness for specific presenting problems and provided by qualified therapists, be available to all in the population of concern who could benefit from it.

10. Neurocognitive therapy and environmental engineering. Pharmacotherapy can reduce the cognitive disorganization of acute psychosis, but stabilized and optimally medicated - people who have SMI often have significant residual neurocognitive impairment. Such impairment is a strong limiting factor in rehabilitation success. More than any other factor, residual neurocognitive impairment is what makes SMI a chronic, disabling condition.

A number of related approaches to directly treating the neurocognitive impairments of schizophrenia have been recently developed. They range from computer-based tasks that exercise basic attention and memory to group-format techniques that enhance social perception and problem solving. Outcome measures that have shown effects of neurocognitive therapy range from social competence to psychotic symptoms to work performance. A meta-analysis of 17 controlled neurocognitive therapy trials (Twamley et al, 2004) supports the approach's effectiveness.

A similar approach, but based on operant learning principles, has proven effective in helping people with severe impairments achieve a level of functioning which allows them to participate in conventional skill

training (Menditto, Baldwin, O'Neal, & Beck, 1991; Silverstein, Menditto, & Stuve, 2000). In this approach, individuals are systematically reinforced with tokens as they successively approximate motor behaviors prerequisite to group participation, such as appropriate motor orientation, eye contact, disregard of ambient distraction, and performance of elemental group-related tasks. This approach is thought to be especially important for people who have the most severe disabilities and functional limitations, who may not otherwise be able to participate in conventional skill training.

There is some overlap between techniques that address functioning at the neurocognitive level and techniques used in CBT (discussed under #9 above) and social skills training (discussed under # 3 above). Integrated packages sometimes include evidence-based techniques from all 3 domains. An evidence-based exemplar is *Integrated Psychological Therapy* (Brenner, Roder, Hodel, Kienzle, Reed & Liberman, 1994).

Neurocognitive impairments that do not respond to treatment can nevertheless be managed through specialized environmental engineering that provides compensatory supports (Goldberg, 1994; Heinssen, 1996; Velligan et al., 2000). Such interventions have been shown to enhance routine daily functioning and adherence to treatment.

For the purposes of the WBPM, best practice requires that neurocognitive rehabilitation and compensatory environmental support be available to individuals in the population of concern whose functioning is limited by residual neurocognitive impairments. Accordingly, neuropsychological assessment must be available to identify residual neurocognitive impairments, inform treatment and measure progress.

11. Acute Treatment, Crisis Intervention and Related Services. There is general agreement that the availability of acute inpatient and/or crisis/respite services is a necessary component of a mental health service system for people with SMI. However, there is some room for debate about the precise nature of crisis intervention services.

One view that has been dominant since the 1960s is that crises in schizophrenia are predominantly the result of psychotic relapse, and the best setting in which to evaluate and treat psychotic relapse is in an inpatient psychiatric unit. Psychiatric inpatient units do provide necessary safety and medical care, but they are not necessarily the most cost-effective alternative. Crises in schizophrenia may be driven by a host of factors other than psychotic relapse, and in such cases addressing those factors in a timely way may be more important than removing the person to a protected environment and administering drugs. As a result, alternative crisis services and 24-hour respite facilities are increasingly included in mental health systems (Brook, 1973; Campos & Gieser, 1985). Often, these are incorporated in a comprehensive case management system. Recent research on a crisis hostel program that includes peer involvement and psychosocial approaches provides evidence for subjective and economic benefits (Dumont and Jones, 2001). Controlled research on crisis hostels has not reached the level of evidence-based practice, but the existing research and the social value of consumer involvement identify crisis hostels and related alternatives to acute inpatient hospitalization as promising practices.

Another predominant view has been that however useful psychosocial treatment may be in the residual phase, pharmacotherapy is the sole treatment of choice for acute psychosis. This presumption is challenged by a twelve year study of drug-free treatment, the Soteria Project (reviewed by Mosher, 1999). In a series of controlled studies, the drug-free condition proved comparable to conventional hospital-and-medication treatment, for a large majority of recipients. The drug-free treatment was also considerably less expensive. The interpersonal therapeutic community model of the Soteria Project is similar to one of the psychosocial treatment conditions previously validated by Paul & Lentz (1977). Although the social-

learning condition (with its contingency management component) produced the best outcome in the Paul & Lentz (1977) trial, the therapeutic community condition was superior to psychiatric treatment as usual, and both social-learning and therapeutic community treatments produced dramatic reductions in need for antipsychotic drugs. Strauss and Carpenter (Strauss & Carpenter, 1977) also report successful treatment of acute schizophrenia without drugs.

Despite these findings, drug-free treatment of schizophrenia, especially in the acute phase, remains outside generally accepted standards of practice. While caution about drug-free treatment is clearly indicated, the available data exacerbate suspicions that treatment of people who have SMI has become overly dependent on psychopharmacology, even in the acute phase. This over-dependence is evident in the belief that antipsychotic medication, acute hospitalization and minimal social supports are sufficient to serve the severely ill population. That belief was widespread among mental health administrators in the 1960s and again in the 1990s, and it produced failed reform attempts in many states, when institutionalized patients were discharged to community programs that provided little more than medication and housing. The belief remains in many quarters today, and is a serious threat to true mental health system reform.

For the purposes of the WBPM, best practice requires availability and use of crisis management services, as well as the spectrum of rehabilitation services that reduce the need for acute inpatient hospitalization.

12. Specialized integrated treatment for co-occuring substance abuse. Co-occurring substance abuse is a widely recognized problem with severe mental illness, implicated as a cause of relapse and a barrier to rehabilitation and recovery. Conventional substance abuse approaches, such as 12-step programs, are effective for some people, and should be included in a service array. In addition, many - people who live with SMI benefit from specialized programs specifically designed to address substance abuse - within the SMI population (Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998; Drake & Mueser, 2000, 2001; Kavanagh, McGrath, Saunders, Dore, & Clark, 2002).

The Substance Abuse and Mental Health Services Administration (SAMHSA) has produced a package for public dissemination that falls under this category, *Co-occurring Disorders: Integrated Dual Disorders Treatment*. The package includes manuals and related materials for developing integrated substance abuse treatment in conjunction with a comprehensive psychiatric rehabilitation service array. The package represents a best practices exemplar for dual disorder services.

13. Specialized models for service integration and provision. Specialized models for integrated provision of psychiatric treatment and rehabilitation have evolved in response to the needs of people with especially severe disabilities resulting from SMI. Three models supported by outcome data *are the psychosocial clubhouse model*, *assertive community treatment*, and *residential social learning programs*.

Psychosocial clubhouse models include a number of specific approaches. The key common element is a social club-like administrative organization, emphasis on peer support, an organized community of participants, a physical residential or occupational setting or both. Evidence-based exemplars include Fairweather Lodge (Fairweather, Sanders, Maynard & Cressler, 1969) and Thresholds (Bond, Dincin, Setze & Witheridge, 1984). Today specific treatment and rehabilitation services are often provided through some form of clubhouse model, including social, living and occupational skill training, in residential settings (e.g. group homes) and day rehabilitation programs. Both residential and day rehabilitation clubhouse programs provide important sites for skill training, therapy, rehabilitation counseling, peer support groups and other rehabilitation/recovery services. The service array may or may not be comprehensive, may or may not include treatment planning and case management. If not comprehensive, specific services are coordinated with other providers. Clubhouse models generally

emphasize consumer involvement and peer support, and are in that sense especially consistent with the social values associated with rehabilitation and recovery.

Assertive community treatment (ACT, also known as Programs of ACT, PACT). ACT is a comprehensive approach to services for people who live with severe and disabling psychiatric disorders (Boust, Kuhn & Studer, 2004). In addition to case management, ACT programs include conventional psychiatric services and varying amounts of rehabilitative services, delivered in an outreach mode that takes the services to the person. At least one version of ACT has been commercially packaged as a proprietary product (Allness & Knoedler, 2003) and a second has been produced for public dissemination by the Substance Abuse and Mental Health Services Administration (SAMSHA, 2004). By following the manual and using the materials, which include quality assurance and program evaluation tools, treatment teams can credibly provide services according to a standard model (fidelity to the model is a key issue in research and implementation, as versions of ACT can be quite different).

There has been much research on the efficacy and cost-effectiveness of ACT programs, but the results are complex (reviewed by Mueser, et al, 1998; Burns & Santos, 1999; Burns, Creed, Fahy, Thompson, Tyrer & Whie, 1999; Monroe-DeVita and Mohatt, 1999; Byford, Fiander, Torgerson, Barber, Thompsom, Burns, Horn, Gilvarry & Creed, 2000; Burns, Fioritti, Holloway, Malm & Rossler, 2001). Within the SMI population, 15%-20% do not function well in ACT, but the reasons for this are unclear. Although the effects of ACT on rehospitalization are relatively robust, it is unclear whether there is a reliable improvement in people's social and personal functioning. Effectiveness appears to be influenced by moderating factors such as the amount of skill training included, various consumer characteristics and the treatment team's control over hospitalization. The transition from institution to community is enhanced by inclusion of focused skill training with case management (MacKain, Smith, Wallace, & Kopelowicz, 1998).

Residential social learning programs evolved from token economies and followed the deinstitutionalization movement into community residential settings (Paul, 1984; Paul & Menditto, 1992). Like clubhouse and ACT programs they emphasize social, living and occupational skill training. The treatment team structure, treatment planning and progress evaluation approaches are comparable to those of ACT. Social learning programs are usually implemented in more highly structured settings and make more use of contingency management and environmental engineering. The people who participate tend to have greater difficulty adhering to a treatment/rehabilitation plan, have more risky or dangerous behavior, and are receiving legally mandated services. Rehabilitation is conducted both within the residential setting by program staff, and in coordination with occupational, vocational and outpatient treatment providers at other sites.

Clubhouse models, ACT and residential social learning programs are evidence-based practices for cost-effective service provision, for overlapping ranges of individuals within the population of concern. Generally, clubhouse models are most cost-effective for people who have realized a substantial degree of stability, are motivated for and invested in recovery. People whose disorder is less stable, have a higher level of disability and/or who are less able to sustain their engagement in rehabilitation and recovery, are expected to benefit more from ACT. There is a range of persons in the population of concern who, in the later stages of the process of recovery, require less service integration and support than clubhouse programs provide, and for them conventional case management is sufficient to coordinate needed services. At the other end of the continuum, a small but significant proportion of the population of concern, at an earlier stage of recovery, does not do well in clubhouse programs or ACT. Also, for legal and public safety reasons, some people cannot access clubhouse programs or ACT until later stages of recovery. For these people, the organizational model of residential social learning-based rehabilitation provides the best alternative. It is important to note, in this regard, that social learning programs' key

outcome is their effectiveness at helping people move to less intensive/restrictive settings, including clubhouse and ACT programs and conventional case management.

Clubhouse, ACT and social learning programs are organizational models in which specific integrated treatment and rehabilitation is provided. All available outcome data indicate that the content of the services is as important as the organizational model. For the purposes of the WBPM, use of any of the organizational models requires high-fidelity treatment planning and progress evaluation, and the full panoply of specific evidence-based practices. No organizational model is effective if there are insufficient services to organize.

The population of concern is expected to span the range of needs that make clubhouse, ACT or residential social learning programs the organizational model of choice. People are expected to require different models as their recovery progresses. After a period of rehabilitation and recovery, many will require only conventional case management. For the purposes of the WBPM, the mental health system should support all 3 organizational models as well as conventional outpatient case management, so that people can be matched with the model optimal for their needs as their rehabilitation and recovery progresses.

14. Therapeutic jurisprudence (TJ). In recent years, important advances in psychiatric rehabilitation have come not just in science and technology, but also legal scholarship. TJ is a set of principles and techniques intended to use the law to benefit and enhance mental health (Daicoff & Wexler, 2003; Winnick, 1991). TJ is especially relevant to SMI (Elbogen & Tomkins, 1999; Spaulding, Poland, Elbogen & Ritchie, 2000).

By definition, the WBPM population of concern has significant legal complications. In the immediate future it will be essential for the professionals who supervise rehabilitation and related services to be proficient in dealing with these complications and making good therapeutic use of legal processes and mechanisms.

Just in the last few years Nebraska has seen 3 developments that will have a profound impact on the WBPM population of concern: a conditional release statute, an outpatient commitment statute, and a mandate for training and education of the state's mental health boards. The conditional release statute permits treatment of institutionalized NRRI (not responsible by reason of insanity) persons in the community, under court supervision. The outpatient commitment statute permits community treatment of persons civilly committed under mental health board supervision. The mandated training and education of mental health boards is intended to promote uniformity and better adherence to statutory criteria for commitment and involuntary treatment. All three of these changes could enhance treatment and rehabilitation for the population of concern, if professionals have the skills and knowledge to effectively use the new laws and an adequate service array is in place. In the specific case of outpatient commitment, clinical trials have shown that application of therapeutic jurisprudence enhances outcome, if quality treatment and rehabilitation services are also available (Ridgely, Borum & Petrila, 2001; Steadman, Gounis, Dennis, et al, 2001).

The WBPM requires that professionals who supervise treatment and rehabilitation for the population of concern have knowledge and skills necessary to apply therapeutic jurisprudence in 3 ways: 1) collaborate with legal authorities and rehabilitation teams to make optimal clinical use of relevant legal processes and mechanisms, 2) collaborate with legal authorities, consumers, advocates and policy makers across the state to further refine mental health law and its implementation, and 3) collaborate with legal authorities to educate consumers, advocates, legal professionals and mental health professionals in therapeutic jurisprudence. Since laws change over time, therapeutic jurisprudence education will be a continuing process. This means that individual consumers, advocates and professionals, and consumer, advocate and

professional organizations, and the judiciary and relevant government agencies must collaborate to create and maintain continuing education resources for this purpose.

15. Risk assessment and risk management. People are in the population of concern because they have been found, at a point in time, to be dangerous to themselves and/or others. Safely serving these people in the least restrictive and most integrated settings possible, particularly community settings, will require highly reliable assessment and management of the consequent risks. Historically, mental health professionals' ability to predict dangerousness has been dubious, but the last decade has seen crucial advances in the relevant technology (Bauer, Rosca, Khawalled, Gruzniewski, & Grinshpoon, 2003; Borum, 1996; Harrison, 2003; Steadman, 2000). Realization of the goals of Nebraska's mental health reform, and the WBPM values of least restrictive settings, will require the best risk assessment and management that science and technology can provide.

Best Practices in risk assessment and management require explicit evaluation of - a person's potential for dangerousness, under existing circumstances and under circumstances anticipated in the foreseeable future (it is no longer acceptable to say simply that a person is not dangerous right here and right now). This includes review and interpretation of the person's social history, use of appropriate psychometric and actuarial instruments and assessment of the person's psychiatric disorder. Risk management requires a complete risk assessment plus a complete enumeration of the conditions, circumstances and environments that could precipitate behavior wherein one is considered to be dangerousness to oneself or others in the future, and a plan for minimizing those risks.

For the purposes of the WBPM, complete risk assessment and management must be performed on all people in the population of concern as they progress through different levels of security and restriction, by a professional with appropriate clinical skills and qualifications.

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A CRASH COURSE IN PEER PROVIDED SERVICE RESEARCH

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Glossary of Terms

Confound: Any variable (other than the one manipulated by the researcher) that might have caused an effect. An alternative causal variable or explanation of an effect.

Convergent research: Multiple studies with different versions of the key elements (e.g., different samples of participants, designs, manipulations of the causal variable, outcome measures, statistical analyses).

Construct validity: A type of validity that indicates whether a measure is correlated with the construct that it purports to assess as it should be.

Content validity: A type of validity that indicates whether a measure contains items from the desired "content domain." This is based on assessment by experts in that content domain.

Correlational analysis: A technique used to measure the relationship between two variables. A correlation coefficient (r) is a statistic that indicates the direction and strength of the relationship between two variables. The most common type of correlation coefficient is the Pearson correlation coefficient. Typically, correlation coefficients range from -1 to 1.

Criterion-related validity: A type a validity that indicates whether a measure is appropriately related to a "criterion." The most common type of criterion-related validity is **predictive validity**, which assesses whether a measure completed now predicts a criterion assessed later. Another type of criterion-related validity is **concurrent validity**, which is whether a measure can be used to replace another measure. A third type of criterion-related validity is **postdictive validity**, which assesses whether a measure completed now is related to a criterion assessed earlier.

Discriminant validity: A statistical assessment of construct validity that indicates whether a measure shows the correct pattern of interrelationships with other variables. It can be broken down into two parts – **convergent validity**, when a measure correlates with other measures of similar constructs, and **divergent validity**, when a measure is NOT correlated with measures of different constructs.

Dismantling studies: A study in which a treatment/service is broken down into its separate parts and assessed.

Face validity: A type of validity that indicates whether a measure appears to measure a construct of interest (e.g., will someone recognize the type of information they are responding to?).

Factor analysis: A statistical method used to describe variability among related variables. It identifies whether variables "hang together" to form "factors."

Fidelity: The degree to which a service was implemented as it was intended to be implemented.

Hypothesis: A guess about what is expected to happen after completion of research and data analysis.

Initial equivalence: When participants in two or more conditions of a study are the same (on average) before manipulation of the causal variable.

Internal consistency reliability: The consistency with which individual items on a measure inter-related to each other. Chronbach's alpha is the most popular statistic used to assess internal consistency reliability.

Natural groups design: A study in which preexisting groups or groups that are "naturally formed" are the conditions that separate people (e.g., gender, age, personality).

Outcomes: Variables of interest that are measured during a study. Also known as Dependent Variables.

Ongoing equivalence: When participants in two or more conditions of a study are the same on average (except for the causal variable) during manipulation of the causal variable, completion of the study procedures, and measurement of the outcome variable(s).

Participatory action research: A form of research that involves all relevant parties in actively examining together current action (which they experience as problematic) in order to change and improve it.

Psychological construct: Attributes that are contrived in order to help organize and explain human behavior. Measures are created to reflect constructs.

Psychometric properties: Aspects of a test or measure that indicate how "good" the test or measure is. Reliability, validity, and standardization are types of psychometric properties.

Qualitative research: A method of scientific inquiry aimed to gather an in-depth understanding of human behavior and the reasons that govern such behavior.

Quantitative research: The empirical investigation of a phenomenon via statistical, mathematical, or computational techniques.

Quasi-experimental studies: A type of study that has some features of a randomized controlled trial but not others. For example, a quasi-experiment may have a manipulated variable but lack controls such as random assignment.
Random assignment: An experimental technique for assigning people to different conditions (e.g., service vs. no service). The purpose of randomization is to achieve initial equivalence between conditions.
Randomized controlled trials: A specific type of scientific experiment that includes random assignment and a control group.
Reliability: The consistency of a measure.
Research: Research is a process of steps used to collect and analyze information to increase our understanding of a topic or issue.
Standardization: When assessments are administered according to the same procedure.
Temporal precedence: When cause precedes effect.
Test-retest reliability: The consistency of scores on a measure if behavior has not changed.
Validity: The extent to which a measure assesses what it claims to assess.

Resources

Web Sites

- **CIMHRRS (Johnson, 2010)**
  - The CIMHRRS is a 52-item instrument based on psychosocial rehabilitation and recovery-oriented concepts used to assess the fidelity of various programs to particular service models, in particular programs that serve people with serious mental illness (SMI). In contrast to traditional fidelity measures, the CIMHRRS assumes a more comprehensive approach to assessing entire service programs rather than relying on narrowed definitions provided by specific interventions, which are often contextualized within a larger and localized service system context. The CIMHRRS was designed specifically to capture the level of integration of psychiatric rehabilitation and recovery-oriented services while taking into consideration the structural and organizational components of a program as well as the functional processes of assessment and treatment provision. Through a systematic evaluation, relative strengths and liabilities of service programs are identified in addition to program characteristics such as structure, organization, and procedures of service provision, which have more global implications in terms of program evaluation and implementation. The results provide an objective and comprehensive assessment of program functioning and integration of psychiatric rehabilitation and recovery-oriented services and can be used to inform clinical and administrative decision-making processes. For more information, see: **http://digitalcommons.unl.edu/psychdiss/20/**
- **A Compendium of Recovery and Recovery-Related Instruments**
  - **http://www.tecathsri.org/pub_pickup/pn/pn-43.pdf (Part 1)**
  - **http://www.power2u.org/downloads/pn-55.pdf (Part 2)**
- **COSP**
  - **Consumer-Operated Services Evidence-Based Practices (EBP) KIT|SAMHSA**
    - http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD
  - **Using Multimedia to Introduce Consumer-Operated Services**
    - http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/UsingMultimedia-COSP.pdf
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  - ... The Consumer-Operated Services Program (COSP) Multisite Research Initiative (1998-2006), funded by SAMHSA, is the largest and most rigorous study of consumer ...
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- **Training In Consumer-Operated Services**
  - ... identified in the literature and the work of peer providers and researchers in conducting the Consumer- Operated Service Programs (COSP) Multisite Research ...
  - http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/Training-COSP.pdf

- **Intentional Peer Support (http//:ncmhr.org/intentional-peer-support.htm)**
- **National Institute of Health's Office of Behavioral and Social Sciences Research offers training in conducting randomized clinical trials**

Articles/Books

- **Burgess, P., Pirkis, J., Coombs, T., & Rosen, A. (2011). Assessing the value of existing recovery measures for routine use in Australian mental health services. *Australian and New Zealand Journal of Psychiatry, Early Online,* 1-14.**
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ORIGINAL PAPER

Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies

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Abstract This study informs new strategies that promote integration of peer providers into the staff of social service agencies. Executive directors, human resource managers, supervisors and co-workers at 27 agencies in New York City were interviewed in-depth. Focus groups with peers were conducted. Consistent with previous research, respondents identified attitudes toward recovery, role conflict and confusion, lack of policies and practices around confidentiality, poorly defined job structure and lack of support as problems that undermined integration. Emerging from the data are strategies related to human resource policies and practices and workgroup relationships and operations that can improve employment of peer staff.

Keywords Peer providers · Employment · Mental Health

Introduction

Increasingly, mental health agencies are including peer providers (peers) on their staffs in recognition of peers as a valuable component of a recovery oriented, best practice approach to rehabilitation services for people with mental health conditions. Peers are persons with mental health conditions who, though without professional credentials, are employed as service deliverers in the mental health provider system. They are hired as role models, counselors, educators, providers of assistance to meet the needs of daily living, and as advocates to empower people with mental health conditions. The purpose of this paper is to present results of a study that explored workplace strategies to help mental health providers improve integration of peers into their staffs so that peers' important contribution to recovery can best be realized.

Recovery is the emergent perspective guiding service programs and treatment approaches for people with serious persistent mental health conditions (consumers) (Ralph, 2000). From this perspective, the goal of services is to instill hope and to support consumers in making their own decisions as they work towards full integration into the mainstream of everyday life (Anthony, 1993, 2000; Fisher, 2003). From a recovery perspective, a developing standard of treatment includes mutual support and advocacy (New Freedom Commission on Mental Health, 2003; Torrey & Wyzik, 2000). One initiative to meet this treatment standard is consumer provided services. These services have been offered by consumer-run programs, by consumer partnerships in which consumers and traditional staff share oversight of the programs and by consumer employees, or individuals providing specialized services in traditional service settings (Davidson, et al., 1999; Salzer, 2002; Solomon & Draine, 1995). The focus of the present paper is peer employees in traditional settings.

Several randomized control trials have demonstrated the impact of services provided by peer employees on positive client outcomes but the evidence in support of their effectiveness has primarily emerged from descriptive studies (Chinman, Young, Hassell, & Davidson, 2006; Simpson & House, 2005; Solomon & Draine, 1995). Overall, however, the

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weight of the evidence suggests that services provided by consumer employees in traditional settings can be as effective, or more effective than, nonpeer provided services (Davidson, et al., 1999; Deegan, 2003; Clarke et al., 2000; Klien, Cnaan, & Whitecraft,1998; Felton et al., 1995; Kaufman, Schulberg, & Schooler, 1994; Lyons, Cook, Ruth, Karver, & Slag, 1996; Paulson et al., 1999; Solomon & Draine, 1995; Chinman, Rosenheck, Lam, & Davidson, et al., 2000). When hired as part of a service team, peers have been found to make a major contribution to the recovery of people with serious mental health conditions (Armstrong, Korba, & Emard, 1995; Besio & Mahler, 1993; Davidson et al., 1999). Consumers who receive peer provided services have fewer hospitalizations, use fewer crisis services, reduce their substance abuse, and experience improved employment outcomes, social functioning and quality of life when compared to those who receive only professional services (Armstrong et al., 1995; Besio & Mahler, 1993; Klien, Cnaan & Whitecraft, 1998; Felton et al., 1995). Further, peer support can stabilize participation in treatment by helping to counter the sense of loneliness, rejection, discrimination and/or frustration that consumers can feel when dealing with the mental health system (Deegan, 1992; Markowitz, 2001; Solomon, 2004).

At the same time, the peers' individual healing benefits from their helper role (Anthony, 2000; Mowbray, 1997; Schiff, 2004; Solomon,2004). Peers can benefit from the social support they receive from the consumers they serve and their nonpeer co-workers, from the experience of helping others identify and resolve problems, and from interacting with other peers who successfully cope with their mental health conditions (Armstrong, et al., 1995; Corrigan & Phelan, 2004; Gates, Akabas, & Oran-Sabia, 1998; Mowbray,1997 ; Davidson, et al., 1999). Finally, peers benefit from the self-sufficiency due to increased income and a sense of self-efficacy and purpose to life that work brings (Akabas & Kurzman, 2005).

Adding peers to the staff of traditional social service agencies, however, has not gone unchallenged. The experience of peers is similar to that of paraprofessional social service workers of the 1960s and 1970s. Initially, using paraprofessionals was heralded as an effective way to provide services appropriate to the culture and expectation of community residents (Alley & Blanton, 1976; Pickett, 1984). By 1970, however, conflicts with professional staff, disillusionment over the poor salaries, lack of job security, and lack of promotion potential undermined the ability of paraprofessionals to work effectively and led to the demise of their use despite their ability to enhance quality of services (Delworth, 1974; Field & Gatewood, 1976; Kurzman, 1990; Pearl, 1974).

Current efforts to employ peers in traditional social service agencies are on the same track. Despite the policy shift to a recovery perspective, many agencies face challenges in translating the recovery approach into practice (Akabas, 1994; Anthony, 2000; Besio & Mahler, 1993; Fisk, Rowe, Brooks, & Gildersleeve, 2000; Chinman, Young, Hassell, & Davidson, 2006; Jonikas, Solomon & Cook, 1997; Mowbray, 1997; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). There is evidence that many agencies fail to implement changes necessary to operationalize the recovery perspective and are often indifferent or hostile to peer presence (Carlson, Rapp, & McDiarmid, 2001; Davidson, Weingarten, Steiner, Stayner, & Hoge, 1997; Dixon, Krauss, & Lehman, 1994; Manning & Suire, 1996; Mowbray, 1997; Mowbray, et al., 1996; Vandergang, 1996).

Specific problems that interfere with peer integration include:

1) *Attitudes toward recovery among nonpeer staff.* Stigma persists among many social service providers who continue to believe that recovery is not possible for consumers (Besio & Mahler, 1993; Davidson, et al., 1999; Fisk et al., 2000; Manning & Suire, 1996).
2) *Role conflict and confusion.* Peers are asked to combine their experiences as consumers with providing service and/or are both recipients and providers of service (Dixon, et al., 1994; Miya, Wilbur, Crocker, & Compton, 1997; Mowbray, et al., 1996; Salzer & Shear, 2002). They are uncertain of the boundaries between being a consumer and an employee or of being a friend to fellow consumers and being their service provider (Dixon, et al., 1994). Nonpeer staff is conflicted when they play the dual roles of therapist and co-worker (Carlson, et al., 2001; Paulson, et al., 1999).
3) *Lack of clarity around confidentiality.* Issues arise with respect to disclosure of personal information by peers to others and disclosure of confidential information to agency staff by the peers about consumers that they serve (Carlson, et al., 2001; Fisk, et al., 2000; Salzer, 1997).
4) *Poorly defined peer jobs.* Lack of job descriptions, unequal wages and benefits, low pay, lack of supervision or training, and poor communication are among the structural factors identified as affecting peer integration into the staff (Dixon, et al., 1994; Manning & Suire, 1996; Mowbray, 1997).

5) *Lack of opportunities for networking and support.* People with severe mental illnesses have restricted social support networks (Sarason, Sarason, & Pierce, 1990; Furukawa, Harai, Hirai, Kitamura, & Takahashi, 1999), however, social support has been demonstrated as having a positive impact on recovery in both formal research (Corrigan & Phelan, 2004) and in personal accounts (Fisher, 2003; Deegan, 2003; Steele & Berman, 2001).

The present study responds to the question of what policies, procedures and structures can be provided to support the contribution of peers to the mental health service system. Without such an understanding, effective solutions to the problems cannot be determined and social service providers remain less successful as employers of peers.

Methodology

Based on an intervention research paradigm, the study was designed as the first step in the development of strategies to promote peer integration using a qualitative, multi-method approach (Rothman & Thomas, 1994; Hohmann & Shear, 2003; Rothman & Tumblin, 1994; Comer, Meier, & Galinsky, 2004; Huxham & Vangen, 2003; Zwerling, Whitten, Davis, & Sprince, 1997). Its goal was to generate an in-depth understanding of the circumstances that allow peers to be effective in their designated roles, and experience improved integration into the organization. With this understanding it becomes possible to inductively generate strategies to promote integration. As will be seen in the discussion which follows, these strategies involve human resource policy and practices, work group relationships and division of labor.

Agency Sample

A pool of 117 social service agencies that provided mental health services in New York City was generated from a list of agencies who received funding from the New York City Department of Health and Mental Hygiene in 2003 and/or agencies that hired graduates of Howie the Harp Advocacy Center, a program that offers training to peers in New York City. The only criterion for inclusion was that the agency provided mental health services. Forty-six agencies were randomly selected from the list and asked to participate in the study and 27 agreed. Of those that participated, 18 employed peers, 4 had never employed peers and 5 had employed peers in the past but none were currently on staff. Agencies currently without peers on staff were included to differentiate issues generally experienced by employees of social service agencies from those that were a function of peer status.

At each agency, interviews were conducted with the executive director (or his or her designee), the individual in charge of recruitment and hire (HR representative), a supervisor and a line staff person in the identified supervisor's unit. At agencies where there was a peer on staff, the supervisor and line staff person were from the peer's work group. A total of 93 staff were interviewed (27 executive directors, 18 HR representatives, 22 supervisors and 26 line staff). The total is shy of the expected 108 because some staff held multiple roles or an individual declined to participate and selection of an alternative staff person was not possible. Table 1 summarizes the characteristics of the participating agencies.

Peer Sample

Peers who received pre-employment training through the Howie the Harp Peer Advocacy Center were invited to attend a focus group to discuss their employment experiences at their current jobs. Fifteen peers volunteered to attend one of two focus groups.

Data Collection

Separate sets of semi-structured telephone interviews were developed for peer and nonpeer agencies. Each set included an interview for the four respondent categories: executive director, HR representative, supervisor, and line staff. Thus, there were a total of eight interview instruments. All interviews covered similar content but were tailored to be appropriate to the respondent's agency role. Questions asked about recruitment and hiring policies and disability management initiatives (including training, career development opportunities and accommodation practices). In

Table 1 Characteristics of Participating Agencies

Agency Characteristic	Peer Agencies (n = 18)	Nonpeer-never peer Agencies (n = 5)	Nonpeer/peer in the past Agencies (n = 4)
Offer services in teams	100%	100%	100%
Multi-site	72%	100%	100%
Multi-service	50%	60%	100%
Employ consumers in other capacities	67%	40%	75%

addition, respondents at agencies with peers or peers in the past were asked about operations and policies specific to peer employees including: (1) peer recruitment, the number of peers hired, the job titles peers have filled, the peers' job tasks and responsibilities, and whether work was full time or part time, temporary or permanent, (2) supervision for peers and the support provided such as training, accommodation, or mentors, and (3) issues of confidentiality, disclosure, role conflict, work overload, or role ambiguity. Questions were not asked with respect to individual peers, and peers at each agency remained anonymous to the researchers. On average, interviews lasted one hour. The interviewer took written notes during the interview to record responses.

Recruitment began in January 2004 and was completed in September 2004. Executive directors were called by the researchers and invited to participate in the study. If they consented, they provided the names of the HR representative, a supervisor (with a peer among his/her supervisees if a peer agency) and a coworker in the same workgroup as the supervisor (currently working with peers if a peer agency). These individuals were invited to participate in the project. Participation was completely voluntary. Four interviewers (three study coordinators and one second year social work Masters student intern) were trained by the co-principal investigator to conduct the interviews.

Peers attending the focus groups were asked how they secured their jobs, what their jobs involved, what they perceived as an ideal peer job, how disclosure occurred, how they felt about their co-workers and the way they were treated, and what they would change. The 90 minute sessions, facilitated by the co-principal investigators, began with completion of an informed consent form which explained the study purpose and requested participants' commitment to maintain confidentiality of the group discussion.

All study instruments and procedures were reviewed and approved by the Columbia University Institutional Review Board.

Data Analysis

The data analysis was guided by an inductive approach that identified themes and patterns across interviews (Strauss & Corbin, 1990; Miles & Huberman, 1994). Interview notes were transcribed into a database. An iterative process was then used by the study team to develop a coding scheme. The process began by randomly selecting an agency and reviewing the set of interviews from that agency. Independently, each team member identified categories of information. The team included the co-principal investigator, two study coordinators, a research assistant (who was also an individual with a mental health condition) and a second year social work Masters student intern.

The team met to combine the lists of codes and to come to consensus on their definitions. Using the combined list, team members repeated the process of independently coding a second set of interviews, and meeting to assess intercoder consistency in the application of the codes and to discuss new codes that emerged. This process was repeated two additional times. At this point no new codes emerged and there was consensus among the group on the meaning and application of the codes. The codes and their definitions were then formalized.

The final list contained 22 codes. One code pertains to individual characteristics of the peers (e.g., mental health diagnosis, cultural background, previous training or education). Four codes describe the peer position (job title, job structure, role, and required qualifications for hire.) Ten codes characterize agency operations and policies (agency mission, agency policies and practices around disclosure, accommodation, benefits, promotion, performance appraisal, supervision, recruitment and hire, orientation, and training and staff development.) Three codes pertain to information about policy and practices specifically for peers (sharing information between peer and nonpeer staff, peer supervision and training targeted to peers). Four codes are related to agency stance toward the employment of people with mental health conditions in general, and peers in particular (perceptions and attitudes toward peers, lack of understanding of the peer position, reasons for hiring the peer and the employment of people with mental health conditions or other at risk factors such as criminal history or substance abuse history at the agency.) Finally, the last code marks strategies that interview respondents identified helped to integrate peers into the staff.

Using the 22 codes, two team members applied the codes to the remaining interviews. The coders met regularly with other team members to modify the coding scheme or code definitions as necessary.

Finally, all information with the same codes were pulled into reports using Atlas-ti and each report assessed for differing or convergent points of view. Reports were then compared to determine where there was redundant information or connections among them. Consistent with other research and experience four major themes emerged from the cross-report analysis: (1) attitudes toward peer providers, (2) role conflict and confusion, (3) lack of policies and practices around confidentiality, and (4) lack of support (Salzer,

2002; Solomon, Jonikas, Cook, & Kerouzc, 1998). These four themes provide the organization for reporting the results.

Results

Attitudes Toward Peer Providers

Current study findings showed that among some agency staff there is a persistence of stigma with respect to the capacity for people with mental health conditions to work in general and the importance of the peer role in particular. Some respondents voiced the belief that having a mental health condition, by definition, meant that the individual was 'sick' and, therefore, unable to give 100% performance in the workplace. They believed that peers were 'cheap' labor who were unable to deal with the stress of working, whose presence on staff had the effect of 'dumbing down' professional staff, who were unreliable, who could not go beyond their own perspectives, and who could not respond to emergency situations.

Others, however, felt that peers "made the concept of recovery real" and they were "a living, breathing reminder that staff's work works!" They believed that peers enhanced the quality of service, helped staff understand clients, increased client satisfaction, increased staff morale, facilitated communication, empowered both clients and staff, and improved the status of the agency in the community.

Positive attitudes towards peers appeared to be related to the extent to which respondents made the connection between peers on staff and the agency mission to promote recovery. "Having a peer on staff is consistent with our mission. It gives a good message to our clients. The organization is putting its money where its mouth is. The peer offers a different type of relationship to consumers." "Peers enrich the lives of clients and facilitate the transition to independence, the same as our mission."

Some staff recognized the connection between agency mission to empower consumers and the employment of peers:

> It has been a long time in coming. Since the mid-80's the agency has been involved in the consumer movement and struggled to see how they could be more inclusive of consumers. They wanted to employ them in order to legitimize the work they were already doing in running groups or volunteering in advocacy.

Conversely, peers were considered expendable when seen as peripheral or unrelated to the agency mission. One respondent from an agency that no longer hired peers commented, "Having a peer specialist is an enhancement to the program. However, it was an enhancement we could not afford."

Others felt that the peer contribution was unimportant because it did not contribute to the agency's bottom line or to the performance measures upon which the agency was evaluated. One executive noted that the agency focus was on maintaining contracted levels of service. Peers did not contribute to service statistics and, therefore, were irrelevant. Another commented, "Peers can't generate revenue."

Finally, for some, the value of peers was minimized when the reason for hire was externally motivated rather than driven by the agency's mission. "The funder requested that we have a peer for the program. With an ACT team, the funder tells us what positions we should hire for...."

Role Conflict and Confusion

Role conflict and confusion was multi-faceted and often caused a breakdown in the ability of peer and nonpeer staff to communicate and work together. A frequent confusion for nonpeer staff was between their role as co-workers and that of clinicians. As one respondent commented, supervisors and co-workers would often 'go clinical' in response to a peer's problem. A peer provider explained, "Some of the psychiatrists and therapists try to therapize me. I stay in my role but other staff don't stay in their roles. They become overly concerned that I'm becoming symptomatic, [that they need to] give me meds."

Nonpeer staff often had difficulty separating mental health issues from work-related issues with regard to peers. For example, when a peer mentioned to a co-worker that he found the enormous amounts of paperwork stressful and asked for advice on how to manage it, the co-worker responded by asking him about his medication compliance. Several supervisors offered their experience. "If a peer calls in sick there is always a question is this about mental health? I am not used to wondering what's wrong if another staff member calls in sick." Another observes, "I will get a phone call from a worker about a peer and the problem isn't really about being a peer at all but just a typical employee problem that the worker is blaming on peer status."

Role conflict and confusion also occurred when peers were both friend and service provider to clients. In this instance, nonpeer staff tended to view the

methods peers used to connect with clients as unprofessional. "Peers need to be more polished, think about issues of consumers more systematically and knowledgeably. They need to be more professional, less casual." "Because they want to help the consumers, the peer sometimes involves his or her own personal feelings, but it is not done in a professional manner."

Factors that appeared to reduce role conflict and confusion included how agencies implemented recruitment strategies for the peer position, how they applied policies related to staff/client relationships, how they defined and operationalized the peer role, and how they provided understanding of the peer role through training.

Peer Recruitment

Role confusion arose frequently when agencies recruited peers from within their client population, especially when there were pre-existing personal relationships between peers and clients or staff.

> In another [unit] it was too difficult for the peer. He had been close friends with some of the consumers before and it was too difficult to cut off friendships. He would have consumers over to his apartment for drinks. His case manager was still on staff. I think there were times when he needed help but didn't ask for it because he was now employed by the place where he had received services. It was his major support network in terms of receiving services and now it was his job and his workplace. This was a big problem.

Recognizing the problems caused by hiring from within, some agencies established policies to not hire internally and developed arrangements to hire from other providers. "What we do now is that we have agreements with other agencies to hire their consumers as peer providers and they hire our consumers."

Policies Related to Staff/Client Relationships

Respondents expressed how role confusion was perpetuated by contradictory or unclear policies and practices, particularly governing staff/client relationships. For example, at some agencies, peers were not expected to abide by the same policies as nonpeer staff. Nonpeer staff perceived this as a double standard, reinforcing a sense of difference between peer and nonpeer staff. Peers, lacking experience with the world of work, often did not understand the policy or the implications of abiding by it. A supervisor commented, "We had a peer that was dating a consumer in our agency. They were dating before he had been hired as a peer. We thought as long as they were discreet, it would be okay." Another observed:

> Professional staff is expected to maintain boundaries. Social workers relate to clients as caretakers and are expected to maintain a professional relationship with clients in line with professional ethics and standards. For peers, it is perfectly acceptable to socialize with consumers. For the peers, where is the abuse if they form personal relationships with the clients? In this context, peer conflict is really reduced. If peers choose to engage in financial or sexual relationships with a client, the burden is on the peer. Peers are not caretakers. If they aren't able to develop personal relationships with clients, it undercuts their work.

Poorly Defined Jobs

Role conflict and confusion resulted from poorly defined or poorly operationalized job tasks. When asked to list the peers' job tasks, respondents generated an extensive array of responsibilities from 'pitch in wherever needed' to lobbying and counseling (see Table 2). Comparison of written peer job descriptions (provided by the HR representative or supervisor) with the list of tasks that respondents actually performed showed that the expectations of peers were often unreasonable and greatly exceeded the formal specified job responsibilities. A supervisor recognized the fallout of this. "Peers have a flooding of tasks and they get overwhelmed. There are too many tasks for peers..."

In addition, some viewed peer tasks as distinct from other staff roles while others did not. When peer tasks overlapped those of nonpeer staff, it left both peer and nonpeer staff confused about their roles. It also led some nonpeer staff to express concern and resentment toward peers. Nonpeer staff felt that peers placed nonpeer jobs in jeopardy by fulfilling the same roles but were 'cheap labor.' Peers felt confused because the unique contribution they could make was lost.

Inadequate Training and Lack of Communication

Role confusion and conflict appeared to occur when agencies did not prepare nonpeer staff for the inclusion of a peer colleague. They were not provided with training on issues around working with someone with a

Table 2 List of Possible Peer Job Tasks

Support to Clients
Help clients with budgeting and ADL
Help clients with entitlements
Plan social activities for clients
Provide job coaching
Provide vocational counseling
Complete intake assessments
Identify resources for clients
Escort clients on outings or to appointments
Act as an advocate for clients
Problem solve with clients
Provide discharge planning
Communicate with collaterals/ family members of clients
Facilitate groups
Co-facilitate MICA groups
Support to Other Staff
Assist case managers with caseloads
Prepare presentations for other staff
Participate in meetings
Provide information to staff about what clients want or need
Provide feedback to other staff regarding clients
Administrative and Non-Specific Tasks
Take responsibility for a clubhouse unit
Put together a resource manual
Document interactions in case notes
Set up facilities for meetings
Pitch in whenever needed
Answer phones and keep statistics
Greet and register clients
Community Outreach
Lobby in Albany (state capital)
Market agency programs in the community
Make presentations

mental health condition or the expectations for the peer at the agency. When asked about what types of training were provided to staff and management, few mentioned training around the Americans with Disabilities Act, accommodation, or mental health issues. Some voiced the opinion that training was not needed. "They are clinicians and they should know how to and be able to relate to the peer." Others, however, recognized the need. "I think the staff needs more training around working with peers, regarding stigma and working with someone who has a mental health condition. The peers don't feel as connected to the staff."

Clients were rarely provided with an understanding of the peer role through training. If the peer was also a friend, clients did not understand how their relationship to the peer needed to change once the peer assumed provider status. "Some clients remember when the Peer Advocate used to be a client and they get jealous because she has moved on and has a job. They think of her as a client, like themselves, and not staff." "One of my consumers, for whatever reason, felt that because I am a recovering addict that I couldn't help her because she has never been addicted, only a mental health consumer – she got very horrible to me – I am having problems..."

Finally, the peers themselves were not provided training on workplace policies and practices and how they applied to their position. Several agencies hired peers who had graduated from a formal peer training program but few were offered training once employed. Several supervisors observed, "Where is the time and resources to have this training you talked about? The peer is 1 employee out of 60, I can't make that kind of investment for one employee when the other 60 need so much." "Peers don't have the education. We have to provide services. We can't be going to training and meetings all the time."

A comment by a peer, however, highlights the challenges they faced without formal training on job expectations:

> We all have certain things that we are supposed to do but I can't get a job description ... I don't want to complain. A lot of responsibility is thrown on me and I need it and want to advance but it is unstructured. All of a sudden my supervisors gave me a two minute lesson on how to do someone's treatment plan and baseline assessment.

Agencies spanned the spectrum on how they helped new hires enter the workplace. At one end of the spectrum a formal orientation was offered to all new employees over several days and every new employee was assigned a mentor to assist with learning about the job and the agency. At the other end of the spectrum, new employees were, at best, asked to read a policy and procedures manual. Learning the job was a matter of trial and error.

Peers were usually offered the same orientation as nonpeer staff. In some cases, however, respondents recognized that the hiring process was a key point of transition for peers from being a consumer to a provider of services. A supervisor observes, "There is a transition that peers go through when they start the job. They need support. They transition from consumer to colleague. For example, they need to transition from calling me Ms. [X] to calling me by my first name."

Some respondents believed that the ability to make the transition was the peers' responsibility and the agency did not have a role in supporting the shift. Other respondents perceived the conflict between peer and nonpeer staff to be greatest at the time of transition and believed that extra support, training, and supervision were needed to ensure peers' smooth shift into the provider role.

Lack of Clarity Around Confidentiality

Respondents identified several dimensions of confidentiality that affected peer integration. These included the peers' right to control disclosure of their peer status, the nonpeer staff perception that client records should not be shared with peers and the peer staff perception that the client information to which they were privy should not be shared with nonpeer staff.

Disclosure of Peer Status

The disclosure of the peer status was perceived as a key factor affecting peer integration. Respondents pointed to the labeling of the position as a major issue. Among the 18 agencies that have peers on staff currently, there were 16 different job titles. The titles fell into two categories, those that identified the peers (e.g., Peer Specialist, Peer Advocate) and those that were generic (e.g., Staff Generalist, Program Aide). In unionized settings titles were set by the union and were generic. In non-unionized settings titles varied and were determined most often by the HR department or the supervisor. They frequently based their selection on agency convention (e.g., all entry level staff had the same title) or in response to external regulation or funding (e.g., the expectation that Assertive Community Treatment (ACT) teams have a peer member or state funding for a peer specialist position).

Respondents tended to feel that titles that disclosed the peer status set peers apart from nonpeer staff and rob peers of control over the disclosure of their status. One observed, "We used the term 'peer advocate' but changed it to 'client advocate' so the peer could choose when to self-disclose." This created a dilemma. Peers were hired because of their mental health status and expected to use their experiences with the mental health system in completing job tasks but revealing their peer status was stigmatizing. One peer commented:

> Can't you advocate for a person no matter what the title is? If I am a person, it doesn't matter what the title is. I have coworkers who jump whenever they hear 'peer' or 'forensic.' I don't have to go into a long story about my life. I can advocate without a title but if I go to society or tell you what I did you will slam the door in my face.

Exploring this dilemma with respondents revealed that misperceptions about peers often resulted from the belief that the title carried an adequate disclosure. Agencies tended not to have formal policies or procedures for peers to manage and control the disclosure of information about their mental health status. It was assumed that the peer title conveyed what co-workers should know. But, as one peer commented, "If you are a Peer Specialist disclosure is automatic – lets people know you are a consumer. But what you've been through they do not know."

Co-workers, for example, were rarely provided a formal introduction to the peer role and peers were not given the opportunity to determine to whom to disclose, when to disclose and what information to share. As a result, staff had a misunderstanding of the peer role and the ability of the peer to join the staff as a productive worker.

A second way that peers struggled to control disclosure of their peer status was when they received mental health services at the employing agency and no provisions were made to ensure that their records were kept confidential. In these instances, the mental health issues of the peer were open to anyone who had access to the records. Like the issue raised by the job title, open records led to a lack of control over disclosure and perpetuated the role of peer as client rather than as colleague.

In anticipation of this problem, some agencies implemented the policy that the records of peers recruited internally were kept confidential in the same way medical records were maintained for all staff and, once hired, peers were required to receive services elsewhere.

Peer Access to Client Records

Many agencies maintained the policy that peers should not have access to client records. This was motivated by either the actual experience of broken confidentiality by the peer, the fear that peers would be unable to abide by confidentiality policies or that the peer position did not need access to this information. "The agency does have a policy in which the peer advocate does not have access to client records. It is not pertinent for the person in the peer position to have access."

The consequence of this stance was frequent miscommunication between peer and nonpeer staff about the goals of treatment, and reduced the potential contribution of peers, often at the expense of the care to the consumer. Without access to the record, peers were left in the dark about the overall treatment plan for the consumers they served. For example, a supervisor complained that the peer neglected to tell staff when a client had stopped taking medication but the peer felt she was operating true to the recovery

perspective by supporting the client's right to choose whether or not to take medication.

Peers not Sharing Information About the Clients with Nonpeer Staff

Finally, as friends of clients, peers would learn about personal issues that had bearing on the clients' treatment. Often, this information could make an important contribution to understanding clients. "I got valuable information from the peer on clients. The information would include how to approach consumers, how to treat them, and ideas on engaging with consumers."

At times, however, peers would choose not to share this information with agency staff because of a sense that they were violating the trust they believed important to their friendship or because of pressure from the client to maintain secrecy as a condition for friendship. For example, one peer provider learned that his roommate, who was a client at the peer's agency, was using drugs but withheld the information from the roommate's counselor because of pressure from the roommate not to tell. "We had issues with our peers being privy to information that staff didn't have, not the other way around..... Peers feel a sense of disloyalty when sharing this information with staff."

Job Structure

The peer job structure had the potential to either isolate peers or help to include them in staff operations. Respondents were asked to list the required qualifications for the peer position, job tasks, and the job structure including number of hours of work each week, whether or not the job was permanent, the level of compensation, and union status.

Qualifications for the peer position included a range of credentials. Most agencies required being a current or former recipient of mental health services, possessing a high school diploma or equivalency, and some previous work experience of any kind. Other qualifications included having one year previous advocacy experience, bilingual ability, state clearance for child abuse, excellent communication skills, bachelor's degree, completion of a peer training program, and previous experience working with consumers.

Job qualifications set the tone for how the peer position was received by nonpeer staff. Some agencies viewed the mental health experience comparable to formal credentials. They placed great value on the unique peer perspective and demonstrated recognition of its worth by accepting experience in lieu of educational requirements when peers sought to switch jobs. Other agencies, however, viewed the peer position as a strictly nonprofessional, dead end job.

Peers were often in positions that were part time, temporary, not compensated at the same rate as nonpeer staff in comparable jobs, and without clear performance standards or paths for promotion. The job structure conveyed the message that peers were less valued by the agency and reinforced the rationale for sidelining peers by nonpeer staff. As a consequence, peers were less likely than nonpeer staff to receive supervision, or be given the opportunities for staff development or promotion.

Management believed that the structure of the peer position was responsive to peer needs. For example, some indicated that they made positions part time or paid peers less because peers did not want to affect their cash benefit by working too many hours or earning too much. Peers indicated, however, that they were not offered benefits counseling to make informed decisions about how much to work. Further, working part time frequently excluded peers from access to employer health care or other benefits. Temporary positions were often a function of the availability of external funding. Agencies were not making a commitment to the peer role or choice regardless of funding.

Lack of Opportunities for Networking and Support

Peers, like all workers, need social support in the workplace in order to best meet job requirements and feel satisfied with their jobs (House, 1981). The opportunities for support, as indicated in the preceding discussion, were affected by staff attitudes, role conflict and confusion, issues of confidentiality and job structure. For example, leadership at some agencies believed that all staff should be treated the same regardless of differences among them. "We try to be consistent with all employees, to do something beyond that would be unfair. We didn't do anything special or different for other employees." The result was that peers were not offered additional training, support, or the accommodation to which they are entitled under the Americans with Disabilities Act that would help them adjust to the work world and operate effectively with other staff.

As indicated above, supervision was recognized as an essential source of support for peers. In most agencies peers receive regular supervision but the role confusion was apparent when supervisors described the support they offered to peers. "I have taken her under my wing. Outside the agency I have been an advocate for her. She is in a situation now where she has lost her

benefits. She looks to me for that type of support." "Also, it was a real struggle for the supervisor having an employee who was someone else's client. It was a problem for the supervisor in terms of what hat to wear."

Job structure also undermined opportunities for support. For example, when positions were part time, not only were there fewer opportunities for supervision, but also fewer opportunities for peers to participate in agency life such as meetings or social events. In fact, some used the part time status as an excuse for scheduling team meetings when peers were not available. At one agency team meetings were scheduled in the morning but peers only worked in the afternoon. In many agencies where peers were not allowed to participate in team meetings, no other forum for sharing information with the clinical team and receiving feedback on their activities was provided.

Implications for Integration of Peers on Staff

Peers have the potential to make a major contribution to the recovery of consumers receiving services through mental health agencies as well as to experience individual benefit from assuming the helper role. The inability to include peers on staff effectively, however, places at stake the valuable contribution to mutual support and recovery that the peer provider position offers both to peers and to the consumers they serve. Equally important, the influence of the peer on shifting agency culture toward the recovery perspective is at risk.

This qualitative, exploratory study provides insight into some of the practices that create problems with integration of peers on staff as well as some of the workplace strategies that promote effective integration. The exploratory study design limits the generalizability of the findings. Although size and type of social service agency varied, the study reflects the experience of agencies in one geographic area. Their importance, however, lies in intervention development. They inform the development of strategies to help include peers on staff. The effectiveness of these strategies will need to be tested by future research.

Confirming previous research, the study showed that integration of peers on staff was undermined by misperceptions and stigma among nonpeer staff about consumers as workers, role conflict and confusion, inadequate policies and practices around confidentiality, poorly defined job structure, and a lack of opportunities for networking and social support (Chinman, Young, Hassell, & Davidson, 2006; Salzer, 2002). Conversely, peer integration was more successful when leadership created an understanding of the importance of the peer role to agency mission, provided training to peers, nonpeers and consumers that reinforced that commitment, clearly defined peer and nonpeer staff roles and helped all staff understand how to work together effectively, established clear policies and practices around sharing information, recruitment and hire of peers, and ensured effective communication and support through supervision and training (Solmon, Jonikas, Cook, & Kerouzc, 1998). Specific strategies to avoid the problems and promote the successful integration emerge from the data, a review of the literature and the experience of the authors in providing extensive training and consultation to agencies that employ peers (see Table 3). These strategies tend to cluster into two types, (1) human resource (HR) policies and practices or (2) workgroup relationships and operations.

HR policies and practices promote integration in several ways. First, they ensure commitment to peers by recognizing and supporting peers as an essential part of the agency's staffing pattern. Study findings suggest that this commitment can be expressed through (1) hiring policies that are responsive to the unique qualifications of peers such as accepting experience in lieu of formal credentials; (2) a job structure that conveys the importance of peers to the agency. Positions that are permanent and independent of changing levels of funding, compensated and evaluated on the same performance standards as nonpeer staff, and provide opportunities for advancement make it clear that peers are as valuable to the agency as their nonpeer co-workers; (3) HR practices that help peers participate in the workplace to the fullest extent possible. Benefits counseling that prepares peers to make informed decisions about the number of hours to work can help to overcome a frequent barrier to workplace participation; (4) orientation and training to all constituencies (peers, nonpeers, consumers). Better staff functioning will result from clarity around roles and required provisions of the ADA; and (5) clear communication of the value of peers in the mission statement that supports recovery, a strong leadership role in supporting the mission, and formalized opportunities to learn about policies and practices such as a mandatory new employee orientation.

Second, HR policies and practices promote integration by responding to issues of role conflict and confusion. Study findings suggest that policies and practices to minimize conflict and confusion include (1) formal recruitment strategies that specify the labor pool from which peers will be recruited (internal or

Table 3 Workplace Strategies to Respond to Problems and Promote Integration

Factor Affecting Peer Integration	Workplace Strategies that Promote Integration
Attitudes toward recovery	Clear recovery position in mission statement Leadership commitment to recovery well communicated Leadership support of recovery Peer position viewed as essential rather than an add-on
Role conflict and confusion	Well-defined recruitment strategies Consistent application of workplace policies to peer and nonpeer staff Written job descriptions for all staff including peers Supervision to ensure that actual job expectations are the same as written job expectations Training to staff and clients to provide understanding of roles New employees receive formal orientation
Lack of confidentiality	Neutral job titles that do not disclose peer status Implement a formal disclosure process for peers Keep previous treatment records of internally recruited peers in confidential files Do not allow peers to receive services in the units where they are employed Training on policies and practices related to confidentiality Establish a formal process for sharing work-related information between peer and nonpeer staff
Job structure	Accepts experience in lieu of formal credentials as HR policy Peer positions are permanent Peer positions have clear path for promotion Apply the same performance standards to peers and nonpeers Compensate peers and nonpeers equally in comparable positions Provide benefits counseling to help inform the peer's decision on hours to work
Social support	Opportunities for interaction in agency life (team meetings) Include peer input in treatment planning and case notes Offer peers training to learn language of the workplace Supervision Meet ADA requirements for accommodation

external to the employing agency), and if recruited internally, how that should occur. For example, recruitment may be limited to sites or units different from those which have the job opening; (2) clear, well communicated guidelines governing staff/client relationships that are implemented consistently across all staff. For example, if the agency policy is that staff cannot have personal relationships with clients, the policy should apply to peer as well as nonpeer staff. Training is important to communicate the guidelines and prepare nonpeer staff to transition from the role of therapist to colleague, prepare peers to transition from the role of consumer to service provider, and prepare clients to transition in their relationship with the peer from friend to service provider; and (3) job expectations are formalized through written job descriptions so that peer and nonpeer staff understand clearly what each other's job involves.

Third, HR policies and practices promote integration by establishing clear policies and practices around issues of confidentiality. Although HIPAA regulations have changed the way that staff handles client information, the issues around confidentiality for peers do not typically receive the same attention. The findings suggest that HR polices and practices to protect confidentiality might include (1) peer job titles that do not disclose peer status, (2) a formal disclosure process that provides peers with control over when to disclose, to whom to disclose and what information to share, (3) confidential records for peers who were treated at the employing agency prior to hire, and (4) a ban on peers receiving mental health services from the agencies where they are employed. To ensure that these individuals have access to treatment, however, the agency might establish a referral system to other treatment providers.

Along with HR policies, practices and structure, study findings suggest that workgroup strategies that build relationships between peer and nonpeer staff and clarify the division of labor are important to effective peer integration. The emergent strategies focus on establishing clear channels of communication between peer and nonpeer staff to share information related to treatment planning, training on how to communicate effectively, and providing opportunities to increase mutual understanding and support. Thus, workgroup strategies might include (1) formal structures for peer and nonpeer staff to share information such as team

meetings, one-on-one meetings between peer and nonpeer staff, mandatory peer and nonpeer entries in case records, mandatory requirements for peer and nonpeer staff to read the records for all new clients, or opportunities for peers to participate in staff development and training activities, particularly those related to treatment philosophies and approaches; (2) training for peer and nonpeer staff on how to respond to issues around sharing information such as providing staff with an understanding of the importance of the information peers gather about clients to clients' treatment, and offering peers specific ways to explain to clients the conditions under which clients can feel that shared information is protected. Training is also needed for supervisors to ensure that they understand HR policies and practices with respect to confidentiality and role definition and are equipped to set them in place and enforce them among their staff; (3) regular supervision to peer staff to ensure that they are receiving the support and accommodation they need to best meet job requirements and to nonpeer staff to help them separate work issues from mental health issues; and (4) informal occasions to interact such as staff lunches or other social events that help staff develop relationships and mutual understanding.

Finally, the data suggest a process for strategy implementation that includes:

1. *Assess the agency to determine how prepared it is to employ peers.* Integration of peers on staff can represent a significant change in the way an agency operates. Determining agency readiness for change begins with an assessment of the extent to which its mission embraces a recovery perspective, leadership is committed to peers on staff, and HR policies are inclusive and thus supportive of difference among all staff.
2. *Create an understanding among all staff and clients of the peer role and the policies and practices which support the peer contribution to services* through formal orientation for all new hires, supervision that includes education about policies and practices, and training for peer staff about being workers and nonpeer staff and clients about working with peers, and interpreting the importance of peers to the agency mission.
3. *Formalize a recruitment process and job structure for peer positions* to establish the policies, practices and structures to guide the recruitment of peers and define the peer position.
4. *Clarify staff roles* through consistent application of formal guidelines governing client/staff boundaries, explicit policies and practices that determine how information is shared about clients between peer and nonpeer staff and specify a disclosure process that allows peers to control sharing information about themselves.
5. *Provide on-going support to staff to maximize peer inclusion* key to achieving the goal of long term retention of peers on staff including formal channels for communication among staff, regular supervision that includes separating mental health issues from work issues, on-going training and role clarification, opportunities for accommodation and opportunities for peers to share their feelings and develop personal connections with nonpeer staff.

Peers remain vulnerable and their positions remain largely temporary, sensitive to shifts in funding and management philosophy. This places great importance on the need to implement strategies to help agencies develop the capacity to employ peers effectively and help peers overcome organizational barriers to carry out their contributory role. The findings reported here take one important step toward this goal. Ultimately peers, and all other staff, are well served by HR policies and practices that are consistent, fair-minded and reflect managerial commitment to recognizing and valuing the difference among all groups and dealing with those differences in an inclusive, culturally competent manner.

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EXHIBIT
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Consumer Outcome Monitoring Package

(COMP)

June 2003

Hello and welcome to the Consumer Outcome Monitoring Package (COMP). In conjunction with the National Evidence Based Practice Project (EBP), we are very pleased that you have chosen to try this application. As an integral part of the EBP project, monitoring outcomes will provide your agency with detailed information of consumer status and characteristics. This information may be used for a variety of purposes. For example, the reports the application provides are a powerful tool for use in team meetings to determine practice protocol or identifying service change elements. You will also be able to write documents that include COMP reports that you can share with consumers, staff, board members and other agency stakeholders. This information will provide a window into the demanding work you do each and every day.

Sponsored in part by SAMHSA, the data components contained in COMP were designed by senior researchers associated with the national project. The School of Social Welfare - University of Kansas, wrote the program application and attempted to make it as easy and flexible to use as possible. Community mental health centers throughout the country agreed to "test" the application. Although we have incorporated changes recommended by the numerous stakeholders involved with COMP, it remains a "work in progress".

We have created a web site that allows you to download the application. This allows you to easily install the application and print out both the Installation Instructions and the User Manual on your computer. Simply type- **research.socwel.ku.edu/ebp** into your web browser and hit the "Go" button:

This is the home page of the COMP application. When you click on the link to the download page you will be asked to enter a user name and password. Type in:

User Name:	**ebp**
Password:	**kujayhawks**
Domain:	(this may not appear; if it does leave it blank)

The download page appears. Next, download the User Manual and Installation Instruction by clicking on the appropriate links. These documents will provide you with the necessary information to use the application and install the application respectively.

Read the Cautions section and the Tips section. This contains important information about using the application.

As you use the COMP application you will notice that the file that holds your agency's Access data is separate from the file that contains the Access application. This was done to ensure that if you accidentally delete a file in the application, your data would not be lost or disrupted. If you happen to delete something in the application, just download the application again and it will re-link to your data.

Important: we strongly recommend that you consistently back up your data. Here are some suggestions, listed in order from the least to the most effective procedure. We suggest that you use at least two of these.

- Copy the file ebp_data.mdb while adding the date to its name (e.g., ebp_data_081503); it can be copied to another directory on your hard drive or to the same directory.
- Copy the file, suitably renamed, to a zip drive.
- Burn the file, suitably renamed, to a CD
- Include these files in the regular backup procedure used by your agency.

Note that doing the procedures above on a regular basis is better than doing them when it occurs to you.

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National Evidence Based Practice Project

Consumer Outcome Monitoring Package (COMP)

User Guide

I. Recovery and Consumer Outcomes

Recovery means more than controlling symptoms. It's about getting on with life beyond the mental health system. As Pat Deegan (1988) wrote:

> The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (p.15).

While the goals of each individual are unique in detail, people with severe mental illness desire the same core outcomes that we all want:

- To live independently in a place we call home
- To gain an education, whether for career enhancement or personal growth
- To have a job that enhances our income, provides a means to make a contribution, and enables us to receive recognition
- To have meaningful relationships
- To avoid the spirit-breaking experiences of hospitalization, incarceration, or substance abuse

If this is true, then mental health services should be focused on the most powerful methods available to help consumers achieve these outcomes. The evidence-based practices that are described in the resource kits were chosen for their ability to achieve one or more of these outcomes.

II. What are consumer outcomes?

Consumer outcomes are those aspects of consumers' lives that we seek to improve through the delivery of mental health services. Medications help consumers manage their symptoms. Supported employment programs help consumers find work in the community. Dual diagnosis groups help consumers reduce their dependence on alcohol and illicit drugs. Relapse prevention programs help consumers stay out of the hospital. Some outcomes are the direct result of an intervention, such as getting a job through participation in a supported employment program, whereas others are indirect, such as improvements in quality of life due to having a job. Some outcomes are concrete and observable, such as the number of days worked in a month, whereas others are subjective and private, such as satisfaction with vocational services.

Consumers have goals for themselves, which they hope to attain through the receipt of mental health services. These goals translate into outcomes. For example, the goal for consumers is obtaining and holding regular jobs in the community. The outcome measure for a supported employment program may be the number of weeks that a consumer has worked at competitive jobs during the past quarter.

We recommend the following outcomes:

- psychiatric or substance abuse hospitalization
- incarceration
- literal homelessness
- independent living
- competitive employment
- educational involvement
- stage of substance abuse treatment

These few outcomes reflect the primary goals of the evidence-based practices. Assertive Community Treatment (ACT), Family Psycho-education, and Illness Management and Recovery share the goal of helping consumers to live independently in the community. Thus, their goal is to reduce hospitalization, incarceration, and homelessness, and to increase independent living. Supported Employment and Integrated Dual Diagnosis Treatment have more direct outcomes, and thus it is important to assess work/school involvement and progress toward substance abuse recovery, respectively.

III. Why monitor consumer outcomes?

Consumer outcomes are the bottom-line for mental health services, like profit is in business. No successful businessperson would assume that the business was profitable just because the enterprise was producing a lot of widgets (e.g. cars, clothes) or employees were working hard. This does not mean that the owner does not need to pay attention to productivity, but rather one would not make the assumption that productivity necessarily leads to profit. In mental health, productivity measures, such as, the number of counseling sessions or the number of consumers served, tell us very little, if anything, about the effects of services on consumers and their welfare.

This fact has led to a broad-based call for outcome monitoring. At the policy and systems level, the Government Performance and Results Act of 1993 requires that all federal agencies measure the results of their programs and restructure their management practice to improve these results. In a parallel fashion, there is a significant movement in human service management toward consumer outcome-based methods (Rapp & Poertner, 1992). Studies have shown that an outcome orientation of managers leads to increased service effectiveness in mental health (Gowdy & Rapp, 1989). This has led Patti (1985) to argue that effectiveness, meaning consumer outcomes, should be the "philosophical lynchpin" of human services organizations.

Effective agencies need to pay attention to both the method used to provide service (e.g.: fidelity ratings) and *how* consumers respond (e.g.: consumer outcomes). One without the other only illuminates part of the picture. Although unlikely, high fidelity programs may not be attending to critical consumer outcomes that reflect quality of life measures of the persons they serve. Monitoring these outcomes both recognizes the practitioner's hard work done on behalf of consumers as well as identifies service elements that may need attention. A simple but accurate phrase to remember: what gets measured, gets attention, gets done.

IV. A Powerful Resource for Program Leaders

If funds are the lifeblood of an organization, then information is its intelligence. Collecting and using consumer outcome data can improve organizational performance. Consider the following vignette.

> Participants in a partial hospitalization program sponsored by a community mental health center were consistently showing very little vocational interest or activity. Program staff began gathering data monthly on consumers' vocational status and reporting this to their program consultant. He returned these data to program staff using a simple bar graph every three months. The result of gathering and using information on consumers' vocational activity was evident almost immediately. Three months after instituting this monitoring system, the percentage of the program's consumers showing no interest or activity in vocational areas declined from an original 64 percent to 34 percent. Three months later this percentage decreased an additional 6 percent, so that 72 percent of program participants were now involved in some form of vocational activity.

This example shows that when information is made available, people respond to it.

Peters and Waterman (1982) in their study of successful companies observed:

> We are struck by the importance of available information as the basis for peer comparison. Surprisingly, this is the basic control mechanism in the excellent companies. It is not the military model at all. It is not a chain of command wherein nothing happens until the boss tells somebody to do something. General objectives and values are set forward and information is shared so widely that people know quickly whether or not the job is getting done—and who's doing it well or poorly (p. 266).

They observed that the data were never used to "browbeat people with numbers" (p.267). The information alone seemed to motivate people.

What is clear from these examples is this: *The collection and feedback of information influences behavior.* Current research suggests several principles to improve organizational effectiveness:

- The role of information in an organization is to initiate action and influence behavior.
- The act of collecting information (measurement) generates human energy around the activity being measured.
- To ensure that information directs human energy toward enhanced performance, data collection and feedback must be used: (a) to foster and reinforce desired behaviors; (b) to identify barriers to performance and ways to overcome them; and (c) to set goals for future performance.
- Feedback directs behavior toward performance when it provides "cues" to workers to identify clear methods for correction and when it helps workers learn from their performance.
- Feedback motivates behavior toward performance when it is used to create expectations for external and internal rewards, is linked to realistic standards for performance, and is directed toward the future versus used punitively to evaluate past performance.

Managers who are committed to enhancing consumer outcomes have at hand a powerful tool. By proactively and systematically collecting and using consumer outcome information, managers can enhance the goal-directed performance of program staff, as well as increase their motivation, professional learning, and sense of reward. Minimally, supervisors and managers should distribute (or post) the outcome data reports and discuss them with staff. Team meetings are usually the best time. Numbers reflective of above average or exceptional performance should trigger recognition, compliments, or other rewards. Data reflecting below average performance should provoke a search for underlying reasons and the generation of strategies that offer the promise of improving the outcome. By doing this on a regular basis the manager has begun to create a "learning organization" characterized by consistently improving consumer outcomes.

V. Consumer Outcome Monitoring Package (COMP)

a. Introduction

The foundation of evidence-based practice is consumer outcomes. The decision to implement an evidence-based practice is based on its ability to produce the highest rates of positive outcomes for consumers. Therefore, one key component of the implementation of an evidence-based practice is the careful monitoring and use of consumer outcome data. The problem for many mental health providers is that current data systems do not capture relevant consumer outcomes or are unable to produce meaningful and timely reports. Providers must find ways to develop evidence-based practices information systems that are easy to implement and to maintain.

We begin with an introduction to our goals for the consumer outcome monitoring package, advice on getting started, and then describe the simple, yet ample, system for monitoring evidence-based practice outcomes. We follow this with ideas on using tables and graphs of outcome data to improve practice, and on expanding basic systems.

The overall goal of the Evidence-Based Practice project is to promote the implementation of effective interventions for the care of persons with severe mental illnesses (SMI) in routine community-based mental health practice settings (e.g., community mental health centers). The areas of evidence-based practices are: (1) illness self-management, (2) case management based on principles of assertive community treatment, (3) family psychoeducation, (4) supported employment, and (5) substance abuse treatment integrated with mental health treatment. As a contributing element for EBP implementation, consumer outcomes will be collected during Phase II of the project. Collecting consumer outcomes will provide participating agencies with critical information necessary to guide practice and to assess the results of implementation.

Each EPB site will have the capacity to use a freestanding program that will provide a spreadsheet for entering the data and will generate agency-specific reports. Data entry will usually be accomplished using a pull-down menu. A pull-down menu button can be found on the right side of the box where you are entering data. When this button is hit, all the options relative to that field are made available. Simply select the correct response and it will automatically be entered into the database. This feature saves a tremendous amount of time that would usually be devoted to typing in all the data. Some data collection elements may be tailored to the individual needs of the agency. For example, the reporting cycle (the frequency which data is collected) may either be monthly or quarterly, depending on your agency needs. We have designed a report package that may assist agencies with outcome measurement beyond EBP participants. Agencies may report on all persons receiving service and use the corresponding report packages for their needs. This capacity will allow agencies to determine the report population, which may include those persons enrolled in the EBP, those eligible but not enrolled, those not eligible, or any combination of the preceding. Consumer-specific data and reports will only be viewed by the agency providing service. However, aggregate data (such as number of hospital incidents for <u>all</u> EBP participants) will be utilized to evaluate EBP implementation.

The subsequent pages provide operating and interpretation guidelines for the COMP data entry and report package. Some items may be adjusted according to your agency's current reporting schema or needs. For example some agencies may choose to report for only case management consumers. For others, reporting may be for all consumers receiving services. When entering data, however, please stay within the definitions for specific consumer status/incident measures. The measures are detailed both within this guide and the application. For other fields like "team", you may tailor the codes to what works best for you. For example, the team code may either by "Supported Employment" or "Smith". However, once you have determined the field format or names that work best for you, **you must continue to use those.** This will provide report consistency within and among sites as well as ensuring your reports contain the correct data. Further, some agencies may prefer to collect individual consumer information using a paper form rather than directly entering data on the computerized screen. Please feel free to use the most effective method for your agency. A data collection form and a sample report package are contained in the Appendix.

b. Questions to Consider before Starting

At least three questions should be answered before data entry begins. First, how often should data be collected? Second, who should enter the data? Third, how should the agency produce, disseminate, and use the reports?

i. *Data Entry Frequency*

As noted earlier, information generated from consumer outcome data can be a tremendous tool for program managers and stakeholders. Information is necessary to monitor program effectiveness and is critical for incorporating change within programs. This outcome report package allows the agency to choose the frequency of data collection and reports, either quarterly or monthly. The exception is movement tables. Movement tables lose sensitivity if the reporting sequence is less than quarterly. Consequently, movement tables will only reflect a consumer's change in status over a three-month period. Further explanation of movement tables may be found in Section III. However, consideration should be given to the purpose and labor necessary to produce the other reports.

Agencies may desire to collect data and use the corresponding reports according to their needs. For an agency in the beginning or middle of a new service initiative, reports associated with monthly data collection may be useful. For example, the agency may have set an annual enrollment goal for a specific service. A monthly report reflecting the number of persons enrolled in the service greatly aids program managers by determining how well their enrollment efforts compare to their goals. In this case, a monthly report would enable the agency to identify enrollment trends much more readily than from quarterly reports. This allows the agency to reflect on whether they are meeting the intended objective and to determine if adjustments to services are necessary in a much timelier manner.

Another component for determining the frequency of reporting is to consider the benefit the information may have for practitioners. For example, a monthly display of the upward trend in consumer enrollment reinforces worker attitudes and recognizes their efforts. This may be a valuable tool in shaping program services.

On the other hand, agencies need to consider the time and energy necessary to collect and enter data. For some agencies that may desire monthly data collection and reporting, the resources needed to accomplish this may not be in place. Consequently, quarterly data collection would present the best option.

Please note that once the agency determines the report frequency, data must be entered according to that frequency. At this time, agencies may not enter data quarterly and then change the schedule to monthly. At a minimum, data will need to be collected on a quarterly basis.

ii. *Entering the Data*

Persons with little computer experience may use COMP. Most data entry fields use "pull-down" menus, making data entry simple. There are at least two options for entering consumer outcome data. First, the data may be entered directly by individual practitioners. This would involve establishing a central computer site at the agency where they could enter their caseload data. The application may also be "networked" at your agency. The agency's computer technician or consultant can assist with this. Second, practitioners could fill out a paper copy (see Appendix) and turn in the data to a central data entry person who would be responsible for entering data.

iii. *Producing, Disseminating, and Using the Reports*

When all consumer data have been entered for the current period, producing the reports is basically a matter of pushing a button. A person from the agency will need to be responsible for ensuring that data are entered in a timely manner and it is entered correctly. Timeliness is straightforward. Ensuring that data are entered correctly will involve reviewing the reports to ensure that nothing looks suspect. This should be done by someone in the agency who is familiar with agency outcome trends and can spot questionable report data. For example, the agency may be serving 100 consumers but the reports only reflect data for 80 consumers. These types of errors can usually be caught and corrected prior to distribution if a knowledgeable person first reviews the reports and takes the action necessary to correct errors.

The purpose for outcome reporting has been discussed previously. Most agency stakeholders may use and benefit from all or some of the consumer outcome report information. All agencies need operating funds, adequately trained staff, consumers who can benefit from the service, and public support to ensure effective service delivery (Rapp & Poertner, 1992). Outcome reporting is intended to aid agencies in focusing their attention on these organizational needs.

Further value of a monitoring system comes in producing tables that summarize the participation and outcomes of groups of consumers. For example, outcome reports may be shared with funders to demonstrate that the number of consumers eligible for a given service far out number those enrolled. This suggests that additional resources are necessary to meet the needs of the population served. Consumers also benefit from seeing reports and reviewing outcomes. For example, they may benefit from seeing how many more persons are now working than in the past. Outcome reports may be shared with community leaders to help educate them about agency services.

The most direct benefit from outcome reports is at the practitioner level. Individual workers begin to associate consumer names and circumstances with report data. For example, a review of the residential status report in a team meeting may show that two persons have moved into a more restrictive setting during this

report period. This may lead to a formative discussion of the dynamics associated with the movement and to team planning around services that may lead to regaining the consumers' previous living status.

In order to use outcome reports most effectively, agencies should determine their need and identify who needs the information to fulfill these objectives. Outcome reports should be distributed regularly to those who need the information.

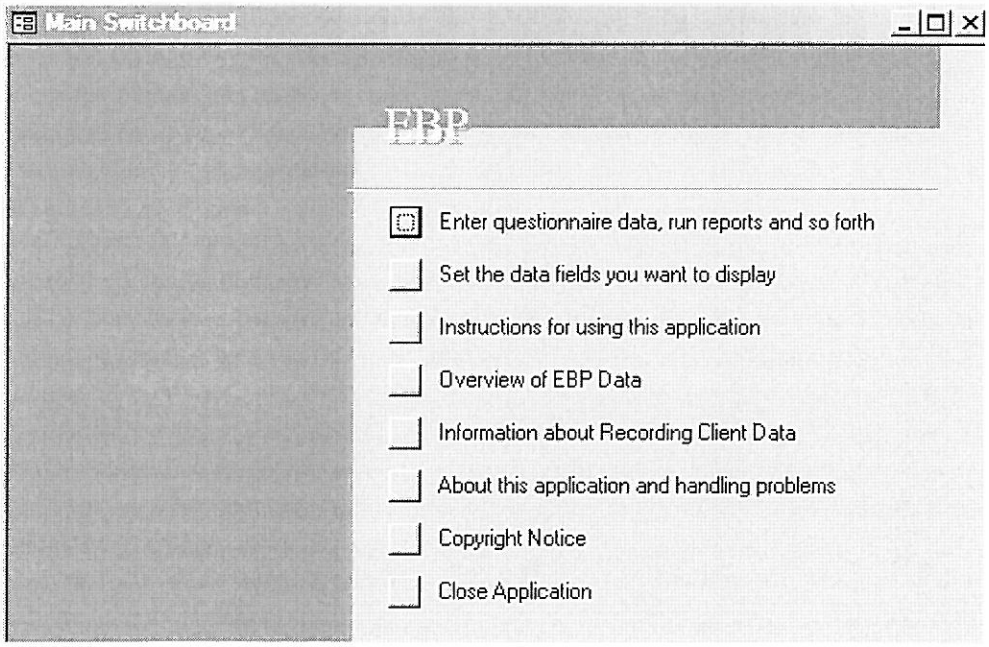
VI. COMP Data Entry and Report Writing

COMP was designed to be a simple, easy, and flexible application for agencies to use. For example, data entry tasks are kept to a minimum and often may be accommodated using pull-down menus. Once data is entered, it will remain in the database. This means that for the next reporting period you only have to change the data elements that are different (e.g.: the time period you are entering data for) in order to enter information. The application may be used on a single computer or a network of many agency computers. Data entry may be done by individual practitioners sitting in front of their computer or they may turn in a paper copy of the data to a central date entry person. Finally, once data has been entered, practitioners may choose what programs, clients, outcomes, and types of reports they want to generate.

a. Using COMP

When you open the application, the first screen that appears is called the Main Switchboard (Figure 1). If a box entitled "EBPXXXX Database" pops up, simply close it. The Main Switchboard allows you to navigate through the application while using the "freestanding" Access program. Freestanding means that the user may have but does not need Microsoft Access on their computer to operate the report package. If Access is not available all necessary commands and functions are contained in the runtime version. Throughout the application, if you are unsure what you should enter into a field, numerous Help functions are built in to assist you with determining what should be entered. Just click the bar and the field's definitions or explanation will appear. Further, once you enter data and save it at the close of the session, the data will remain in the database so reentering information that has not changed between data entry time periods is unnecessary. For the next time period, you simply enter only data that has changed.

i. Figure 1. **Main Switchboard**



From the Switchboard, you may choose from the following options:

ii. Switchboard #1) Enter questionnaire data and run reports.

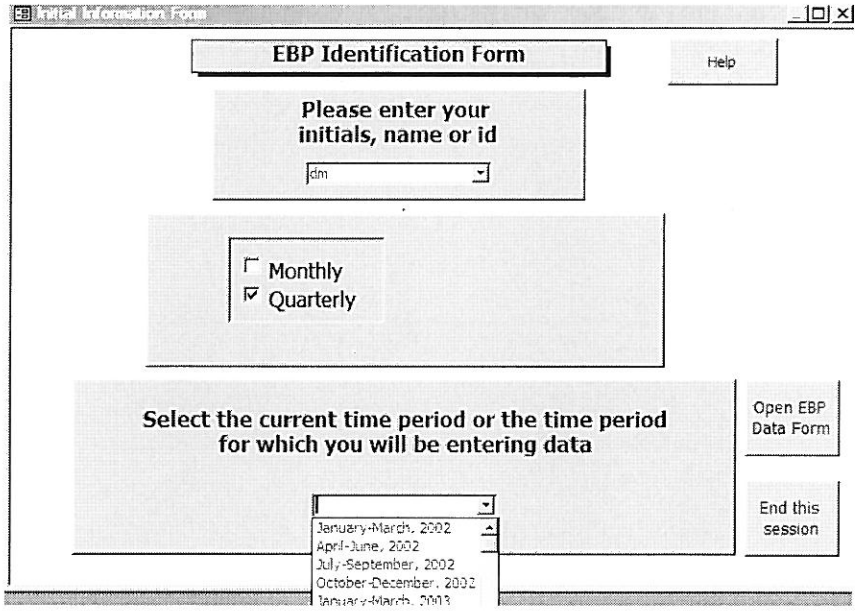
This button will be the most commonly used option selected from the Main Switchboard. Its selection is the first step necessary for entering data and running reports. Please review the next button "Switchboard #2) Set the data fields you want to display" prior to operation, however.

After selecting this option, the first screen that appears is the **"EBP Identification Form"** (Figure 2) (Note: The very first time you use the application, you will be asked to enter your Agency Code. Just type in the name of your agency). Here you are asked to do the following:

a. Enter your initials or select them from the drop-down provided. This will identify who is entering information for each consumer.
b. If necessary, choose whether you will be entering data for each consumer monthly or quarterly. When possible the software will indicate this choice.
c. Choose the month or the quarter you plan to enter data for.

These fields must be completed to continue. If one field is inadvertently skipped, you will be asked to fill in the missing data. After completing these steps, choose the "Open EBP Data Form" button to continue or select "End this Session" to leave the application.

A. Figure 2. **Initial Information Form**



After selecting the "Open EBP Data Form" button, the **"Evidence Based Practice Form"** (Figure 3) appears. Initially, it will be blank. To begin entering data, click the "**Add a Record**" button on the bottom of the screen (Figure 4).

B. Figure 3. **Evidence Based Practice Form**

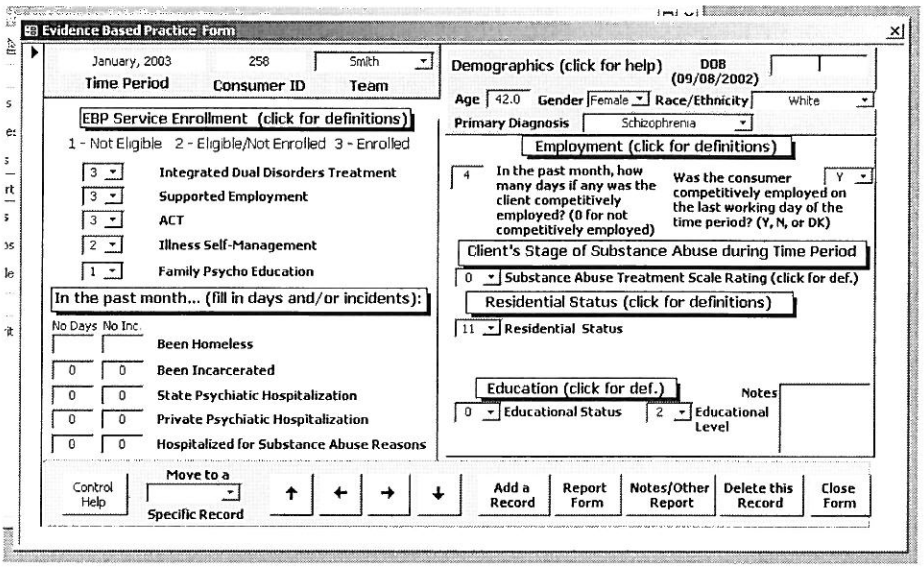
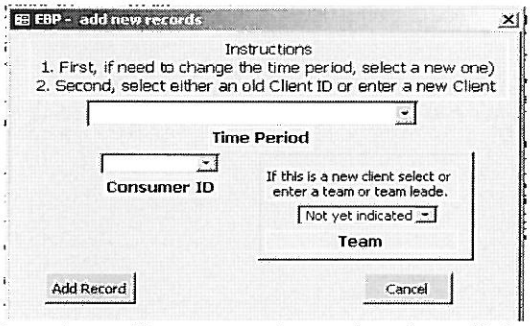


Figure 4. **Add a Record**



To add a record, select the time that reflects your data using the pull down menu. Enter the consumer's ID. You will be asked to repeat the ID to ensure correct entry. Enter the name of the team. After completing, hit the Add a Record button and the data will be put into the database. You are now ready to complete the rest of the data entry elements on the Evidence Based Practice Form.

At a minimum, the following sections on the EBP Form will need to be completed on *each* consumer receiving EBP services or persons you want to include in reporting. The time period will automatically be filled in. The consumer's identification number goes in next (Consumer ID) Like most fields used in COMP, once an ID is initially entered, you may pull down to that ID thereafter. Identify your work group in the Team box if not done previously. Use terms to identify teams that you use in your day-to-day operation. For example, Team 1, Smith or Supported Employment, etc. Fill in the Consumer Demographics. Once initially completed, the Consumer Demographic data will fill in automatically any time you enter the Consumer's ID. The consumer demographic data captured in this application are: Date of Birth, Age, Race/Ethnicity, and Primary Diagnosis. Use the pull down menus for race and diagnosis.

The next step involves identifying the consumer's EBP status. Note that the only EBP services that appear are the ones you selected using the Main Switchboard. The data collected from the remaining sections of the form will be used to generate reports for both agency and EBP implementation evaluation. It will be important for each person completing the form to become familiar with the definitions of the outcomes in order to provide consistency in the ratings. The EBP Service Enrollment box identifies the practice and status of the consumer. This domain reflects the penetration of persons involved with the EBP compared to the rest of the

population being served by the mental health agency. The data can mirror the number of persons being served by the EBP(s) or those receiving other services throughout the agency as well. At this point, the agency will need to determine what consumers they want to collect data and write reports for. For example, some agencies may want to report on only EBP or case management consumers. Other agencies may choose to write reports for everyone receiving any type of service. For each consumer, use the pull down menu to choose one of the following options:

1. Determining Eligibility for EBP

>1) **Not eligible for the EBP.**
   a. A consumer who does not meet the criteria for the EBP.

>2) **Eligible but NOT enrolled.**
   b. A consumer in service who does meet the criteria for the specific EBP but is not receiving the EBP service. All EBPs have criteria for service.

>3) **Enrolled in the EBP service.**
   c. A consumer who meets the EBP criteria and is receiving the service.

For example, for agencies with a Dual Disorder EBP, choosing "Not eligible" would mean that the consumer did not have a SMI and drug/alcohol diagnosis. Choosing Eligible but not enrolled" means the consumer meets the EBP criteria but is not receiving the service. Last, by choosing "Enrolled", the consumer meets the EBP criteria and is currently receiving the service.

The next block of data captures the length of time that the consumer may have experienced any of following life-distressing events during the reporting period. For example, identifying the number of days that the consumer was homeless during the reporting period. Record these days in the box next to the event.

The following definitions apply to these event categories:

2. Consumer Events

>Homeless: Record the number of days and number of incidents the consumer spent homeless during the reporting period. Homeless means the consumer lacks a fixed, regular, and adequate nighttime residence.

>Incarceration: Record the number of days and number of incidents the consumer spent incarcerated in jails or other criminal justice lock-ups during the reporting period.

>State Psychiatric Hospitalization: Record the number of days and number of incidents the consumer spent in a state psychiatric hospital during the reporting period. This includes hospitals, usually public whose primary function is the treatment of mental disorders.

>Private Psychiatric Hospitalization: Record the number of days and number of incidents the consumer spent in a private psychiatric hospital during the reporting period. This includes those hospitals, usually private whose primary function is the treatment of mental disorders.

>In-patient Substance Abuse Hospitalization: Record the number of days and number of incidents the consumer spent in a hospital whose primary function is treatment for substance abuse disorders during the reporting period. This includes those hospitals, both public and private whose primary function is the treatment of substance disorders.

3. Competitive Employment Status

Next, record the consumer's competitive employment status. There are two domains for this field. First, you have the opportunity to record the number of days the consumer was involved in competitive work during the reporting period (If your agency is not interested in capturing the number of days consumers work, just leave the field blank). Competitive employment is viewed as working in a paid position (almost always outside the mental health center and for at least 5 hrs per week) that would be open to all community members. This would exclude persons working in sheltered workshops, transitional employment positions, or volunteering. It may include persons who are self-employed but the person must work regularly (a minimum of five hours per week) and be paid for the work. If the consumer meets these criteria, record the number of days the consumer worked during the reporting period. For example, a person may work one day a week for five hours during the reporting period (you would enter "12" for a quarterly report period. This measure will allow you to identify the number of days consumers are involved in competitive work activity within and between report periods. **Second**, use the next pull down menu to record whether the consumer is competitively employed on the **last** day of the report period. This measure will be used to determine the percentage of consumers who are competitively employed.

The subsequent section is used for those consumers who are participating in the Dual Diagnosis Treatment EBP. Record the consumer's stage of substance abuse recovery, according to the following nine categories. N/A is used for persons who do not have a substance abuse problem or diagnosis.

4. Stages of Substance Abuse Recovery

>NA: Not Applicable: No history of substance abuse disorder.

>Pre-Engagement: The person (not client) does not have any contacts with a case manager, mental health counselor, or substance abuse counselor.

>Engagement: The client has had contact with an assigned case manager or counselor, but does not have regular contacts. The lack of regular contact implies lack of a working alliance.

>Early Persuasion: The client has regular contacts with a case manager or counselor, but has not reduced substance use for more than a month. Regular contacts imply a working alliance, and a relationship in which substance abuse can be discussed.

>Late Persuasion: The client is engaged in a relationship with a case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least 1 month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.

>Early Active Treatment: The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.

>Late Active Treatment: The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) but for less than 6 months.

>Relapse Prevention: The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least 6 months. Occasional lapses, not days of problematic use, are allowed.

>In Remission or Recovery: The client has had *no* problems related to substance use for over 1 year and is no longer in any type of substance abuse treatment.

The last two sections on the EBP Form capture the consumer's residential and educational status. Use the following definitions to determine the consumer's status in each domain on the last day of the reporting period and choose that status from the pull-down menu. Figure 1 has the pull down menu for educational status.

5. Residential Arrangement Status

>Institutional

1. **State Psychiatric Hospital** - This includes those state hospitals whose primary function is the treatment of mental disorders.
2. **General Hospital Psychiatric Ward-** This status includes those psychiatric wards that are located in general medical centers that provided short-term, acute crisis care.
3. **Substance Abuse Hospitalization-** This includes those hospital wards, both public and private whose primary function is the treatment of substance disorders.
4. **Nursing Home or ICF/MH-** This level includes those facilities who are responsible for medical & physical care of a consumer and has been licensed as such by the state.

>Lives with Others Who Provide Substantial Care

5. **Adult Foster Care-** Situations where a consumer is living in a single family dwelling with a non-relative who provides substantial care. Here (as with #8) substantial care can be assessed as to the degree that the non-relative(s) is responsible for the daily care of the individual and who may have guardianship responsibilities. Such things as taking medication, transportation, cooking, cleaning, restrictions on leaving the home, money management, etc., are looked at. If the consumer is not able to do a majority of the daily living tasks without the aid of the caretaker, the caretaker would be providing substantial care
6. **Lives with Relatives (heavily dependent for personal care and control)-** Here the individual consumer and relatives should be consulted to the degree that family members are responsible for the daily care of the individual consumer. An important distinction between this status and #9 is to ask, "If the family was not involved, would the person be living in a more restrictive setting?" In assessing the extent to which the members provide substantial care, such things as taking medication, transportation, cooking, cleaning, control of leaving the home, money management etc., can be considered. If the consumer is unable to independently perform a majority of the daily living functions, the family member(s) are providing substantial care.

>Board and Care or Other Semi-Independent Setting

7. **Group Home-** A group home is defined here as a residence that is run by staff who provide many functions (shopping, meal preparation, laundry, etc.) that are essential to independent living.
8. **Boarding Home-** A boarding home is a facility that provides for a place to sleep and meals, but it is not seen as an extension of a mental health agency, nor is it staffed with mental health personnel. These facilities are largely privately run, and consumers have a high degree of autonomy.
9. **Supervised Apartment Program-** Here, the individual(s) are living largely independently in apartments sponsored by a mental health agency. In assuring whether someone fits in this category, look at the extent to which MHC staff have control over key aspects of the living arrangements. Example characteristics of control include (1) the MHC signs. the lease, (2) the MHC has keys to the house/apt., (3) the MHC provides on-site day or evening staff coverage, or (4) the MHC mandates consumers to participate in certain mental health services, e.g., med. clinic, day program, etc., in order to reside in the home/apartment. Consumers merely receiving case management support or financial aid would not be considered in the status but would be in independent living.

>Independent Living

10. **Lives with Relatives (but is largely independent)-** As with status #8, an assignment to this category requires information provided by the consumer and family. The key consideration relates to the degree that the individual is able to perform the majority of those tasks essential to daily living without the supervision of a family member.
11. **Independent Living-** This consumer is living independently. This would include those living with spouses or friends, family and who are capable of self-care. This category includes consumers who live independently with case management support. The consumer is largely independent may yet chooses to live with others for reasons not related to mental illness. The reasons for shared housing could include personal choice related to culture and/or financial considerations.

>Temporary

12. **Emergency Shelter-** This status would include those temporary arrangements that are due to a crisis or misfortune that are not specifically related to a recurrence of the consumer's illness. While many emergency shelters provide emotional support, it is due to an immediate crisis largely out of the person's control.
13. **Homeless-** This includes an individual who lacks a fixed, regular, and adequate nighttime residence. An assignment of this status should alert staff to the importance of directing efforts at locating shelter for the person who desires it.

>Other

This status should be clearly defined in the space provided by those completing the form.

6. Educational Status

>No Educational Participation

1. **No educational participation**

>Pre-Educational

2. **Avocational/Educational Involvement-** These are organized classes in which the consumer enrolls consistently and expects to take part for the purpose of life enrichment, hobbies, recreation, etc. These classes must be community based; not run by the Mental Health Center. Classes are those that any citizen could participate in, not just persons with SMI. If any of these activities involve college enrollment, mark it under a college status.
3. **Pre-educational Explorations-** Individuals in this status are engaged in educational activities with the specific purpose of working towards an educational goal. This status would include individuals who attend a college orientation class with the goal of enrollment, meet with the financial aid office to apply for scholarships, and apply for admission for enrollment. This status may also include those persons who attend a mental health center sponsored activity focusing upon an educational goal, e.g., campus visits with a case manager to survey the location of buildings of where they will be taking classes; consumer, case manager and College Services for Students with Disability meeting to secure entitlements.

>Basic Educational Skills

4. **Working on GED-** This status includes those who are taking classes to obtain their GED.
5. **Working on English as Second Language-** this includes those who are taking classes in English as a second language in a community setting.
6. **Basic Educational Skills-** This includes those who are taking adult educational classes focused on basic skills such as math and reading.

>Post-Secondary/High School Educational Involvement

7. **Attending a 1)Vocational School or Apprenticeship, 2) Vocational Program (e.g.: CAN) or 3) High School-** This status includes: Those participating in community based vocational schools those learning skills through an apprentice, intern, or practicum setting, on the job training to acquire more advanced skills, participating in correspondence courses which will lead to job certification, and young adults attending high school.
8. **Attending College: 1-6 Hours-** Attends college for 6 hrs or less per term. This status continues over breaks, etc., if the individual plans to continue their enrollment. This status suggests regular attendance by the individual. Includes correspondence, TV, or video courses for college credit.
9. **Attending College: 7 or More Hours-** Attends college for more than 7 hrs per term. This status continues over breaks, etc., if the individual plans to continue their enrollment. Regular attendance with expectations of completion of course work is essential for assignment to this status.

>Other

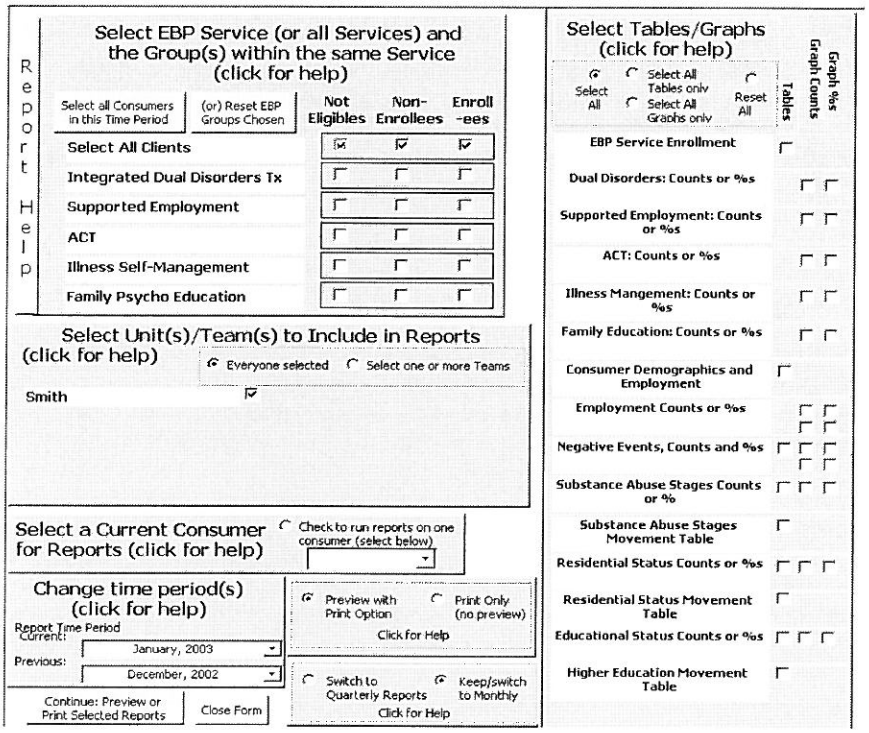
This status should be clearly defined in the space provided by those completing the form.

The above section discusses the information that will be used to write agency reports. The tool bar on the bottom of the **Evidence Based Practice Form** allows you to navigate through the cases you have entered or add and delete cases. The Move to a Specific Record box is a pull down menu where you may go to any case in the spreadsheet. Just pull down to the desired case and the screen data will reflect that consumer's information. This can be very helpful when changes need to be made. For example, you can use this arrow to find the case you want to update during the next report period. The Up Arrow will move you to the very first record in the spreadsheet. The Right Arrow will move the screen data to the very next case in the spreadsheet. Conversely, the Left Arrow moves the data on the screen back one case. The Down Arrow places the data from the very last record on the screen. You also may need to add new cases as consumers enter your program. You do this by hitting the Add a Record button. When this is done the screen will go to the field's default settings. All you need to do is enter the consumer's data. Note, however, there is an accuracy check involved with Consumer ID. Once you put in the consumer's identification number, you will be asked to repeat the procedure. This is done to ensure you have not misentered the information. The Delete this Record completely removes the case from the database. Use this command carefully. Generally, it should **only be used when you have "mistakenly" entered a new record**. The final two buttons let you depart from the **EBP Form**. The Report Form button takes you to the **Select Groups for Reports** screen where you can choose what information you want to see in a report. The Close this Form button does exactly that. You do not have to worry about saving the data you just entered, the application automatically saves the information during closing.

C. Selecting Data for Reports

After you have completed entering all data for the reporting period you are ready to design the reports. This is done by selecting the appropriate data fields on the **Select Groups for Reports** screen (Figure 5).

1. Figure 5. **Select Groups for Reports**



i. Select EBP Service and Groups

This screen prepares COMP to write your specific reports. The first task is to determine the consumers you want to include in the report. First, determine what service and EBP enrollment status you are interested in. You may select All Consumers or consumers who are receiving a specific EBP. Next you will need to select whether you want the report to include EBP "not eligible, eligible but not enrolled, enrolled" or any combination of these. For example, you may want to write reports for only those consumers enrolled and receiving EBP Supported Employment services. In this case, only the box under "Enrollees" and across from "Supported Employment" would be checked. You may select all consumers or reset ones already checked by using the corresponding buttons.

ii. Select Unit(s)/Team(s)

You can further refine your reports by choosing the team(s) you want to include. You may choose to include all teams by clicking the Everyone Selected button or select a combination of teams by selecting their respective buttons.

iii. Select a Current Consumer for Reports

By selecting this option, you can write any report for any one current consumer. Use the pull-down to select the consumer.

iv. Time Period and Print Options

The first box on the bottom of the screen allows you to Select the time periods you will be using. Use the "Current Time Period" pull down menu to select the last time period that you want the reports to reflect. The "Previous Time Period" box allows you to choose what past time period you want to compare to the "Current Time Period" (the previous time period is the default). After selecting both these time periods, the Movement Table Reports will reflect the differences between these two periods. The box next to it contains the preview and print commands. The Preview with Print Option button allows you to write the reports and preview them prior to printing. The Print Only button will immediately print all the reports you have selected without displaying on your computer screen. After selecting one of these options, hit the Continue: Preview or Print Selected Reports and your reports will be generated. Finally, hitting the Close Form button will close the screen.

v. Switch to Quarterly Reports

Many agencies may be reporting data on a monthly basis. However, for some reports (e.g.: Movement Tables) it is beneficial to view the information on a quarterly basis. Use the "Switch to Quarterly Report" button to write quarter reports using your monthly data. Obviously, if you are collecting data quarterly, this option is unavailable.

The next step involves selecting the report(s) you want to write. On the far right-hand side of the **Select Groups for Reports**, you will notice a list of the reports you may write. Select all Tables to run all the reports or tailor your needs by selecting any combination of the available reports by selecting its button. **A detailed description of the type of reports and how to use them is contained in Section VII**. Select from the following reports:

vi. Select the Report(s)

For most reports, you have an option of selecting summary graphs or graph timelines. Timeline graphs display data over time and may represent either the number or the percentage of consumers.

EBP Enrollment Table

This table gives you the number of "Not Eligible, Eligible but NOT in EBP Service, and Enrolled in EBP Service". It also provides percentages of those enrolled to those eligible for each EBP listed.

EBP: Counts or %s

These reports will display a timeline graph of the all persons in the selected EBP.

Consumer Demographic Table and Employment

This report details the number and percent of consumer demographic data. This includes gender, ethnicity, and diagnosis. It also contains the average age of the consumers contained in the report and a breakdown of vocational activity.

Negative Events

Here you will find data that reflects the number of events and days consumers have experienced a life-distressing event (psychiatric hospitalization, substance abuse hospitalization, incarceration, and homelessness) during the report period. The information in this table records the number of persons, number of days, and the number of days per consumer for those with at least one event.

Substance Abuse Stage Movement Table

For Dual Disorder EBP consumers, this table compares the consumer's treatment status from the last reporting period to the current time period.

Residential Status

This summary table outlines the number and percentage for consumer's residential status.

Residential Movement Table

This table compares the consumer's residential status from the last reporting period to the current time period.

Supported Employment Movement Table

This table compares the consumer's vocational status from the last reporting period to the current time period.

Educational Status

This summary table outlines the number and percentage for consumer's educational status.

Education Movement Table

This table compares the consumer's educational l status from the last reporting period to the current time period.

iii. Switchboard #2) **Set the data fields you want to display.**

This button discusses the data categories you may choose to collect for reporting. The reports that are written in this application use these fields. However, your agency may not want to write reports that capture the entire selection. This option allows you to eliminate data entry fields for which you are not interested in. Simply unselect the button and the field will not be represented in the data entry form. Initially, all data fields may be selected except for those referring to specific Evidence Based Practices.

- ☐ The first group of fields shown on the screen defines consumer demographic data. These include age, gender, ethnicity, and diagnosis. The next grouping of data refers to events that may have occurred in the consumer's life during the reporting. They include whether the person has experienced homelessness, incarceration, psychiatric hospitalization, or inpatient substance abuse hospitalization. The next group of data specifies the specific evidence based practice at your agency. **You must select at least one field of practice from this grouping in order to use the application**. The final grouping of data refers to the consumer's status. The category is in this grouping include competitive employment, substance abuse treatment, living arrangement, and educational involvement.

iv. Switchboard #3) **Instructions for using this application.**

This button displays operating instructions for this application that are outlined in this manual.

v. Switchboard #4) **Overview of Evidence Based Practice.**

This button pulls up the overall goal for the EBP implementation project.

- ☐ The description may be found in Section a. "Introduction" on page 10 of this manual.

vi. Switchboard #5) **Information about recording consumer data.**

This button defines the data elements used in the application.

- ☐ The description of the elements may be found in Section B. "Evidence Based Practice Form" on page 16 of this manual.

vii. Switchboard #6) **About this application.**

This button describes the application and how to contact support staff if you run into problems with the application.

- ☐ Software Version: 1.0
  Environment: Access 2000/2002
  Stand-alone (Does not require that the user have a copy of Access
  Release Date: 09/01/2002
  Primary Users: State CMHCs

viii. Switchboard #7) **Copyright and citation notice.**

This button defines the copyright and citation for the application.

- ☐ Copyright © 2002 University of Kansas, School of Social Welfare. All rights reserved.
- ☐ Citation:
  Press, A.N., Marty, D., & Rapp, C. (2002). Consumer Outcome Monitoring Package (COMP). University of Kansas, School of Social Welfare, Lawrence: Kansas.

ix. Switchboard #8) **Close application.**

This button closes the COMP application.

VII. Using Reports

The single factor that will most likely determine the success of an information system is its ability to provide useful feedback to practitioners. It is all well and good to worry about what to enter into a system, but ultimately its worth is in converting data into information. For example, the data may show that twenty consumers worked in a competitive job during the past quarter, but it is more informative to know that this represents only 10% of the consumers in the supported employment program and only three of these were new jobs. For information to influence practice, it must be understandable and meaningful, and it must be delivered in a timely way. In addition, the monitoring system must tailor the information to suit the needs of various users as well as promote its use for influencing practice.

Below are some examples of the reports and a worksheet that are generated from the Consumer Outcome Monitoring Package.

a. *Summary Tables.*

Whether for an entire program or for a single practitioner's caseload, rates of participation and outcome should be displayed for the past quarter. Such a table can address the following kinds of questions. How many of my consumers participated in our supported employment program last quarter? How many of my consumers worked competitively during the last quarter? What proportion of consumers in our program for persons with severe mental illness was hospitalized last quarter? How did the hospitalization rate for those on assertive community treatment teams compare to the rate for consumers in standard case management? How many consumers with a substance use disorder have yet to participate in our integrated dual diagnosis treatment program? Simple percentages or proportions, based on at least quarterly tallies, provide important feedback for both program management and clinical service provision.

The summary data table in Figure 6 shows an agency participating in two EPB projects.

i. Figure 6

National Evidence Based Practice Project (EBP) Monthly Service Status

Number of Persons

	Not Eligible	Eligible but NOT in EBP Service	Enrolled	Percent Enrolled of Eligible Persons
Supported Employment	**0**	**30**	**60**	**67%**
ACT	**30**	**15**	**90**	**86%**

This agency provides both ACT and Supported Employment services. The Supported Employment team serves a total of 90 consumers. Of those, 60 are receiving supported employment services while 30 consumers are eligible but receiving a service other than supported employment. Consequently, sixty-seven percent of persons eligible for supported employment are currently receiving the service.

This report provides program managers and other stakeholders quick assess to current consumer information. These types of reports are often used by agency personnel to better understand consumer

participation or to compare actual conditions with agency targets or goals. They are also used frequently in annual reports or in presentations for persons outside of the agency as descriptors of agency service.

Figure 7 is a summary table that documents the current residential status for all consumers receiving the EBP service. This summary table is more detailed than the previous summary tables. All consumers are categorized into specific residential settings. The specificity of this type of report allows the viewer to examine the status of a group of consumers.

ii. Figure 7

Residential Status	Number Consumers		Percent Consumers
ICF-MH or Other Institutional Setting		7	7%
State Psychiatric Hospital	1		
General Hospital Psychiatric Ward	1		
In-Patient Substance Abuse Hospitalization	1		
Nursing Home	4		
Lives with Others Who Provide Substantial Care		3	3%
Family Care Home	0		
Relatives have major responsibility for personal care and control: is primarily dependent	3		
Board and Care or Other Semi-Independent Setting		6	6%
Group Home	2		
Boarding Home	1		
Supervised Apartment Program	3		
Independent Living		84	84%
Lives with Family (but is primarily Independent	3		
Lives alone or with spouse, largely capable of self-care	81		
Temporary		0	
Homeless	0		
Emergency Shelter	0		
Other		0	
Total		100	100%

This review often leads to questions and processing of information to determine if a current consumer's status is appropriate to his or her needs and desires. For example, one consumer is presently in a state hospital. Team members would be encouraged to discuss the consumer's situation regarding the dynamics of why hospitalization was necessary. Could there have been diversion efforts or supports put in place to prevent hospitalization? What programming may be necessary to enable the person to safely return to the community? This type of report helps ensure attention to the needs of all consumers and yet provides sufficient detail to discuss single consumer cases.

b. *Movement tables.*

The last type of report provided in the consumer outcome report package is a movement table. Movement tables summarize changes from the previous quarter and provide a lot of information in a relatively small display. They are created by cross-tabulating the same variable from two successive quarters. These reports document changes in consumer status over time, usually from one quarter to the next. Movement tables capture increments of progress. Quarterly information is most often used, because consumer status for most programs remains fairly constant from month to month. For example, supported employment programs may average five competitive job placements a month. The number of placements may only reflect a small percentage of the total population served. Consequently, using data from quarter to quarter captures a larger percentage of consumer movement and best reflects useful information for program managers.

An example of a movement table is shown in Figure 8. The data used to create movement tables come from other tables in the report package. In this example, the data contained in the residential summary table are collapsed into the four broad categories for the movement table. The horizontal data cells reflect the residential status for consumers on the EBP team for the beginning quarter. This is signified by the label "From: FY(Fiscal Year)01: Qtr: 2. Thus, the data used to anchor the movement table was taken from Oct-Dec, 2000. The vertical data cells reflect the most recent quarterly information (To: FY: 01 Qtr: 3). The data is also presented hierarchally. The residential status categories are ordered from most restrictive setting (Institutional) to least restrictive (Independent). This report allows for the comparison of consumer residential status between the two successive quarters. For example, the data denoted in the light green diagonal cells ranging from the upper left quadrant to the lower right reflect persons who remained in the same residential status between quarters. These consumers would be considered to be in a stationary status. For example, two people were in an institution in Qtr: 2 and remained in an institution in Qtr: 3. The data cells above the stationary light green

i. Figure 8

TO: FY: 01 Qtr: 3

		Institutional	Substantial Care	Semi-Independent	Independent
FROM: FY: 01 Qtr: 2	**Institutional**	**2**	**1**	**1**	**3**
	Substantial Care	**3**	**8**	**1**	**3**
	Semi-Independent	**1**	**0**	**2**	**4**
	Independent	**1**	**3**	**2**	**100**
	Totals	7	12	6	110

Movement Score: 1.18 **Total Cases in Both Quarters: 105**

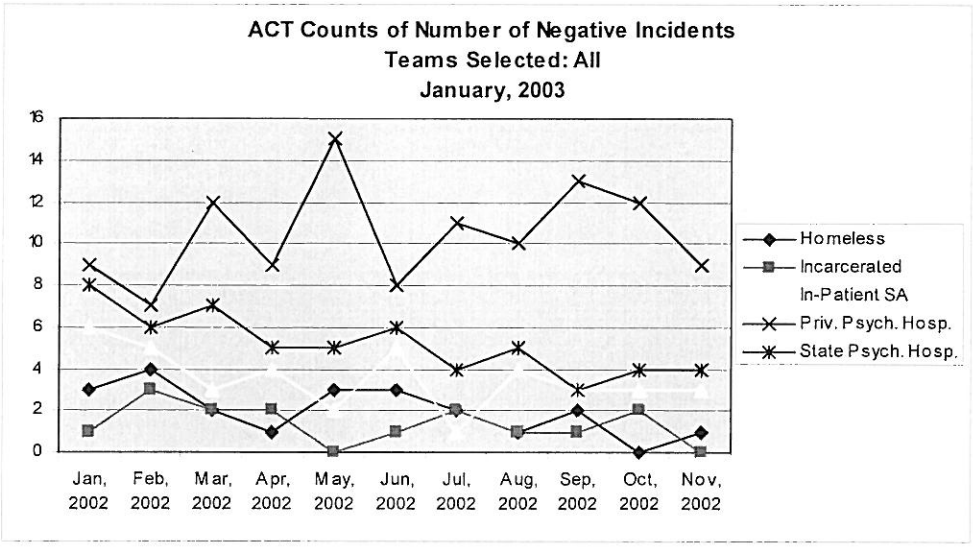
diagonal line, represent consumers who moved into a less restrictive environment between quarters. For example, three persons moved from institutional care to independent living. The pink cells denote the number of persons who moved into a more restrictive setting between quarters. Three people moved from substantial care to institutional living. The Totals row is a sum for all persons in a given residential status for the current quarter.

Movement tables also provide an index of the overall change in population characteristics as well as a count of cases present in each quarter. The Movement Score is an index of overall change between quarters. Adding up all consumers above the stationary line and dividing it by the sum of all persons below determines the movement score. In this example, the Movement Score is calculated by dividing 13 (consumers in statuses above the stationary line) by 11 (consumers below the stationary line). The movement score provides a quick reference for determining service effectiveness. In general, a positive score is considered as movement in the right direction. A score of "1" means that there was no overall movement in consumer status between the quarters. Total Cases in Both Quarters simply represents the number of same consumers remaining in service for both quarters.

The information obtained from movement tables allows users to consider the changes that have occurred to the consumers they are working with. The data may stimulate discussion around the progress that consumers are making or the challenges they are presented with.

c. Timeline or Longitudinal Plots

A longitudinal plot is an efficient and informative way to display participation or outcome data for more than two successive periods. The idea is to plot a participation or outcome variable over time, to view performance in the long term. A longitudinal plot can be for an individual, a caseload, a specific evidence-based practice, or an entire program. A single plot can also contain longitudinal data for multiple clients, caseloads, or programs, for comparison. Below is an example comparing critical, spirit breaking incidents for one team over a 12 month period.



This plot reveals that with the exception of Private Psychiatric Hospitalizations, all other critical outcomes for the ACT team appear to be going in a positive direction. Longitudinal plots are powerful feedback tools, as they permit a longer-range perspective on participation and outcome, whether for a single client or a group of clients. They enable a meaningful evaluation of the success of a program, and they provide a basis for setting goals for future performance.

d. *Worksheet*

Now that you have the selected reports, it is time to use the information. Figure 9 is a worksheet that accompanies most of the reports you will write. It is designed to provide you with a method for analyzing data and implementing improvements.

i. Figure 9

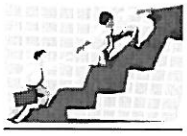
Are you satisfied with your team's performance for this reporting period?

YES- What data from the report reflects exceptional performance?

How will you Celebrate and Acknowledge your team's SUCCESS?

NO- Our team CAN do better!

What numbers from the report data reflects performance you would like to improve?



GOAL 1)	*GOAL 2)*
Right now, our report data says we are here:_____	Right now, our report data says we are here: _____
By the end of the next report period, our report data will improve to: _____	**By the end of the next report period, our report data will improve to:** _____

What FIRST STEPS will the team take to accomplish each GOAL?

GOAL 1) **Step 1**	*GOAL 2)* **Step 1**
GOAL 1) **Step 2**	*GOAL 2)* **Step 2**

The first section asks you a very basic question. Are you satisfied with your team's performance for this reporting period? If the answer is "Yes", you should identify who or what is responsible for the success and acknowledge them. Often, since the reports are tailored to capture team performance, this could be as simple as

saying "well done" in a team meeting. For significant accomplishments, you may suggest that the team go out for lunch or bring treats to team meeting.

If you answer "No", the worksheet provides an opportunity to develop a plan of action for improvement. In the previous Summary Table example, the agency identified 30 persons who were eligible for Supported Employment but were not enrolled. That means that only 67% (60 out of 90) of the persons eligible for the service are enrolled. The agency wants to offer Supported Employment to more consumers. This information would be captured under What numbers from the report data reflects performance you would like to improve? Next, under Goal 1, Right now, our report data says we are here:, you would put "67% Enrolled". After discussing the problem with agency staff and team personnel, it is decided that it is reasonable that 10 of the 30 persons eligible for service would be referred and provided Supported Employment during the next reporting period. This would increase the percentage of enrolled to those eligible to 77% (70 out of 90). Continuing with the worksheet, 77% would be placed next to By the end of the next report period, our report data will improve to:.

Now that you know what you want to do to improve your practice, it's time to think about how to do it. The worksheet provides you with a section for documenting the two essential steps that will move you toward your goal. In the above example, the team may decide to review all their cases to determine which workers would be able to take additional referrals as well as how many (Step 1). Once this was decided, the workers would be assigned new referrals and a time frame for doing an intake would be established (Step 2).

Obviously, different agencies and practitioners will have different practice priorities and aspirations. The worksheet is sufficiently flexible to accommodate these different needs. It is designed to provide a simple mechanism for examining consumer outcomes and developing ways for implementing more effective service delivery. Once you have determined how you want to improve, it is important to revisit your goals and steps on a routine basis. Social service workers are used to changing priorities and demands. Often, this may interfere with or detract from working on the established goals you have set using the outcome reports. It will be essential for the team to be reminded of and track their progress. This is usually accomplished during team meetings. By doing this, not only will the team maintain focus on their priorities, but also discussing progress during team meetings allows workers to identify any problems they may be encountering. The team can then help with suggestions or support. You may also find it useful to document your progress using charts or graphs over time. These can be placed in a visible location and team members can visually see the progress being made.

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Appendix

Quarterly Report Form

Quarter: Jan-Mar Apr-Jun Jul-Sep Oct-Dec **Year:** _____ **Reported by:** _____

Agency: _____ **Team:** _____ **Discharge Date:** _____

Client ID: _____ **Client DOB:** _____ **Client Age:** _____ **Client Gender:** M F

Client Ethnicity: _____ **Client Primary Diagnosis:** _____

Indicate the client's evidence-base service status on the last day of the quarter:

	Unknown	Not Eligible	Eligible	Enrolled
Integrated Dual Disorders Treatment				
Supported Employment				
Assertive Community Treatment				
Illness Management & Recovery				
Family Psychoeducation				

In the past 3 months, how many times and days has the client:

	# days	# incidents
Been homeless?		
Been incarcerated?		
Been in a State Psychiatric Hospital?		
Been in a Private Psychiatric Hospital?		
Been hospitalized for substance abuse reasons?		

In the *past 3 months*, how many *days* was the client competitively employed? _____ days
(0 is used when the client is not competitively employed)

Was the client competitively employed on the last day of the reporting period? Yes No

What is the client's stage of substance abuse treatment on the last day of the quarter *(Circle one)?*

N/A	Pre-engagement	Engagement	Early Persuasion	Late Persuasion	Early Active Treatment	Late Active Treatment	Relapse Prevention	In Remission or Recovery

What is the client's current living arrangement on the last day of the quarter *(Circle one)?*

0. N/A or Unknown	**6.** Lives with relatives (heavily dependent for personal care)	**11.** Independent Living
1. Psychiatric hospital	**7.** Group home	**12.** Homeless
2. Substance abuse hospitalization	**8.** Boarding house	**13.** Emergency Shelter
3. General hospital psychiatric ward	**9.** Supervised apartment program	**14.** Other (specify): _____
4. Nursing home or IC-MH	**10.** Lives with relatives (but is largely independent)	_____
5. Family care home		

What is the client's current educational status on the last day of the quarter *(Circle one)?*

0. N/A or Unknown	**6.** Basic educational skills
1. No educational participation	**7.** Attending vocational school, vocational program (CNA training), apprenticeship, or high school
2. Avocational/Educational involvement	**8.** Attending college: 1-6 hours
3. Pre-educational explorations	**9.** Attending college: 7 or more hours
4. Working on GED	**10.** Other (specify): _____
5. Working on English as second language	

Client's Highest Level of Education (circle one): No HS or GED HS Diploma or GED

Some college Associates degree Vocational training certificate BA/BS Masters/Ph.D.

Monthly Report Form

Month: 1 2 3 4 5 6 7 8 9 10 11 12 **Year:** _____ **Reported by:** _____

Agency: _____ **Team:** _____ **Discharge Date:** _____

Client ID: _____ **Client DOB:** _____ **Client Age:** _____ **Client Gender:** M F

Client Ethnicity: _____ **Client Primary Diagnosis:** _____

Indicate the client's evidence-base service status on the last day of the month:

	Unknown	Not Eligible	Eligible	Enrolled
Integrated Dual Disorders Treatment				
Supported Employment				
Assertive Community Treatment				
Illness Management & Recovery				
Family Psychoeducation				

In the past month (30 days), how many times and days has the client:

	# days	# incidents
Been homeless?		
Been incarcerated?		
Been in a State Psychiatric Hospital?		
Been in a Private Psychiatric Hospital?		
Been hospitalized for substance abuse reasons?		

In the *past* month (30 days), how many *days* was the client competitively employed? (0 is used when the client is not competitively employed) _____ days

Was the client competitively employed on the last day of the reporting period? Yes No

What is the client's stage of substance abuse treatment on the last day of the month *(Circle one)?*

N/A	Pre-engagement	Engagement	Early Persuasion	Late Persuasion	Early Active Treatment	Late Active Treatment	Relapse Prevention	In Remission or Recovery

What is the client's current living arrangement on the last day of the month *(Circle one)?*

0. N/A or Unknown **1.** Psychiatric hospital **2.** Substance abuse hospitalization **3.** General hospital psychiatric ward **4.** Nursing home or IC-MH **5.** Family care home	**6.** Lives with relatives (heavily dependent for personal care) **7.** Group home **8.** Boarding house **9.** Supervised apartment program **10.** Lives with relatives (but is largely independent)	**11.** Independent Living **12.** Homeless **13.** Emergency Shelter **14.** Other (specify): _____ _____

What is the client's current educational status on the last day of the month *(Circle one)?*

0. N/A or Unknown **1.** No educational participation **2.** Avocational/Educational involvement **3.** Pre-educational explorations **4.** Working on GED **5.** Working on English as second language	**6.** Basic educational skills **7.** Attending vocational school, vocational program (CNA training), apprenticeship, or high school **8.** Attending college: 1-6 hours **9.** Attending college: 7 or more hours **10.** Other (specify): _____

Client's Highest Level of Education (circle one): No HS or GED HS Diploma or GED

Some college Associates degree Vocational training certificate BA/BS Masters/Ph.D.