BEST PRACTICES

**Nebraska Department of Health and Human Services
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Nebraska Behavioral Health Reform

Academic Support Work Group

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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

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.

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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, <u>familiarity</u> 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 <u>adherence</u> 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 <u>organizational</u> models in which specific integrated treatment and rehabilitation is provided. All available outcome data indicate that the <u>content</u> 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.

<u>14. Therapeutic jurisprudence (TJ).</u> 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, <u>if</u> 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, <u>if</u> 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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