

Evidence-Based Practices: Recovery and Wellness Management Program

Implementation Manual for Program Leaders

Introduction

Welcome to the Recovery and Wellness Management Program implementation manual. It has been produced as part of an effort to promote treatment practices in community mental health service settings that are known to be effective in supporting the recovery of adults with severe mental illnesses. The goal: to improve the lives of participants by increasing the availability of effective mental health services. The manual begins by providing general information about the Implementing Evidence-Based Practices, including the philosophy and values. Descriptions of the materials contained and their proposed role in the implementation process follow this. The basic structure of an implementation plan is outlined. Specific suggestions for implementing the practice of Recovery and Wellness Management are presented in the Implementation Tips documents. This guide also contains selected references on Recovery Management and Wellness and a special population's appendix, which provides a review of the literature addressing the range of populations for which this practice has demonstrated efficacy or effectiveness. If you have any questions or comments, please contact Gerald A. Theis at: 262.605.6506 (e-mail address: gtheis1@wi.rr.com.)

Background

What are “evidence-based practices”?

Evidence-based practices are services for people with severe mental illness (participants) that have demonstrated positive outcomes in multiple research studies. Over the past 15 years, researchers in mental health service systems have gathered extensive data to support the effectiveness of several psychosocial and pharmacological treatments. In 1998, the Robert Wood Johnson Foundation convened a consensus panel of researchers, clinicians, administrators, participants, and family advocates discussing the research and to determine which practices currently demonstrated a strong evidence base. This project is an offshoot of these efforts.

The six evidence-based practices

Six practices were identified as currently demonstrating a strong evidence base:

- Standardized pharmacological treatment
- Recovery management and wellness management
- Supported employment
- Family psychoeducation
- Assertive community treatment
- Integrated dual disorders treatment (substance use and mental illness)

Other evidence-based practices for the treatment of persons with severe mental illnesses are being identified and will be promoted as the research evolves. This list of identified practices is not intended to be complete or exclusive. There should be many evidence-based practices in the future. Some promising practices being researched currently include peer support programming; supported housing, trauma services, and treatment for people with borderline personality disorder

Research has shown that providing practice guidelines to practitioners alone does not change practice. Change is most likely to occur and be sustained if all the major stakeholders in the mental health system are engaged and involved in the process of change. Therefore the materials and guidelines in this implementation manual are geared toward five different stakeholder groups.

The manual is also designed to address three stages of change:

- Engaging and motivating for change (why do it)
- Developing skills and supports to implement change (how to do it)
- Sustaining the change (how to maintain and extend the gains)

Program Philosophy and Values

The program rests on two philosophical tenets:

First, mental health services for people with severe mental illnesses should have the goal of helping people to develop high-quality, satisfying, functional lives. That is, services should aim not just at helping participants stay out of the hospital and reducing or stabilizing symptoms, but also at helping them to pursue their own personal recovery process. People want services that help them to manage their illnesses and to move ahead with their lives.

Second, participants and their families have a right to information about effective treatments, and in areas where evidence-based practices exist, participants and family members have a right to access effective services. Evidence-based practices are not intended to be exclusive, mandatory, or rigid. Rather, they imply self-knowledge, self-determination, choice, individualization, and recovery.

Defining Recovery

There have been many efforts to define the recovery philosophy. The Participant Advisory Panel for the Implementing Evidence-Based Practices Project drafted the following brief statement.

The principles of recovery that informed the development of the implementation resource kit materials are:

- Hope
- Personal responsibility
- Education
- Self-advocacy
- Support

The cessation of symptoms is not necessarily equal to recovery. Each person develops their own definition of recovery, which many view as a journey rather than a destination.

It is important to know what is meant by “support.” While the support of others is a valuable element in recovery, it does not include solving problems for another person or giving advice.

Empowerment is another critical component to recovery. A person becomes dis-empowered when choices are made for them, even when well-meaning supporters do it. Dis-empowerment also occurs when assumptions or judgments are made concerning an individual and their choices.

Recovery is most easily achievable when a person and those around them recognize the individual as a whole and complete person regardless of symptoms. One of the most valuable things a person can do for someone with psychiatric symptoms is to listen.

Components of the Recovery and Wellness Management Implementation Manuals

The following describes the purpose and content of the manual materials. This section is followed by a description of the use of these materials in the implementation process.

Implementation User's Guide

This document describes the implementation User's Guide and how to use it. It includes selected references for the particular evidence-based practice.

Articles

Included in the implementation manual are copies of general articles about evidence-based practices and implementation, and an article describing the research evidence for this particular practice.

Information for Stakeholders (five documents)

These documents describe the evidence-based practice and highlight features of the practice most pertinent to the particular stakeholder being addressed. These are engagement pieces that address the question: why should I, as participant, family member, practitioner, program leader, or administrator be interested in this practice?

Implementation Tips for Program Leaders

This document provides practical guidance for agency program leaders on how to implement the evidence-based practice in a community mental health setting. It includes strategies for building consensus in organizations preparing for change and tips on how to develop policies and procedures to support the practice.

Statement on Cultural Competence

This document addresses the need for practitioners and policymakers to integrate the design and delivery of the evidence-based practices within a culturally responsive context.

Fidelity Scale

Research indicates that the quality of implementation of the practice—adherence to principles of the model—strongly influences outcomes. The fidelity scale enables mental health program leaders to evaluate their program in comparison to the recommended principles.

General Organizational Index

This index measures a set of general operating characteristics hypothesized to be related to an organization's overall capacity to implement and sustain any evidence-based practice. The items on the general organizational index (GOI) were derived from clinical experience and the research literature. It is designed to be used with the fidelity scale as a companion assessment tool.

Monitoring Participant Outcomes

Using outcome measures to evaluate and track participant gains and program success is critical for effective implementation of an evidence-based practice. Simple outcomes are identified that can be monitored as part of routine clinical practice. The tracking of outcome measures is used as a feedback mechanism for clinicians, supervisors, and administrators.

Workbook for Practitioners and Supervisors

The workbook is designed as a primer for practitioners. It describes the knowledge and skill practitioners need in order to provide an effective intervention. There are two sets of materials: practitioner's guide and educational handouts.

How to Use the User Guides

Materials - An implementation plan

Effective implementation of evidence-based practices is best achieved by using the User Guides in combination with Practitioner manual and structured training and consultation. A brief description of a basic implementation plan that includes these supports is provided below.

Consensus building

Build support for change

- Identify key stakeholders
- Provide information to all stakeholders
- Develop consensus regarding a vision for the practice at your agency
- Convey a vision and a commitment to all stakeholders

Communicating how the practice benefits participants and family members can generate enthusiasm for the implementation of the evidence-based practice.

Use of implementation manual materials:

- Distribute information documents to the key stakeholder groups.
- Hold informational meetings with key stakeholder groups. Have opinion leaders within the different stakeholder groups co-host these meetings. An introductory PowerPoint presentation can be used to structure the informational meeting.

Developing an implementation plan

An action plan

- Identify an agency implementation leader—"Champion"
- Establish an implementation steering team that includes representatives from all stakeholder groups
- Secure a consultant
- Develop an implementation plan

Responsibilities of the implementation leader and implementation steering team include identifying personnel, resources, and processes (administrative support and system changes) needed to support the evidence-based practice; an assessment of training needs; and development of an implementation timeline.

By developing partnerships with community organizations including peer support programs, participant and family advocacy groups, NAMI, and others depending on the specific practice, the implementation leader and the implementation steering quality team can most effectively develop support for the practice. These groups may contribute to the development of an implementation plan.

Consultants can work with public mental health authorities and program leaders to inform them about the practice, to evaluate an agency's or system's commitment to change, and to assess current realities of financial incentives, staffing, and structure.

Use of implementation manual materials

Manual materials are designed to be shared with the individuals in an agency that make and carry out decisions about the local resources and processes. This includes people who have responsibility for program management, training, policy development, program standards, data management, and funding.

Enacting the implementation

Making it happen

- Involve agency personnel at all levels to support the implementation
- Host a “kick-off” training where all stakeholders receive information about the practice
- Host a comprehensive skills training for agency personnel who will be providing the practice
- Arrange opportunities to visit programs that have successfully implemented the practice
- Review current agency outcome measures relative to the practice and modify outcome data to monitor the practice. Learn how to make use of outcome measures in clinical practice and supervision
- Work with a consultant to learn how to use the fidelity scale to identify strengths and weaknesses in the implementation effort

Monitoring and evaluation

Sustaining change: how to maintain and extend the gains

- Establish a mechanism for continuous feedback regarding how the practice is being provided in an agency
- Publicize outcome improvements from the practice
- Use fidelity scales to monitor the practice implementation

Monitoring and evaluation occur in several ways. First, the use of consultants to provide side-by-side, ongoing consultation during the first one to two years of the program is very helpful. Consultants who are experienced in the practice can recognize problems and recommend changes to address them.

Use of implementation manual materials

It is useful for programs to become comfortable early on with the measures that will be used for monitoring and evaluating the delivery of the practice: outcome measures and the fidelity scale. The information collected can be used not only to identify areas that are problematic, but also to identify areas of excellence. Feedback from these measures may be used to promote and strengthen clinical and programmatic effectiveness.

Please refer to:

Monitoring Participant Outcomes

Recovery Management and Wellness Fidelity Scale

General Organization Index

Implementation Manual and User’s Guide

Terminology

Terms used in the Implementation Manual materials

For the sake of clarity and consistency, in most instances common terms are used to identify these groups throughout the implementation manual materials. In some situations more precise, or alternative, terminology is used. For instance, in the Supported Employment implementation manual materials, the term “employment specialist” is often used rather than “practitioner.”

Participant, people who have experienced psychiatric symptoms

These terms refer to persons who are living with severe mental illness and who use professional mental health services—the participants of mental health services. The term “participant” is most frequently employed in the manual materials.

Family and other supporters

This terminology refers to families and other people who provide support to a participant, and recognizes that many participants have key supporters who are not family members.

Practitioners and clinical supervisors

The term “practitioner” refers to the people who deliver the evidence-based practice. This is used instead of clinician, case manager, nurse, psychiatrist, therapist, etc. except when referring to a specific kind of role (e.g., the employment specialist in supported employment, or the prescriber in medication management). The term “clinical supervisor” is used to distinguish between an administrative supervisor and the person supervising the clinical work of the practitioner.

Mental health program leaders

This term is used to describe the person at the mental health provider organization who is trying to put the practice into effect. This term is used instead of program supervisor, operations director, program manager, or program administrator. Use of this term makes it clear that this person’s job is to lead with the support of the agency’s administration.

What is the Recovery and Wellness Management Program?

The Recovery and Wellness Management Program consists of a series of weekly or biweekly sessions in which mental health practitioners help people who have experienced psychiatric symptoms develop personal strategies for coping with mental illness and moving forward in their lives. The program can be provided in individual or group formats and generally lasts between 3 to 6 months.

With the permission of the person who has experienced psychiatric symptoms, family members and other supporters may be asked to read the educational handouts, attend some sessions, and help the person develop and implement plans for coping with symptoms, reducing relapses, and pursuing recovery goals.

How do practitioners benefit from the Recovery and Wellness Management Program?

Practitioners benefit by:

- Learning a comprehensive, step-by-step approach to helping people gain skills in managing mental illness
- Saving time by receiving ready-to-use materials for conducting sessions
- Gaining skills in using motivational strategies, cognitive behavioral strategies, and educational strategies
- Experiencing increased job satisfaction from seeing improved outcomes, such as people reducing relapses and hospitalizations and making progress in their goals for recovery

How does the program compare to what is currently offered at community mental health centers?

This program pulls together the main components of effective recovery management programs and provides a comprehensive, structured, step-by-step approach. It provides materials that have a recovery orientation and are user friendly both for practitioners and for persons who have experienced psychiatric symptoms. The program also heavily emphasizes helping people put knowledge into practice in their every day life.

What will people learn in the Recovery and Wellness Management Program?

The following subjects are covered in educational handouts:

- ❖ Recovery Strategies
- ❖ Practical Facts About Mental Illness
- ❖ The Stress-Vulnerability Model and Treatment Strategies
- ❖ Building Social Support
- ❖ Reducing Relapses
- ❖ Using Medication Effectively
- ❖ Coping with Stress
- ❖ Coping with Problems and Symptoms

What resource materials do practitioners receive as part of the Recovery and Wellness Management Program?

- A Practitioners' Guide, with practical tips for teaching people about mental illness and helping them develop strategies for each of the 8 topic areas
- Educational handouts, checklists, and planning sheets for each of the 8 topic areas
- A fidelity scale to measure whether the program is being implemented as designed
- Outcome measures to assess whether the program is having a positive impact on participants

Implementation Tips for Program Leaders

This document is designed to help mental health program leaders who are seeking to implement the Recovery and Wellness Management Program at their clinical site. This program is the result of consolidating the main components of effective Recovery Management programs which emphasize helping people who have experienced psychiatric symptoms to develop strategies for managing their own wellness. It is a comprehensive, structured, and step-by-step program, which provides ready-to-use materials.

Leading the implementation

The Recovery and Wellness Management Program is more likely to be successfully implemented if a specific identified person is responsible for leading the implementation. The identified leader is more likely to succeed if he or she has the backing of senior administrators and the respect of on-line staff. We recommend a person-centered management approach, such as the one articulated by Charles Rapp and his colleagues. This approach encourages practitioners to focus on goals set by the person, to use person-centered outcome data to guide ongoing management decisions, and to see leadership as an ongoing learning experience. Progress and success are measured by person-centered outcomes rather than by process measures such as hours of therapy or day treatment.

The implementation leader's job is to assist the agency in identifying and overcoming obstacles to successful implementation. This may include advocating for funding, rallying the support of the Executive Director or other key leaders, or bringing in consultants when needed. Many authors have written about the process of leading change in healthcare.

The task of implementing the Recovery and Wellness Management Program can be broken into three phases:

- ❖ Building momentum for change
- ❖ Making the change
- ❖ Maintaining and extending the gains.

Building momentum for change

- Programs have found the following strategies to be helpful:
- Work to get early buy-in from key leaders at the clinical site. Titled leaders and informal leaders are both important. They can help you with the rest of the process.
- Get the agency CEO to visibly articulate support for the Recovery and Wellness Management Program.
- Work with your local NAMI and participant groups to build consensus for change among key stakeholders.
- Bring in a consultant to inspire the staff. Consultants tend to be more successful if they have credibility to the practitioners. Practitioners indicate that presenter credibility is increased if the presenter is a practitioner, demonstrates that he or she understands the population, expresses an acceptable value set, and/or is well-known in the field.
- Bring in people who have experienced psychiatric symptoms to talk about their experiences with learning to manage their wellness and how it has helped them to move forward in recovery. This strategy works best if people have received services from local programs or from programs similar to your own.
- Connect your practitioners with professionals who have similar roles. Case managers tend to listen to case managers, physicians to physicians, and so on.
- Educate practitioners about studies that demonstrate the effectiveness of the components of the Recovery and Wellness Management Program. See the article, "Recovery Management and Recovery for Severe Mental Illness: A Review of the Research," by Kim Mueser, et al.,

- Organize retreats to predispose practitioners to implement the Recovery and Wellness Management Program. Retreats can be used to educate practitioners, to help them appreciate the importance of the Recovery and Wellness Management Program, and to engage them in planning the implementation.
- Place the Recovery and Wellness Management Program in the context of the larger recovery paradigm across the agency. Articulate how the Recovery and Wellness Management Program will assist the agency in fulfilling its mission, that is, assisting people in their recovery process.
- Anticipate the impact of the change on operations and other programming.

Making the change

The goal of the implementation leader is to redesign the process of care so that it becomes natural and easy for practitioners to provide Recovery and Wellness Management Program on a regular basis. It will be helpful to anticipate the following issues:

Time frame

Generally, it takes about a year for practitioners to feel comfortable and confident providing the Recovery and Wellness Management Program.

Staff qualifications

Academic credentials are less important than being able to develop a collaborative relationship with people who have experienced psychiatric symptoms. Practitioners who are flexible and optimistic about the recovery process tend to be very good at providing Recovery Management programs.

Staff responsibilities

The Recovery and Wellness Management Program is a comprehensive model which assists staff members, especially case managers, in fulfilling current job responsibilities effectively. To implement the program on an individual basis, practitioners need to be able to schedule weekly or biweekly sessions of 45 to 60 minutes, for three to six months (depending on how much time the person needs to cover the eight topic areas). To implement the program on a group basis, practitioners need to be able to schedule weekly or biweekly group sessions of 45 to 60 minutes with six to eight people in each group. The groups last from 3 to 6 months (depending on how much time the group members need to cover the eight topic areas).

Training

Practitioners will need knowledge about the symptoms and treatment recommendations for schizophrenia, bipolar disorder and major depression. They will need training in the core values of Recovery Management and Recovery and training in its teaching principles, which include developing a collaborative relationship with people who have experienced psychiatric symptoms, teaching basic facts about mental illness, using motivation-based techniques, and using basic cognitive behavioral techniques.

Supervision and support

Weekly group supervision is recommended. Supervision should include regular validation of participant strengths and practitioner strengths. In supervision, practitioners will benefit from discussing possible solutions for difficulties they may be encountering in sessions.

Clinical team meeting

Practitioners providing the Recovery and Wellness Management Program are part of the clinical team and should attend the clinical team meetings.

Equipment

Because of the extensive educational handouts required to conduct sessions, practitioners need to have access to file cabinets, xeroxing, and shelf space.

Paperwork

Practitioners will need to complete a “Strengths and Knowledge Inventory” for each person and complete a Recovery Management and Wellness Progress Note for each session. They will also need to document the person’s goals and progress toward goals at least once a month and to administer review questions at the end of each of the eight topic areas covered in the educational handouts. Other paperwork may be required by the funding sources and local regulations.

Tracking people’s goals

Practitioners will assist people in identifying recovery goals. Together they will assess progress towards these goals at least once a month.

Policies and procedures

Relevant policies and procedures should be reviewed and revised to support the implementation of the Recovery and Wellness Management Program.

Maintaining and extending the gains

- Put in place a process that lets staff know how many people are participating in the program and the extent to which they are accomplishing their goals.
- Visibly recognize staff members who have made the Recovery and Wellness Management Program a success in your agency. Consider revising job performance reviews to include an assessment of skills in providing the Recovery and Wellness Management Program.
- Find ways to tell each other success stories. Consider devoting a portion of each clinical meeting to sharing good news. This could include feedback and anecdotes from participants, family members, and employers.
- Sponsor events to celebrate achievements made by participants in the Recovery and Wellness Management Program. Provide an opportunity for people to talk about what they have learned and accomplished.
- Become a training site to stay fresh and interested and help pass on your knowledge and experience to others.

Statement on Cultural Competence

Cultural Competence is about adapting mental health care to meet the needs of participants from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care.

Above all, cultural competence aims to improve the quality of care and to help participants recover quicker and better. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.

This statement on cultural competence lays out ways for programs to tailor their evidence-based practices to the cultures they serve. It is meant as a guide, rather than a set of fidelity measures. The statement begins with the basics: what is culture how does it affect care, what is cultural competence, and why is it important. It then gives examples of how cultural competence is translated into practice.

What is culture, and how does it affect care?

A culture is broadly defined as a common heritage or set of beliefs, norms, and values shared by a group of people. People who are placed, either by census categories, or through self-identification, into the same racial or ethnic group are often assumed to share the same culture; however, not all members grouped together in a given category will share the same culture. There is great diversity within each of these broad categories and individuals may identify with a given racial or ethnic culture to varying degrees. Others may identify with multiple cultures, including those associated with their religion, profession, sexual orientation, region, or disability status.

Culture is dynamic. It changes continually and is influenced both by people's beliefs and the demands of their environment. Immigrants from different parts of the world arrive in the United States with their own culture but gradually begin to adapt and develop new, hybrid cultures that allow them to function within the dominant culture. This process is referred to as acculturation. Even groups that have been in the United States for many generations may share beliefs and practices that maintain influences from multiple cultures. This complexity necessitates an individualized approach to understanding culture and cultural identity in the context of mental health services.

The culture someone comes from influences many aspects of care, starting with whether the person thinks care is needed or not. Culture influences what concerns that person brings to the clinical setting, what language is used to express those concerns, and what coping styles are adopted. Culture affects family structure, living arrangements, and how much support someone receives in time of difficulties. Culture also influences patterns of help seeking? whether someone starts with a primary care doctor, a mental health program, or goes to a minister, spiritual advisor, or community elder. Finally, culture affects how much stigma someone attaches to mental health problems, and how much trust is placed in the hands of providers.

It's easy to think of culture as only belonging to participants without realizing how it also applies to providers and administrators. Their professional culture influences how they organize and deliver care. Some cultural influences are more obvious than others, like the manner in which clinicians ask questions or interact with participants. Less obvious but equally important are what hours a clinic has, the importance the staff attaches to reaching out to family members and community leaders, and the respect they accord to the culture of each participant entering their doors.

Knowing how culture influences so many aspects of mental health care underscores the importance of adapting programs to respond to, and be respectful of, the diversity of the surrounding community.

Why cultural competence?

For decades, many mental health programs neglected the growing diversity around them. Often, people from non-majority cultures found programs off-putting and hard to access. They avoided getting care, stopped looking for care, or, if they managed to find care, they dropped out. The result was troubling disparities: many minority groups faced lower access to care, lower use of care, and poorer quality of care. Altogether, those disparities translated into millions of people suffering needless disability from mental illness.

Disparities are most apparent for racial and ethnic minority groups such as African Americans, American Indians and Alaska Natives, Asian Americans, Hispanic Americans, and Native Hawaiians and other Pacific Islanders. But disparities also affect many other groups, such as women and men, children and older adults, people from rural areas, and people with different sexual orientations, or with physical or developmental disabilities.

Starting in the late 1980's, the mental health profession responded with a new approach to care called "cultural competence." Cultural competence was originally defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

What is cultural competence?

Cultural competence is an approach to delivering mental health services grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The Surgeon General defined cultural competence in the most general terms as "the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values." In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

While participants, families, providers, policymakers, and administrators have long acknowledged the intrinsic value of cultural competence, insufficient research has been dedicated to identifying its key ingredients. Therefore, the field still struggles to define, operationalize, and measure cultural competence. The word "competence" is somewhat misleading. Competence usually implies a set of criteria on which to evaluate a program. But this is not yet true for cultural competence, which is still under-researched. The term "competence," in this context, means that the responsibility to tailor care to different cultural groups belongs to the system, not to the participant. Every provider or administrator involved in delivering care from mental health authorities down to clinical supervisors and practitioners bears responsibility for trying to make their programs accessible, appropriate, appealing, and effective for the diverse communities that they serve. Many do it naturally.

How is cultural competence related to evidence-based practices?

Evidence-based practices are for every participant who enters care, regardless of what culture they come from, according to the Surgeon General.¹ But programs often need to make adjustments to evidence-based practices in order to make them accessible and effective for cultural groups that differ in language or behavior from the original study populations. The adjustments should facilitate, rather than interfere with, a program's ability to implement evidence-based practices using the fidelity measures in this toolkit.

In a nutshell, to deliver culturally competent evidence-based practices means tailoring either the practice itself or the context in which the practice is delivered to the unique communities served by a mental health program.

In time, there may be specific fidelity measures used to assess a program's cultural competence. But this is not the case now. The concept of cultural competence is too new and the evidence base is too small. While the evidence is being collected, programs can and should take the initiative to tailor evidence-based practices to each of the cultural groups they serve, like translating their information brochures into the languages often used in their communities. Other steps are featured in the next section.

Many providers ask, how can we know if evidence-based practices apply to a particular ethnic, racial, or cultural group if the research supporting those practices was done on a very different population? The answer is that we will not know for sure until we try; but the limited research that does exist, suggests that evidence-based practices, with minor modifications or not, work well across cultures. Furthermore, because evidence-based practices represent the highest quality of care currently available, it is a matter of fairness and prudence to provide them to all people who may need them. Yet the question remains, how can we do this effectively?

How can cultural competence be put into practice?

All programs are encouraged to be more culturally competent, even though research has not yet generated a set of evidence-based practices to achieve cultural competence.

A variety of straightforward steps can be taken to make programs more responsive to the people they serve. The steps might apply to all facets of a program and need not be restricted to the evidence-based practice covered by this toolkit.

The following steps are meant to be illustrative, not prescriptive:

- Understand the racial, ethnic, and cultural demographics of the population served
- Become most familiar with one or two of the groups most commonly encountered
- Create a cultural competence advisory committee consisting of participants, family and community organizations
- Translate your forms and brochures
- Offer to match a participant with a practitioner of a similar background
- Have access to trained mental health interpreters
- Ask each participant about their cultural background and identity
- Incorporate cultural awareness into the assessment and treatment of each participant
- Tap into natural networks of support, such as the extended family and community groups representing the culture of a participant
- Reach out to religious and spiritual organizations to encourage referrals or as another network of support
- Offer training to staff in culturally responsive communication or interviewing skills.
- Understand that some behaviors considered in one culture to be signs of psychopathology are acceptable in a different culture
- Be aware that a participant from another culture may hold different beliefs about causes and treatment of illness

Cultural competence is also important for planners and for mental health authorities. Here are a few examples of the ways a public mental health authority or program administrators can become more culturally competent.

- Designate someone with part-time or full-time responsibility for improving and monitoring cultural competence
- Create a strategic plan to incorporate cultural competence into programs throughout a system
- Establish an advisory committee that includes representatives of all the major racial, ethnic, and cultural groups being served
- Address barriers to care (cultural, linguistic, geographic or economic)
- Provide staffing that reflects the composition of the community being served
- Conduct regular organizational self-assessments of cultural competence
- Collect and analyze data to examine disparities in services
- Designate specific resources for cultural competence training
- Include cultural competence in quality assurance and quality improvement activities and projects

Vignette 5— Recovery and Wellness Management Program

Lupita, a 17-year old high school senior, arrived in a San Antonio emergency room after a suicide attempt. The psychiatrist on call happened to be the same one who had diagnosed Lupita's bipolar disorder a year ago. He thought that she had been taking her medications properly, but blood tests now revealed no traces of lithium or antidepressant.

The psychiatrist tried to communicate with Lupita's anxious parents waiting in the visitor area, only to learn that they spoke only Spanish and no English. She had mistakenly assumed that because Lupita, a second generation Mexican American, was highly acculturated, so were her parents. She contacted the hospital's bilingual social worker who discovered that the parents felt powerless for months as they watched their daughter sink into a severe depression, all the while lacking the motivation to take her medications. The social worker, whose family had similarly emigrated from a rural region of Mexico, knew to gently ask the parents if they could read and understand the dosage directions for Lupita's medication. Finding that the parents had limited literacy in both English and Spanish helped the psychiatrist and social worker to tailor a treatment program that would not depend on the written word. Seeing the parents as essential to Lupita's recovery and knowing she lived at home, the psychiatrist encouraged the parents, through the interpreter, to accompany their daughter to an Recovery and Wellness Management Program. The hospital had organized programs for Spanish-speaking families because Latinos are a majority group in San Antonio.

During the weekly sessions, the social worker translated for the family and helped them with scheduling Lupita's psychiatric visits and to apportion the correct combination of pills in a daily pill container. Understanding that the family had no phone, the social worker worked with them to find a close neighbor who might allow them use of the phone to relay messages from her and to contact her if Lupita stopped taking her medications.

Using Fidelity Scales for Evidence-Based Practices

What is fidelity?

Fidelity refers to the degree of implementation of an evidence-based practice (EBP). A fidelity scale measures fidelity. Such scales have been developed for each of the six EBPs included in the Implementing EBP t (assertive community treatment, supported employment, integrated treatment for dual disorders, Recovery Management, family psychoeducation, and medication guidelines). Each scale assesses approximately 15 to 30 critical ingredients of the EBP, based on its underlying principles and methods. The scale items provide concrete indications that the practice is being implemented as intended.

Why measure fidelity?

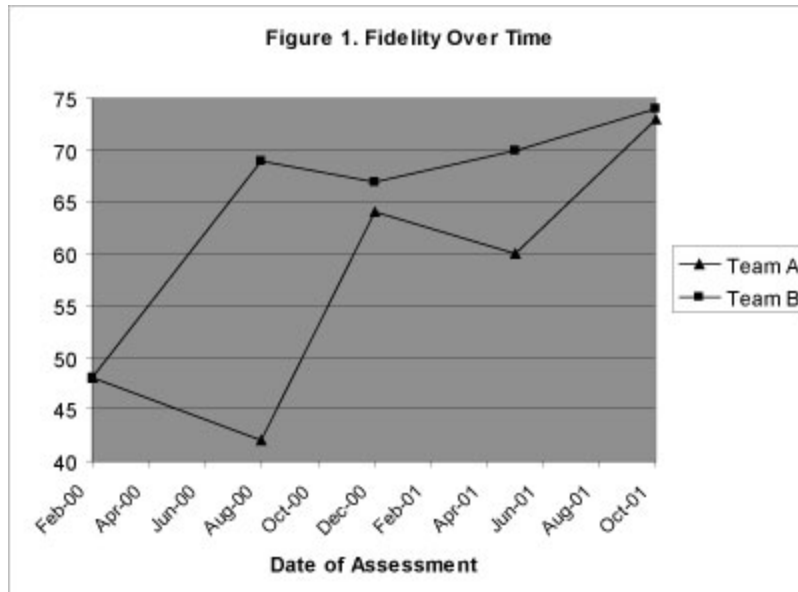
Several assumptions underlie the use of fidelity scales. First, a fidelity scale should adequately sample the critical ingredients of the EBP to differentiate between programs that follow the practice and those that do not. Research suggests that fidelity scales for supported employment and for assertive community treatment do accomplish this. Second, fidelity scales should be sensitive enough to detect progress in the development of a program from the start-up phase to its mature development. There is some evidence that fidelity scales achieve this goal as well. Third, high-fidelity programs are expected to have greater effectiveness than low-fidelity programs in achieving desired participant outcomes. Several studies comparing fidelity ratings to outcomes also support this assumption.

One key use of fidelity scales is for monitoring programs over the course of their development (and even after they are fully established). Experience by implementers suggests that routine use of fidelity scales provide an objective, structured way to give feedback about program development. This is an excellent method to diagnose program weaknesses and clarify strengths for providing positive feedback on program development. Fidelity scales also provide a comparative framework for evaluating statewide trends and outliers. The strategic use of repeated evaluations of programs using fidelity scales, either on an individual program or statewide level, is based on the general principle that whatever is paid attention to is more likely to be improved.

How are fidelity scales used?

In the Implementing EBP Project we have developed fidelity scales that are simple to understand. EBP items are rated on a 5-point response format, ranging from 1 equaling no implementation—to 5 equaling full implementation, with intermediate numbers representing progressively greater degrees of implementation. The response alternatives are behaviorally anchored, identifying measurable elements of the practice. Independent evaluators using multiple sources of information make the most valid ratings. Sources of information include interviews with staff, observation of team meetings, review of charts, and intervention observations. A daylong site visit is the optimal method for acquiring this information. Interviewers should be familiar with the EBP being rated. Although we recommend outside raters, fidelity scales can also be used by program managers to conduct self-ratings. The validity of self-ratings (or any ratings, for that matter) depends on the knowledge of the person making the ratings, access to accurate information pertaining to the ratings, and the objectivity of the ratings. We encourage the use of self-ratings, with appropriate caveats regarding potential biases that could be introduced by raters invested in seeing a program “look good” or who do not fully understand the principles of the EBP. In addition to the scales developed for independent evaluators and program managers, companion fidelity measures intended for participants and family members are under development for some EBPs.

Graphing fidelity ratings



We recommend that programs implementing an EBP graph their fidelity ratings over time, using their total fidelity score. By graphing this score, a program can see its change over time. When the program shows greater fidelity over time, this serves to reinforce their efforts. Another feature of graphing fidelity is to examine the cut-off score for “full implementation.” A program can use this score as a target and measure accordingly.

Recovery Management and Recovery Fidelity Scale

| | 1 | 2 | 3 | 4 | 5 |
|---|--|--|--|--|---|
| 1. # People in a Session or Group: IMR is taught individually or in groups of 8 or less participants. | Some sessions taught with over 15 participants | Some sessions taught with 13-15 participants | Some sessions taught with 11 or 12 participants | Some sessions taught with 9 or 10 participants | All IMR sessions taught individually or in groups of 8 or less |
| 2. Program Length: Participants receive at least 3 months of weekly IMR sessions or equivalent (e.g., biweekly for at least 6 months). | <20% of IMR participants receive at least 3 months of weekly sessions | 20%-39% of IMR participants receive at least 3 months of weekly sessions | 40%-69% of IMR participants receive at least 3 months of weekly sessions | 70%-89% of IMR participants receive at least 3 months of weekly sessions | •90% of IMR participants receive at least 3 months of weekly sessions |
| 3. Comprehensiveness of the Curriculum: <ul style="list-style-type: none"> • Recovery strategies • Mental illness facts • Stress-vulnerability model • Social support • Using medication • Preventing relapse • Stress management • Coping symptoms • Mental health system | Curriculum materials include only 1 topic, or educational handouts are not available | Curriculum materials include 2 or 3 topic areas | Curriculum materials include 4 or 5 topic areas | Curriculum materials include 6 or 7 topic areas | Curriculum materials include 8 or 9 topic areas |
| 4. Provision of Educational Handouts: All participants participating in IMR receive IMR handouts. | <20% of IMR participants receive educational handouts | 20%-39% of IMR participants receive educational handouts | 40%-69% of IMR participants receive educational handouts | 70%-89% of IMR participants receive educational handouts | •90% of IMR participants receive educational handouts |

| | | | | | |
|---|--|--|---|--|--|
| 5. Involvement of Significant Others: At least one IMR-related contact in the last month OR involvement with the participant in pursuit of goals (e.g., assisting with homework assignments). | <20% of IMR participants have significant other(s) involved | 20% -29% of IMR participants have significant other(s) involved | 30% -39% of IMR participants have significant other(s) involved | 40-49% of IMR participants have significant other(s) involved | •50% of IMR participants have significant other(s) involved |
| 6. IMR Goal Setting <ul style="list-style-type: none"> • Realistic and measurable • Individualized • Pertinent to recovery process • Linked to IMR plan | <20% of IMR participants have at least 1 personal goal in chart | 20% -39% of IMR participants have at least 1 personal goal in chart | 40% -69% of IMR participants have at least 1 personal goal in chart | 70% -89% of IMR participants have at least 1 personal goal in chart | •90% of IMR participants have at least 1 personal goal in their chart |
| 7. IMR Goal Follow-up: Practitioners and participants collaboratively follow up on goal(s) (See examples in the IMR Practitioner Workbook) | <20% of IMR participants have follow-up on goal(s) documented in chart | 20% -39% of IMR participants have follow-up on goal(s) documented in chart | 40% -69% of IMR participants have follow-up on goal(s) documented in chart | 70% -89% of IMR participants have follow-up on goal(s) documented in chart | 70% -89% of IMR participants have follow-up on goal(s) documented in chart |
| 8. Motivation-Based Strategies: <ul style="list-style-type: none"> • New info & skills • Positive perspectives • Pros & cons of change • Hope & self-efficacy | <20% of IMR sessions use at least 1 motivation-based strategy | 20-39% of IMR sessions use at least 1 motivation-based strategy | 30-39% of IMR sessions use at least 1 motivation-based strategy | 40-49% of IMR sessions use at least 1 motivation-based strategy | •50% of IMR sessions use at least 1 motivation-based strategy |
| 9. Educational Techniques: <ul style="list-style-type: none"> • Interactive teaching • Checking for understanding • Breaking down info • Reviewing info | <20% of IMR sessions use at least 1 educational technique | 20% -39% of IMR sessions use at least 1 educational technique | 30% -39% of IMR sessions use at least 1 educational technique | 40% -49% of IMR sessions use at least 1 educational technique | •50% of IMR sessions use at least 1 educational technique |
| 10. Cognitive -Behavioral Techniques: <ul style="list-style-type: none"> • Reinforcement • Shaping • Modeling • Role playing • Cognitive restructuring • Relaxation training | <20% of IMR sessions use at least 1 cognitive-behavioral technique | 20%-39% of IMR sessions use at least 1 cognitive-behavioral technique | 30%-39% of IMR sessions use at least 1 cognitive-behavioral technique | 40%-49% of IMR sessions use at least 1 cognitive-behavioral technique | •50% of IMR sessions use at least 1 cognitive-behavioral technique |
| 11. Coping Skills Training: <ul style="list-style-type: none"> • Review current coping • Amplify current coping or develop new coping skills • Behavioral rehearsal • Review effectiveness • Modify as necessary | Few or none of the practitioners are familiar with the principles of coping skills training | Some of the practitioners are familiar with the principles of coping skills training, with a low level of use | Some of the practitioners are familiar with the principles of coping skills training, with a moderate level of use | The majority of the practitioners are familiar with the principles of coping skills training and use it regularly | All practitioners are familiar with the principles of coping skills training and use it regularly |
| 12. Relapse Prevention Training: <ul style="list-style-type: none"> • Identify triggers • Identify early warning signs • Stress management • Ongoing monitoring • Rapid intervention as needed | Few or none of the practitioners are familiar with the principles of relapse prevention training | Some of the practitioners are familiar with the principles of relapse prevention training, with a low level of use | Some of the practitioners are familiar with the principles of relapse prevention training, with a moderate level of use | The majority of the practitioners are familiar with the principles of relapse prevention training and use it regularly | All practitioners are familiar with the principles of relapse prevention training and use it regularly |

Cover Sheet

Date: _____

Rater(s): _____

Program Name: _____

Address: _____

Contact Person: _____ (Title:) _____

Phone: _____ Fax: _____

E-mail: _____

Names of the IMR Practitioners: _____

Number of participants identified as receiving IMR services: _____
(The IMR questions refer to these participants.)

Sources Used:

- _____ Progress notes
- _____ Chart review
- _____ IMR curriculum review
- _____ Interview with IMR Program Director/Coordinator
- _____ Interview with IMR Program leader
- _____ Interview with IMR practitioners
- _____ Interview with participants

Number of IMR practitioners: _____

Number of IMR participants served in preceding year: _____

Date program was started: _____

Score Sheet

Program: _____ Date of Visit: _____

Informants – Name(s) and Positions: _____

Number of Records Reviewed: _____ Rater: _____

| | | RATINGS | | | | |
|--------------------|--------------------------------------|---------|---|---|---|---|
| 1. | # People in a Session or Group | 1 | 2 | 3 | 4 | 5 |
| 2. | Program Length | 1 | 2 | 3 | 4 | 5 |
| 3. | Availability of Educational Handouts | 1 | 2 | 3 | 4 | 5 |
| 4. | Provision of Educational Handouts | 1 | 2 | 3 | 4 | 5 |
| 5. | Involvement of Significant Others | 1 | 2 | 3 | 4 | 5 |
| 6. | IMR Goal Setting | 1 | 2 | 3 | 4 | 5 |
| 7. | IMR Goal Follow-up | 1 | 2 | 3 | 4 | 5 |
| 8. | Motivation-Based Strategies | 1 | 2 | 3 | 4 | 5 |
| 9. | Educational Techniques | 1 | 2 | 3 | 4 | 5 |
| 10. | Cognitive-Behavioral Techniques | 1 | 2 | 3 | 4 | 5 |
| 11. | Coping Skills Training | 1 | 2 | 3 | 4 | 5 |
| 12. | Relapse Prevention Training | 1 | 2 | 3 | 4 | 5 |
| 13. | Behavioral Tailoring for Medication | 1 | 2 | 3 | 4 | 5 |
| TOTAL SCORE | | | | | | |

Progress Note: Recovery and Wellness Management

Name: _____ ID# _____ Date: _____

Name of significant other(s) involved in session: _____

Problem or goal specified by the treatment plan that is the focus of the person's treatment:

Personal goal that was set in this session or followed up in this session:

TREATMENT/INTERVENTIONS PROVIDED:

Motivational interventions (check all that apply):

- connect info and skills with personal goals
- promote hope & positive expectations
- explore pros and cons of change
- re-frame experiences in positive light

Educational interventions (check the topic(s) that were covered):

- Recovery strategies
- Practical Facts about Mental Illness
- Stress-Vulnerability
- Social Support
- Using Medication
- Reducing relapses
- Coping with Stress
- Coping w/ Symptoms & Problems
- Mental Health system

Cognitive-behavioral interventions (check all that apply):

- reinforcement
- shaping
- modeling
- role playing
- cognitive restructuring
- relaxation training

Specific evidence-based skill taught (identify which one(s))

coping skill for dealing with symptoms:

relapse prevention skill: _____

behavioral tailoring for medication:

Homework that was agreed upon:

OUTCOME (person's response to info, strategies & skills provided in the session)

Person's perspective: _____

Practitioner's perspective: _____

PLAN for next session: _____

Person's signature: _____ Practitioner's signature _____

Using General Organizational Index for Evidence-Based Practices

Overview

The General Organizational Index (GOI) measures a set of general operating characteristics of an organization hypothesized to be related to its overall capacity to implement and sustain any evidence-based practice. The items on the GOI were derived from clinical experience, although the research literature also supports the importance of many of these factors. Whereas the fidelity scales are specific to each EBP, the GOI refers to operating characteristics that should be very similar across the EBPs.

The GOI is intended to be a companion assessment tool used at the same time as the EBP fidelity scale is administered. When conducting fidelity site visits, the implementation monitors should include GOI interview items (as outlined in the General Organizational Index Protocol).

The same set of 10 items is used for all 5 evidence-based practices (EBPs). One item—G2—has two alternate forms, G2A and G2B. G2A, for family psychoeducation, Recovery Management and recovery, and supported employment, refers to information provision. G2B, for assertive community treatment and integrated dual disorders treatment, refers to screening. With the exception of item G2A/B, the wording of all the items is the same for all EBPs. However, in administering this index, the implementation monitor should tailor the language to fit with the specific practice.

Why measure general organization characteristics?

The rationale for the use of the GOI is similar to the one given for fidelity scales (See “Using Fidelity Scales”). Clinical experience suggests that agencies that generally do an excellent job in implementing a practice have the GOI elements in place within the organization. Programs scoring high on the GOI are expected to be more effective in implementing an EBP and in achieving desired outcomes.

We also recommend that agencies implementing an EBP use the GOI as a self-assessment tool for monitoring programs over the course of their development (and even after they are fully established). Considerable experience by implementers has suggested that routine use of such indices provide an objective, structured way to give feedback about program development.

How is the GOI used?

The assessment philosophy for the GOI mirrors that for fidelity scales. The GOI contains simple-to-understand face-valid items that are rated on a 5-point response format, ranging from 1 equals no implementation to 5 equal's full implementation, with intermediate numbers representing progressively greater degrees of implementation. The response alternatives are behaviorally anchored; that is, they identify concrete measurable elements of the practice. Our experience is that independent evaluators using multiple sources of information make the most valid ratings. Typical sources of information include interviews with staff, observation of team meetings, review of charts, and observation of interventions. Although we recommend outside raters, the GOI can also be used by program managers to conduct self-ratings. The validity of self-ratings (or any ratings, for that matter) depends on the knowledge of the person making the ratings, access to accurate information pertaining to the ratings, and the objectivity of the ratings. We discourage the use of self-ratings, with appropriate caveats regarding potential biases that can be introduced by raters who are invested in seeing a program “look good” or who do not fully understand the principles of the General Organizational Index. In addition to the scales developed for independent evaluators and program managers, companion fidelity measures intended for participants and family members are under development for some EBPs.

Monitoring Participant Outcomes

What are participant outcomes?

Participant outcomes are those aspects of participants' lives that we seek to improve or to manage successfully through the delivery of mental health services. Medications help participants manage their symptoms. Supported employment programs help participants find work in the community. Dual disorders groups help participants reduce their dependence on alcohol and illicit drugs. Relapse prevention programs help participants stay out of the hospital. Some outcomes are the direct result of an intervention, such as getting a job through participation in a vocational 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. Every mental health service intervention, whether considered treatment or rehabilitation, has both immediate and long-term participant goals. In addition, participants have goals for themselves, which they hope to attain through the receipt of mental health services. These goals translate into outcomes, and the outcomes translate into specific measures. For example, the goal of a supported employment program is community integration through employment. The outcome for participants 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 participant has worked at competitive jobs during the past quarter.

Why monitor participant outcomes?

Participant 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 participants served, tell us very little, if anything, about the effects of services on participants 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 participant outcome-based methods (Rapp & Poertner, 1992). Studies have shown that an outcome orientation of manager's leads to increased service effectiveness in mental health (Gowdy & Rapp, 1989). This has led Patti (1985) to argue that effectiveness, meaning participant outcomes, should be the "philosophical linchpin" of human services organizations.

Recovery and participant 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 generally desire the same core outcomes that we all want:

- ❖ To live independently in a place called 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 participants achieve these outcomes. The evidence-based practice that is described in this resource kit was chosen for its ability to achieve one or more of these outcomes.

A powerful resource for program leaders

If funds are the lifeblood of an organization, then information is its intelligence. Collecting and using participant 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 participants' 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 participants' vocational activity was evident almost immediately. Three months after instituting this monitoring system, the percentage of the program's participants 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 organizational 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:
 - to foster and reinforce desired behaviors;
 - to identify barriers to performance and ways to overcome them; and
 - 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 participant outcomes have a powerful tool. By proactively and systematically collecting and using participant 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 participant outcomes.

Outcomes and evidence-based practices

The foundation of evidence-based practices is participant outcomes. The decision to implement an evidence-based practice is based on its ability to help participants achieve the highest rates of positive outcomes. Therefore, one key component of the implementation of an evidence-based practice is the careful monitoring and use of participant outcome data. The problem for many mental health providers is that current data systems do not capture relevant participant 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.

The following material is designed to guide programs that are implementing an evidence-based practice in developing a practical and useful information system. Some programs may go their own way and develop a system anew. Other programs may adapt existing information systems to suit their needs for monitoring participant outcomes. These guidelines will help programs to make such beginnings and adaptations. In addition, programs may wish to expand the evidence-based practices information systems that we describe, to build on the success they have had using a basic system or to customize a system to their needs and context. We encourage such expansion once a basic system has been implemented successfully, and we make recommendations for such enhancements at the end of this section.

We begin with advice on getting started, and then we describe a simple, yet comprehensive, 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.

Guidelines for an evidence-based practices information system

Many practitioners feel overwhelmed by the demands of their jobs and cannot imagine adding the burden of collecting participant outcomes. Reporting systems already exist in many mental health settings, but they are time-consuming, and they do not provide useful feedback to improve practice. Thus, resistance is likely when implementing a new system to monitor participant outcomes. To overcome this resistance we recommend starting with a very simple system and making the system practical and immediately useful.

Start simply

At the outset, the system must be simple to implement, use, and maintain. Complexity has doomed numerous well-intended attempts to collect and use participant outcome data. One way to keep it simple is to limit the amount and sources of information that it contains. Begin with a few key participant outcomes and build the system around them. Collect data from practitioners, without the initial need for data collection from participants and families. Start with simple reports that tabulate results for the past quarter and show time trends, and then let experience with the system determine what additional reports are needed.

Fit the needs of practitioners

The system must not create undue burden for practitioners, and it must provide information to them that is useful in their jobs. If possible, the system should collect already known information about participants, and it should require little time to record the data. The system should fit into the workflow of the organization, whether that means, for example, making ratings on paper or directly into a computer. It should collect information on participation in evidence-based services and on participant outcomes. Program leaders and practitioners can then keep track of what services participants are using and how they are doing on key outcomes. It should produce easy-to-read and timely reports that contribute to planning and lead to action, for individual participants, for treatment teams, and for the program as a whole.

These two guidelines may lead to a system that consists of a single outcome measure that is collected regularly and used by the program leader and practitioners to monitor their progress toward stated goals for an evidence-based practice. For example, a supported employment program may decide to monitor the rate of competitive employment among those participants who have indicated a desire to work. Practitioners may be asked to indicate whether each participant has worked in a competitive job during the past quarter. These data can then be tallied for the entire program to indicate the employment rate during the past quarter, which can be compared to prior quarters and can be used to develop performance goals, based on participant choices for the upcoming quarter.

The system suggested by these two guidelines can be implemented in a variety of ways, from paper and pencil to multi-user computer systems. Begin with whatever means you have available and expand the system from there. In the beginning, data may be collected with a simple report form, and hand-tallied summaries can be reported to practitioners. A computer with a spreadsheet program (e.g., EXCEL) makes data tabulation and graphing easier than if it is done by hand. A computerized system for data entry and report generation presents a clear advantage, and it may be the goal, but do not wait for it. Feedback does not have to come from a sophisticated computer system to be useful. It is more important that it is meaningful and frequent.

As a participant outcome monitoring system develops, program leaders and practitioners will weave it into the fabric of their day-to-day routines. Its reports provide tangible evidence of the use and value of services, and they will become a basis for decision-making and supervision. At some point, the practitioners may wonder how they did their job without an information system, as they come to view it as an essential ingredient of well-implemented evidence-based practices.

Once a basic system has been implemented for a single evidence-based practice, we encourage programs to consider expanding to a comprehensive system for monitoring multiple evidence-based practices. We provide two additional guidelines for developing such a system.

Include all evidence-based practices in one system

The system should monitor the participation of participants in all evidence-based practices. This can be as simple as recording whether participants are eligible for each practice, and in which practices they have participated during the past quarter. For those practices that are implemented, participation rates can be monitored over time, as a means of monitoring the penetration of the practices in the population of eligible participants. For those practices that are not yet implemented, the system will create incentive to do so.

Likewise, the system should monitor a core set of outcomes that apply across evidence-based practices and that are valued by participants and families, as well as by providers and policymakers. For example, keeping people with mental illness in stable community housing, rather than in institutions or homeless settings, is an agreed-upon outcome for several evidence-based practices. Consequently, keeping track of quarterly rates of hospitalization, incarceration, and homelessness will enable evaluation of the effectiveness of a range of services.

Make the data reliable and valid

For an information system to be useful, the data must be reliable and valid. That is, the data must be collected in a standardized way (reliability), and the data must measure what it is supposed to measure (validity). Thus, the outcomes must be few in number and concrete, in order for practitioners to stay focused on key outcomes, to understand them in a similar way, and to make their ratings in a consistent and error-free fashion. To enhance reliability and validity, we recommend simple ratings (e.g., Did the participant hold a competitive job in this quarter?), rather than more detailed ones (e.g., How many hours during this quarter did the participant work competitively?). In addition, reliability will be enhanced if the events to be reported are easy to remember, and thus we recommend collecting data at regular and short intervals, such as quarterly at the outset, and we recommend collecting data for salient events. We recommend the following outcomes:

- Psychiatric or substance abuse hospitalization
- Incarceration
- 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, family psychoeducation, and Recovery Management and wellness share the goal of helping participants 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 disorders treatment have more direct outcomes, and thus it is important to assess work/school involvement and progress toward substance abuse recovery, respectively. A Quarterly Report Form is presented at the end of this section as an example of a simple, paper-based way to collect participation and outcome data on a regular basis.

Using tables and graphs in reports

The single factor that will most likely determine the success of an information system is its ability to provide useful and timely 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 participants worked in a competitive job during the past quarter, but it is more informative to know that this represents only 10 percent of the participants 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 and to answer the queries of each of them.

The outcome monitoring system should format data for a single participant into a summary report that tracks participation in practices and outcomes over time. This report could be entered in the participant's chart, and it could be the basis for a discussion with the participant of treatment and rehabilitation progress and options. Further value of a monitoring system comes in producing tables and graphs that summarize the participation and outcomes of groups of participants. Below are some examples of tables and graphs that are useful when implementing and sustaining an evidence-based practice.

Quarterly summary tables

Whether for an entire program, for a specific team, or for a single practitioner's caseload, rates of participation in practices and participant outcomes should be displayed for the past quarter. Such a table can address the following kinds of questions.

- How many of my participants participated in our supported employment program last quarter?
- How many of my participants worked competitively during the last quarter?
- What proportion of participants in our program for persons with severe mental illness were hospitalized last quarter?
- How did the hospitalization rate for those on assertive community treatment teams compare to the rate for participants in standard case management?
- How many participants with a substance use disorder have yet to participate in our integrated dual diagnosis treatment program?

Simple percentages or proportions, based on quarterly tallies, provide important feedback for both program management and clinical service provision.

Movement tables

Movement tables summarize changes from the previous quarter. They are created by cross-tabulating the same variable from two successive quarters. For example, participation in the family psychoeducation program can be cross-tabulated as shown below.

| | | Participation during Q2 | |
|-------------------------|-----|-------------------------|-----|
| | | No | yes |
| Participation during Q1 | no | 50 | 20 |
| | yes | 10 | 40 |

This table indicates that, out of 120 participants overall, 50 participants did not participate in the program during either quarter (no/no), 40 participated during both quarters (yes/yes), 20 began participation during

Quarter 2 (no/yes), and 10 stopped participation after Quarter 1 (yes/no). Thus, there was a net gain of 10 participants in the family psychoeducation program from Quarter 1 to Quarter 2. The same kind of table can show changes in outcomes between quarters as well. This would answer a question such as, “Were more participants working in competitive jobs during the most recent quarter, as compared to the previous quarter?” Movement tables can be prepared for various groupings of participants. For example, the net gain in competitive employment could be compared across caseloads from multiple case managers or across multiple vocational specialists.

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 participants, caseloads, or programs, for comparison. Below is an example comparing one case manager’s caseload to all other participants in a supported employment program over a two-year period.

This plot reveals that JP’s participants were slower to find employment in the first year (Quarters 1-4), when compared to other participants in the program, but they made continued progress throughout year two (Quarters 5-8), whereas the rate of employment for the other participants has leveled off. Longitudinal plots are powerful feedback tools, as they permit a longer-range perspective on participation and outcome, whether for a single participant or a group of participants. They enable a meaningful evaluation of the success of a program, and they provide a basis for setting goals for future performance.

Recommendations for additions to the basic evidence-based practices information system

Mental health service programs that are sophisticated in using information systems or that have been successful in implementing a start-up system may want to collect and use more information than we recommend for a basic system. For example, programs may want more detailed participation data, such as the number of group sessions attended or the number of contacts with a case manager. They may want to include additional participant outcomes or to collect them in a more detailed way.

Programs may also want to collect feedback directly from participants and family members. Recipients of services are important informants for programs seeking to improve outcomes. Programs may want to know if participants are satisfied with their services and the outcomes they have achieved. They may seek input from participants about how to improve the services, practically and clinically. Programs may want to know if the services are helping participants and families to achieve their goals. These are worthy ambitions, and such data have become part of many monitoring and quality improvement systems.

We did not recommend collecting data from participants and family members as part of a basic system for monitoring participant outcomes for a number of reasons. First, we recommend starting with a set of outcomes that practitioners can reported quickly and accurately. The task of collecting data from participants and families could impede progress and distract focus. Second, there are no well-validated questionnaires to assess many of the constructs that are frequently included in participant and family surveys. Outcomes such as satisfaction, quality of life, and recovery are multifaceted and difficult to measure objectively. Third, it is hard to obtain a representative sample of respondents. Mailed surveys are often not returned. Interviews may be done with those individuals who are easy to reach and cooperative. Questions may be asked only of those who show up for routine appointments. Unless the data are collected from a representative sample, it is difficult to interpret the findings, because it is not clear to whom they generalize. Fourth, there may be better ways to get feedback from participants than by trying

to collect quantitative data from them. A program may be better off holding focus groups for participants or families to discuss a specific evidence-based practice with the practitioners or with quality improvement personnel. Likewise, a program may learn more about participant perceptions of services and their feelings about recovery from qualitative interviews with a small group of participants. Fifth, quality improvement personnel may be better able and qualified to collect, analyze, and interpret data from participants and families. A treatment team may collect informal feedback from participants through their day-to-day contacts, but it may be better left to others to collect systematic data. In many agencies, formal reporting systems already include participant-based assessments, and it may be possible to build on these efforts rather than to duplicate them.

Yet, programs may want to collect data from the recipients of their services. If a basic outcome monitoring system has been implemented, then expanding data collection to include participants and family members may be appropriate and feasible. Programs are encouraged to explore their options, although it is important to remain mindful of the issues discussed above.

Self-Assessment developed in New York, as examples for programs to consider.

When thinking about expanding data collection beyond the basic set of outcomes, it is important to realize that more is not necessarily better. Unless the data can be reported reliably and validly, the value of adding more data to the monitoring system is illusory. The old adage, “garbage in, garbage out,” must be kept in mind when the temptation is present to expand a working system. Feedback that is based on unreliable, invalid, or unrepresentative data may be no better for a system than no feedback at all. Nevertheless, the thoughtful and gradual expansion of a working system for collecting and using participant outcome can increase the value of the feedback. The litmus test is not what and how much data a program collects, but rather whether the program uses the data to inform and improve the practice.

Participant Outcomes—Quarterly Report Form

Participant ID: _____ Reported by: _____

Date: _____ Quarter: _____

Indicate the participant’s status during the past 3 months. Check all that apply:

| Evidence-Based Practice | Eligible | Enrolled |
|-------------------------------------|-----------------|-----------------|
| Integrated Dual Disorders Treatment | | |
| Supported Employment | | |
| Assertive Community Treatment | | |
| Recovery Management & Recovery | | |
| Family Psychoeducation | | |

In the past 3 months, how many weeks has the participant:

- _____ Held a competitive job?
- _____ Been homeless?
- _____ Been incarcerated?
- _____ Been hospitalized for psychiatric reasons?
- _____ Been hospitalized for substance use reasons?

What has been the participant’s stage of substance abuse treatment during the *past 3 months*? Circle one.

- N/A
- Engagement
- Persuasion
- Active treatment
- Relapse prevention

What is the participant’s current living arrangement? Circle one.

1. Psychiatric hospital
2. Substance use 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. Lives with relatives (but is largely independent)
10. Supervised apartment program
11. Independent living
12. Other (specify)
13. Emergency shelter
14. Homeless

What is the participant’s current educational status? Circle one.

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 or apprenticeship, vocational program (CNA training) or attending high school
8. Attending college—1-6 hours
9. Attending college —7 or more hours
10. Other (specify)

Definitions for Quarterly Report Form

Each person completing the form should become familiar with the definitions of the data elements in order to provide consistency among reporters.

Heading information

Participant ID

The participant ID that is used at your agency. This is usually a name or an identifying number. This information will only be accessible to the agency providing the service.

Reported by

The name of the person who completed the form—the case manager or other staff member from the mental health agency who have access to the desired information.

Date

The date the report was completed.

Quarter

The time frame for the reporting period. For example, January–March, April–June, July–September, October–December.

Evidence-based practice

Eligible

Does the participant meet the participation criteria for a specific EBP?

For example, all persons who have a severe mental illness and a drug/alcohol diagnosis are eligible for participation in integrated dual disorders treatment. Each EBP has criteria for program participation that should be used to determine eligibility.

Enrolled

Is the participant participating in a particular EBP service? Note: aggregate data about eligibility and enrollment can be used to determine the penetration of services to eligible persons served by a mental health agency.

For the following incidents, the quarterly report should record the number of weeks the participant spent in the specific incident category during the 3 months of the reporting period.

Employment

In the past 3 months, how many weeks has the participant held a competitive job?

Competitive employment is viewed as working in a paid position (almost always outside the mental health center) that would be open to all community members to apply. 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 and be paid for the work.

Incidents reporting

Been homeless?

Record the number of weeks the participant spent homeless during the reporting period. This refers to individuals who lack a fixed, regular, and adequate nighttime residence.

Been incarcerated?

Record the number of weeks the participant spent incarcerated in jails or other criminal justice lock-ups during the reporting period.

Been hospitalized for psychiatric reasons?

Record the number of weeks the participant spent hospitalized primarily for treatment of psychiatric disorder(s) during the reporting period. This includes both public and private hospitals whose primary function is the treatment of mental disorders.

Been hospitalized for substance use reasons?

Record the number of weeks the participant spent hospitalized primarily for treatment of substance use disorder(s) during the reporting period. This includes those both public and private hospitals whose primary function is the treatment of substance use disorders.

Stage of substance abuse treatment

What has been the participant's stage of substance abuse treatment during the past 3 months?

For those persons participating in integrated dual disorders treatment, please indicate the appropriate stage of substance abuse treatment. N/A is used for persons who do not have a substance use problem or diagnosis.

Engagement. This category includes Pre-engagement and Engagement.

- The person does not have any regular contacts with an assigned case manager, mental health counselor, or substance abuse counselor. The lack of regular contact implies lack of a working alliance.

Persuasion. This category includes Early Persuasion and Late Persuasion.

- The participant has regular contacts with a counselor but has not yet reduced substance use for more than a month (early persuasion), or has reduced substance use for at least one month while discussing substance use issues or attending groups (late persuasion). Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

Active Treatment. This category includes Early Active Treatment and Late Active Treatment.

- The participant 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 as a goal, even though he or she may still be abusing (early active treatment). This category also includes persons engaged in treatment, who have acknowledged that substance abuse is a problem, and have achieved abstinence but for less than 6 months (late active treatment)

Relapse Prevention. This category includes Relapse Prevention, and In Remission or Recovery.

- The participant is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence for at least 6 months. Occasional lapses, not days of problematic use, are allowed (relapse prevention). This category also includes participants who have had no problems related to substance use for over one year and are no longer in any type of substance abuse treatment (in remission or recovery).

Residential and educational status

These data provide your agency with an ongoing record of the participant's residential and educational status. Record the status that applies to the participant on the last day of the reporting period.

What is the participant's current living arrangement?

1. **Psychiatric hospital.** This includes those hospitals, both public and private, whose primary function is the treatment of mental disorders. This includes state hospitals and other freestanding psychiatric hospitals.
2. **Substance use hospitalization.** This includes those hospitals, both public and private, whose primary function is the treatment of substance use disorders.
3. **General hospital psychiatric ward.** This category includes psychiatric wards located in general medical centers that provide short-term, acute crisis care.
4. **Nursing home or IC-MH.** This category includes facilities that are responsible for the medical and physical care of a participant and have been licensed as such by the state.
5. **Family care home.** This category is for situations in which a participant is living in a single family dwelling with a non-relative who provides substantial care. Here (as with #8), substantial care is determined by the degree that the nonrelative(s) is responsible for the daily care of the individual. Such things as medication management, transportation, cooking, cleaning, restrictions on leaving the home, and money management are considered. The non-relative may have guardianship responsibilities. If the participant is not able to do a majority of the daily living tasks without the aid of the caretaker, the caretaker(s) is providing substantial care.
6. **Lives with relatives (heavily dependent for personal care).** Here the individual participant and relatives should be consulted to the degree that family members are responsible for the daily care of the individual participant. 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, and money management can be considered. If the participant is unable to independently perform a majority of the daily living functions, the family member(s) is providing substantial care.

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 house.** 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 participants have a high degree of autonomy.
9. **Lives with relatives (but is largely independent).** As with status #8, an assignment to this category requires information provided by the participant and family. The key consideration relates to the degree that the individual is able to perform the majority of tasks essential to daily living without the supervision of a family member
10. **Supervised apartment program.** Here, the participant is living (fairly independently) in an apartment sponsored by a mental health agency. In determining whether someone fits in this category, look at the extent to which mental health staff have control over key aspects of the living arrangements. Example characteristics of control include:
 - the mental health agency signs the lease,
 - the mental health agency has keys to the house or apartment,
 - the mental health agency provides onsite day or evening staff coverage, or
 - the mental health agency mandates participant participation in certain mental health services—medication clinic, day program, etc.—in order to reside in the house or apartment. Participants only receiving case management support or financial aid are NOT included in this category; they are considered to be living independently (#11).
11. **Independent living.** This category describes participants who are living independently and are capable of self-care. It includes participants who live independently with case management support. This category also includes participants who are largely independent and choose to live with others for reasons not related to mental illness. They may live with friends, a spouse, or other family members. The reasons for shared housing could include personal choice related to culture and/or financial considerations.
12. **Other.** This status should be clearly defined in the space provided by those completing the form.
13. **Emergency shelter.** This category includes temporary arrangements due to a crisis or misfortune that are not specifically related to a recurrence of the participant's illness. While many emergency shelters provide emotional support, the need for emergency shelter is due to an immediate crisis not related to the participant's mental illness.
14. **Homeless.** This category includes individuals who lack a fixed, regular, and adequate nighttime residence.

What is the participant's current educational status?

1. **No educational participation.**
2. **Avocational/educational involvement.** These are organized classes in which the participant 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 severe mental illness. If any of these activities involve college enrollment, use status #8 or #9.
3. **Pre-educational explorations.** Individuals in this status are engaged in educational activities with the specific purpose of working towards an educational goal. This includes individuals who attend a college orientation class with the goal of enrollment, meet with the financial aid office to apply for scholarships, or apply for admission for enrollment. This status also includes 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 classrooms; meetings with the case manager and college staff to secure entitlements.
4. **Working on GED.** This status includes people 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.
7. **Attending vocational school or apprenticeship, vocational program (CAN training),** or attending high school. This status includes those participating in community based vocational schools; learning skills through an apprenticeship, internship, or in a practicum setting; involved in on-the-job training to acquire more advanced skills; participating in correspondence courses which lead to job certification; and young adults attending high school.
8. **Attending college: 1–6 hours.** This individual attends college for 6 hours or less per term. This status continues over breaks, etc., if the individual plans to continue his/her 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.** This individual attends college for more than 7 hours per term. This status continues over breaks, etc., if the individual plans to continue his/her enrollment. Regular attendance with expectations of completion of course work is essential for assignment to this status.
10. **Other.** This status should be clearly defined in the space provided by those completing the form.

| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Quality of Life Self-Assessment

This survey asks you to tell us how things are going for you these days. It should take you about 5 minutes to complete. When finished, please give the survey to your care Coordinator so that you can review the results together.

Please print your name, your Care Coordinator's name and today's date below.

Your name (please print): _____

Your Care Coordinator's name: _____

Today's date: _____

In this section, we ask you to rate how things are going in different areas of your life. For each statement below, circle the answer that best matches your experience.

| Overall, how would you rate ... | (Circle one choice for each statement) | | | | Should this be on your service plan? | |
|--|--|----------|---------|-----------|--------------------------------------|----|
| | 0 | 1 | 2 | 3 | Yes | No |
| The place where you live (your housing). | Poor | Fair | Good | Excellent | Yes | No |
| The amount of money you have to buy what you need. | Poor | Fair | Good | Excellent | Yes | No |
| Your involvement in work, employment. | Poor | Fair | Good | Excellent | Yes | No |
| Your level of education. | Poor | Fair | Good | Excellent | Yes | No |
| Your access to transportation to get around. | Poor | Fair | Good | Excellent | Yes | No |
| Your social life. | Poor | Fair | Good | Excellent | Yes | No |
| Your participation in community activities (leisure, sports, spiritual, volunteer work). | Poor | Fair | Good | Excellent | Yes | No |
| Your ability to have fun and relax. | Poor | Fair | Good | Excellent | Yes | No |
| Your physical health. | Poor | Fair | Good | Excellent | Yes | No |
| Your level of independence. | Poor | Fair | Good | Excellent | Yes | No |
| Your ability to take care of yourself (staying healthy, eating right, avoiding danger). | Poor | Fair | Good | Excellent | Yes | No |
| Your self-esteem (how you feel about yourself). | Poor | Fair | Good | Excellent | Yes | No |
| The effect of Alcohol & other drugs on your life. | Severe | Moderate | Minimal | None | Yes | No |
| Your mental health symptoms. | Severe | Moderate | Minimal | None | Yes | No |
| Overall, how things are going in your life? | Poor | Fair | Good | Excellent | Yes | No |
| Is there anything else that you want on your service plan? | | | | | | |

Selected Bibliography for Recovery and Wellness Management Program

Summary of research supporting the components of Recovery Management and Wellness

* Mueser, K, Corrigan, P, Hilton, D, Tanzman, B, Schaub, A, Gingerich, S, Essock, S, Tarrier, N, Morey, B, Vogel-Scibilia, Herz, M: "Recovery Management and Recovery: A Review of the Research," submitted to Psychiatric Services.

Studies showing that education increase knowledge about mental illness

Goldman, CR, Quinn, FL: Effects of a patient education program, "in the treatment of schizophrenia. Hospital and Community Psychiatry 39:282-286, 1988.

* Macpherson, R, Jerrom, B, Hughes, A: A controlled study of education about drug treatment in schizophrenia. British Journal of Psychiatry 168:709-717, 1996.

Bäumel, J, Kissling, W, Pitschel-Walz, G: Psychoedukative gruppen für schizophrene patienten: Einfluss auf wissensstand und compliance. Nervenheilkunde 15:145-150, 1996.

Studies showing that behavioral tailoring improve taking medication as prescribed

*Boczkowski, J, Zeichner, A, DeSanto, N: Neuroleptic compliance among chronic schizophrenic outpatients: An intervention outcome report. Journal of Consulting and Clinical Psychology 53:666-671, 1985.

*Azrin, NH, Teichner, G: Evaluation of an instructional program for improving medication compliance for chronically mentally ill outpatients. Behaviour Research and Therapy 36:849-861, 1998.

*Cramer, JA, Rosenheck, R: Enhancing medication compliance for people with serious mental illness. The Journal of Nervous and Mental disease 187:53-55, 1999.

Kelly, GR, Scott, JE: Medication compliance and health education among outpatients with chronic mental disorders. Medical Care 28:1181-1197, 1990.

Studies showing that relapse prevention training reduces relapses and rehospitalizations

Buchkremer, G, Fiedler, P: Kognitive vs. handlungsorientierte Therapie (Cognitive vs. action-oriented treatment). Nervenarzt 58:481-488, 1987.

* Herz, MI, Lamberti, JS, Mintz, J et al: A program for relapse prevention in schizophrenia: A controlled study. Archives of General Psychiatry 57:277-283, 2000.

Perry, A, Tarrier, N, Morriss, R et al: Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. British Medical Journal 318:149-153, 1999.

Studies showing that teaching coping skills reduce severity of symptoms

* Leclerc, C, Lesage, AD, Ricard, N et al: Assessment of a new rehabilitative coping skills module for persons with schizophrenia. American Journal of Orthopsychiatry 70:380-388, 2000.

*Lecomte, T, Cyr, M, Lesage, AD et al: Efficacy of a self-esteem module in the empowerment of individuals with schizophrenia. Journal of Nervous and Mental Disease 187:406-413, 1999.

*Schaub, A: Cognitive-behavioural coping-orientated therapy for schizophrenia: A new treatment model for clinical service and research, in Cognitive Psychotherapy of Psychotic and Personality Disorders: Handbook of Theory and Practice, Vol. Edited by Perris, C, McGorry, PD Chichester, John Wiley & Sons, 1998.

Schaub, A, Mueser, KT, "Coping-oriented treatment of schizophrenia and schizoaffective disorder: Rationale and preliminary results," presented at the 34th Annual Convention of the Association for the Advancement of Behavior Therapy, New Orleans.

References for Practitioners Seeking More Information Related to Providing the Recovery and Wellness Management Program

Bipolar Disorder

Fawcett, P, Golden, B, Rosenfeld, N. New hope for people with bipolar disorder. Prima Publishing, 2000.
Miklowitz, D. The bipolar survival guide: What you and your family need to know. New York: Guilford, 2002.

Cognitive-behavioral techniques for psychotic disorders

Fowler, D. Cognitive behavioral therapy for psychosis: From understanding to treatment. *Psychiatric Rehabilitation Skills* 4(2): 199-215, 2000.

Rector, N, Beck, A. Cognitive behavioral therapy for schizophrenia: An empirical review. *Journal of Nervous and Mental Disease* 189:278-287, 2001.

Tarrier, N. & Haddock, G. Cognitive-behavioral therapy for schizophrenia: A case formulation approach. In Hofmann, S & Tompson, M (Eds), *Treating chronic and severe mental disorders: A handbook of empirically supported interventions*. NY: Guilford. 2002.

Depression

Copeland, ME. *The depression workbook*. Oakland: New Harbinger, 1999.

DePaulo, J.R. *Understanding depression: What we know and what you can do about it*. Wiley, 2002.

Family interventions

MacFarlane, W. *Multifamily groups in the treatment of severe psychiatric disorders*. New York: Guilford Press, 2002.

Mueser, K & Glynn, S: *Behavioral family therapy for psychiatric disorders*. Oakland, New Harbinger Publications, 1999.

First person account of Recovery Management

Leete, E. How I perceive and manage my illness. *Schizophrenia Bulletin* (15)2: 197-200, 1989.

Motivational interviewing

Miller, WR, Rollnick, S: *Motivational interviewing: Preparing people to change*. 2nd edition. New York: Guilford, 2002.

Recovery research

Ralph, R. Recovery. *Psychiatric Rehabilitation Skills* (4)3: 488-517, 2000.

Schizophrenia

Herz, M, Marder, S.: *The comprehensive treatment and management of schizophrenia*. Baltimore, Lippincott, Williams, and Wilkins, 2002.

Mueser, K. & Gingerich, S. *Coping with schizophrenia: A guide for families*. Oakland, New Harbinger Publications. 1994.

Social skills training

Bellack, A, Mueser, K, Gingerich, S, Agresta, J: *Social skills training for schizophrenia: A step-by-step guide*. New York: Guilford Press, 1997.

Gingerich, S. Guidelines for social skills training for persons with mental illness. In Roberts, A and Greene, G. *Social workers desk reference*, pages 392-396, 2002.

Lieberman, R.P. Social and independent living skills (SILS) modules (trainers' manuals, participant workbooks, video packages, etc.) can be found at www.mentalhealth.ucla.edu.

Stigma

Corrigan, P. & Lundin, R. *Don't call me nuts: Coping with the stigma of mental illness*. Chicago: Recovery Press, 2001.

Wahl, O. *Telling is risky business: Mental health participants confront stigma*. New Brunswick, NJ: Rutgers University Press. 1999.

Substance abuse and the stages- of-change model

Connors, G, Donovan, D, DiClemente, C. *Substance abuse treatment and the stages of change*. New York: Guilford Press. 2001.

Velasquez, M, Maurer, G, Crouch, D, DiClemente, C. *Group treatment for substance abuse: A stages-of-change therapy manual*. New York: Guilford Press.

Working collaboratively with people who do not believe that they have a psychiatric disorder.

Amador, X., Johanson, A: *I am not sick: I don't need help*. Petonic, NY: Vida Press, 2000.

Amador, X, Gorman, J: *Psychopathologic domains and insight in schizophrenia*. *The Psychiatric Clinics of North America* 21:27-42, 1998.

*

Selected Articles

Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illnesses, *Psychiatric Services* 52:45-50, 2001.

Drake RE, Goldman HH, Leff HS, et al: Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services* 52:179-182, 2001.

Goldman HH, Ganju V, Drake RE, et al: Policy implications for implementing evidence-based practices. *Psychiatric Services* 52: 1591-1597, 2001.

Mueser KT, Corrigan PW, Hilton DW, et al: Recovery Management and recovery: A review of the research, *Psychiatric Services*, in press.

Leete E: How I perceive and manage my illness, *Schizophrenia Bulletin* 15(2), 197-200, 1989.

References

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation*, 11(4), 11-19.

Gowdy, E., & Rapp, C. A. (1989). Managerial behavior: The common denominators of effective community based programs. *Psychosocial Rehabilitation Journal*, 13, 31-51.

Patti, R. (1985, Fall). In search of purpose for social welfare administration. *Administration in Social Work*, 9(3), 1-14.

Peters, T.J., & Waterman, R.H. (1982). *In search of excellence*. New York: Harper & Row.

Rapp, C. A., & Poertner, J. (1992). *Social Administration: A Participant-Centered Approach*. New York: Longman.