

Toolkit on
Manuals and Workbooks
for Psychosocial Interventions

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This **Toolkit** is one of a series of such kits commissioned by the Evaluation Center@HSRI. The Center is a grant of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The mission of the Evaluation Center is to provide technical assistance related to the evaluation of adult mental health system change.

The Center offers seven programs all of which are designed to enhance evaluation capacity. **The Consultation Program**, which provides consultation tailored to the needs of individual projects; **the Topical Evaluations Networks and Web Program**, make use of multiple methods of communication via the internet; **the Toolkit Program**, which provides evaluators with tested methodologies and instruments related to specific topics; **the Materials Program**, an evaluation materials program which supplies evaluators with original papers on selected topics and identifies relevant literature in the field; **the Conferences and Training Program** designed to enhance the evaluation skills of producers and consumers of evaluations; **Multi-cultural Program** focusing on evaluation issues related to culturally, racially and ethnically diverse populations; and the **Knowledge Assessment and Application Program**, focuses on filling the gap between knowledge development and knowledge application activities.

The Toolkits are designed to provide evaluators with complete descriptions of methodologies and instruments for use in evaluating specific topics. Based on information from a needs assessment study conducted by the Center and on feedback from evaluators in the fields, we have identified a number of important topics that evaluators are frequently interested in examining. Expert consultants have been engaged to review the background of these topics and to compile Toolkits that provide evaluators with state-of-the-art evaluation techniques to use in their own work.

The Evaluation Center@HSRI is also interested in supporting “user groups” for its Toolkits. These groups will provide a forum for Toolkit users to share their expertise and experiences with the Toolkits. If you would like to participate in a user group, please complete the postcard enclosed and return it to the Evaluation Center@HSRI.

We hope that this *Toolkit on Manuals and Workbooks for Psychosocial Interventions* will be helpful to those evaluators who are interested in a step-by-step guide for preparing a manual or workbook for a practice or intervention. The manual or workbook may be for a practice that is already evidence-based or for one that is about to be tested.

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CHAPTER 1.

Overview

Purpose of Toolkit

Manuals and workbooks are instrumental in ensuring that practices happen. A practice is a complex of services designed to improve service recipient outcomes. Manuals and workbooks are designed to help mental health program leaders implement a practice. Practice change is promoted by interventions that predispose providers to change (i.e., why do it), enable the change (i.e., how to do it), and reinforce the change (i.e., maintain and extend the gains) (Green 1991; Green et al., 1980). Manuals and workbooks can play a role in all three phases of change. They can be created to motivate individuals to adapt and/or use practices. Manuals and workbooks can also provide materials that will enable providers to offer high fidelity services. Manuals and workbooks also provide materials and supports, such as fidelity measures and simple outcome measures, so that providers can maintain and extend the gains.

Manuals and workbooks are only one among many types of materials and activities that support the adoption of a practice. Others are training, supervision, consultation, pamphlets and brochures, videos, posters, web-based technologies and lists of commonly asked questions and answers (Torrey et al. 2001). Different audiences and stakeholder groups require different types of materials to support adoption of a practice.

The purpose of this toolkit is to provide a step-by-step guide for preparing a manual or workbook for a practice. The manual or workbook may be for a practice that is already evidence-based or for one that is about to be tested. According to Chambless and Hollon (1998) the efficacy of a treatment is best shown in a controlled study that shows that the benefits observed are due to the effects of the treatment and not to chance alone. Other criteria for establishing the evidence-base for a practice are listed in Leff, Mulkern, Drake, Allen, and Chow (under review).

To achieve their purpose in promoting a practice, manuals and workbooks should contain certain essential elements. This toolkit describes these elements, as well as, provides exemplary illustrations. Some of the elements described here were suggested by research and evaluation of the dissemination of new technologies. Other elements were suggested by theories about and observations of technological change. We have identified the extent of the evidence base for each element. Where there is empirical evidence demonstrating the effectiveness of a particular element, we have provided the appropriate reference to the study that produced the evidence. For elements recommended on the basis of theory, consensus or logic, we indicate that as well.

This toolkit is not intended to be a summary of the evidence for the efficacy or effectiveness of manuals and workbooks. In fact, as we discuss in the next section, some believe that manuals may not be the best approach to guiding the delivery of all practices and that in some cases it may even be harmful (Klein, 1997). The toolkit's goal is to contribute to the construction of manuals and workbooks for adoption and testing of practices that have the best possible chances of positively influencing consumer outcomes.

This toolkit will be useful to many types of professionals. **Program developers** who have developed programs and wish to test or disseminate the programs can use this toolkit as a guide for describing their program to others who might wish to implement the programs. The toolkit provides **program planners and administrators**, who have to decide whether their agencies should implement particular programs or services, with an inventory of things they need to know to make these decisions. **Program trainers** responsible for developing training materials will find this toolkit useful for considering the contents of their training manuals and other curricular materials. Finally, **regulators, evaluators and advocates** responsible for assessing whether agencies have the necessary materials for implementing effective services can use this toolkit to assess the adequacy of materials for guiding and training staff.

Framework for Reviewing Manuals and Workbooks

The first phase of the development of this toolkit involved a review of the literature on manual-based practices to identify candidate elements of manuals and workbooks. In addition, a meeting was held during September 2000 with successful and potential manual developers of evidence-based practices. This meeting also included potential manual users. The second phase was focused on reviewing manuals and workbooks for illustrations of candidate elements. The last phase of the project involved the selection of exemplary illustrations for the different elements identified in phase one and two of the project. The review focused on manuals and workbooks for adults. However, many of the same principles may also apply for manuals and workbooks for children and adolescents.

An internal group met to discuss the illustrations identified. The focus of the discussions was centered on what made the illustrations exemplary. Illustrations were considered to be exemplary if they were clear, precise and helpful in making information easier to understand and digest. In some cases multiple examples were included because they were considered to be exemplary for different reasons. Table 1 provides a list of the manuals and workbooks reviewed during this project. Information on how to obtain each of the manuals and workbooks is presented in Appendix B.

TABLE 1.

List of Manuals and Workbooks Reviewed for Project.

Ahern, L., & Fisher, D. (1999). *Personal Assistance in Community Existence (PACE)*. Lawrence, MA: National Empowerment Center, Inc.

Allness, D.J., & Knoedler, W.H. (1998). *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up*. Arlington, VA: NAMI.

Becker, D.R., & Drake, R.E. (1993). *A Working Life: The Individual Placement and Support (IPS) Program*. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center.

Cook, J.A., & Knox, J. (1994). *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliate*. Chicago, IL: Thresholds National Research and Training Center.

Hodge, M., & Giesler, L. (July 1997). *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness*. Ocean Ridge, Fla: National Association of Case Management (NACM).

Miller, A.L., Chiles, J.A., Chiles, J., & Crismon, M.L. (January 2000). *Texas Algorithm of Medication Algorithms (TIMA) Schizophrenia Procedures Manual TIMA Physician Manual*.

Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Managed Care. (October 2000). *Keys to Quality: Conducting a Performance Improvement Project for Behavioral Health in Managed Care Based on the Principles of QISMC*. Prepared by the Evaluation Center@HSRI.

The Schizophrenia Patient Outcomes Research Team (2001). *Measuring Conformance to Treatment Guidelines: The Example of the Schizophrenia PORT*. Cambridge, MA: The Evaluation Center at HSRI.

Schizophrenia PORT Treatment Recommendations. Final Version (September 30, 1996). Center for Mental Health Services Research at the University of Maryland, Health Services Research and Development Center at John Hopkins University, and RAND Corporation, Survey Research Associates at MEDSTAT.

Stein, L.I., & Santos, AB. (1998). *Assertive Community Treatment of Persons with Severe Mental Illness*. New York: W.W. Norton.

CHAPTER 2.

Essential Elements of Manuals and Workbooks

Manuals and Workbooks

We define manuals and workbooks as materials that provide sufficient detail to allow trained personnel to replicate practices. Treatment manuals evolved to improve the internal validity of psychotherapy outcomes studies (Addis & Krasnow, 2000).

Utilization of Manuals and Workbooks

There is evidence that adherence to certain empirically supported manual-based treatments can be associated with positive outcomes (Addis & Krasnow, 2000). Some investigators (Hibbs, Clarker, Hechtman, Abikoff, Greenhill, & Jensen 1997) propose that manuals are essential to outcome studies because they enable replication, specify treatment components, and facilitate the monitoring of treatment fidelity and integrity. Castonguay and colleagues (1999) point out that treatment manuals should be considered steps in the advancement of scientific knowledge and continual efforts to improve the quality and impact of treatments. However, other studies have suggested that under certain conditions, manuals may have harmful effects (Addis & Krasnow, 2000; Klein, 1997).

Doubts about Manuals and Workbooks

Klein (1997) argues that the value of manuals for psychosocial practices has yet to be proven. Other concerns about manuals are that they promote adherence to a single theoretical perspective, impede clinical flexibility, overemphasize technique at the expense of theory, ignore the role of the individual therapists, rely on diagnostic categories that draw attention away from the complexities of individual life situations, and increase training costs (Addis & Krasnow, 2000; Klein, 1997). Some suggest manuals are more appropriate as instruments of research rather than practice (Fonagy, 1999). Yet another concern with manuals is that qualities of a treatment which are not described in a manual may turn out to be the qualities that are most crucial to the success of the treatment (Klein, 1997). The authors of this toolkit believe that manuals and workbooks are necessary to improving treatment and that issues such as the ones raised above can be addressed in the production and testing of manuals.

It is important to note that manuals alone are not sufficient to support adoption of a practice. They need to be supplemented by additional training, supervision, and consultation and well as other additional materials noted earlier.

Other Important Considerations

Manuals and workbooks can only promote change if they are sought and read. Several noteworthy approaches to influencing persons to consider systems and practice change are: academic detailing and social marketing. Further consideration of these approaches is beyond the scope of this manual. However, Appendix C contains information about resources on these topics.

To increase the probability they will be read, manuals and workbooks should be written in accessible language (e.g. reading level), be attractively designed, and have features like tables of contents, glossaries, and indices that facilitate their use. Professional editors often can improve the attractiveness and readability of manuals. At the time of this manual's preparation fees for editing a manual ranged from \$200 to \$400 a day. Editing an entire manual of approximately 75 pages might cost 2 –3 thousand dollars.

Choosing how to produce copies of manuals and workbooks can be complicated. An extended discussion of this is beyond the scope of this manual. However, we note the cost of printing and handling, availability of storage space, and willingness to maintain records of orders and payments are among the factors that should be considered.

Essential Elements of Manuals and Workbooks

Table 2 presents the essential elements of manuals and workbooks that were identified during phases one (review of literature) and two (selection of exemplary illustrations). We have grouped the elements into five major areas: 1) introduction to the manual or workbook; 2) elements which predispose providers to offer the practice (i.e., why do it); 3) elements to help program leaders to set up and structure the practice (i.e., how to do it); 4) elements to help program leaders to maintain and extend the gains; and 5) supporting elements that facilitate access to materials in manuals and workbooks or refer readers to additional information about the intervention available outside of the manual or workbook.

TABLE 2.

Essential Elements of Manuals and Workbooks.

- I. Introduction to the manual or workbook.
 1. Description of the purpose of the manual or workbook.
 2. Description of planning process.
 - II. Elements that predispose providers to offer the practice (i.e., why do it).
 1. Description of the practice including theory behind practice and principles of the practice.
 2. Description of the supporting research.
 - III. Elements to help program leaders to set up and structure the practice (i.e., how to do it).
 1. Eligibility/admission criteria.
 2. Boundaries- the applicability or use of practice with special populations or need to adapt a practice.
 3. Relationship to and importance of other services in service system to manualized practice.
 4. Roles: Descriptions of staff duties and responsibilities.
 5. Training, consultation, and supervision requirements/recommendations.
 6. Administration.
 7. Facility design.
 8. Provider to consumer ratios, or total caseloads, required to provide services included in the practice.
 9. Specific service components or approaches comprising the practice.
 10. Program costs, financing and financial management.
 11. Recommendations for promoting change in healthcare settings.
 12. Case examples.
 13. Illustrations.
 14. Flowcharts/logic models and algorithms.
 15. Checklists- exercises and assessments.
 16. Sample plans or list of components.
 17. Sample assessment forms or list of assessment items.
 18. Sample schedules for staff and consumers.
 19. Components of service records or sample medical records and other administrative databases/record keeping.
 20. Start-up experiences.
 21. Common difficulties, obstacles, or problems that occur when conducting the practice.
 - IV. Elements to help program leaders to maintain and extend the gains.
 1. Fidelity scales and process indicators.
 2. Simple performance and outcome measures and evaluation designs.
 3. Quality improvement process.
 4. Evaluating the manual or workbook.
 - V. Supporting elements.
 1. Definitions/glossary.
 2. References to other materials, activities, and resources to facilitate adoption and implementation.
-

Sections I-V recommend and discuss elements that manuals and workbooks should include and present exemplary illustrations for each element. As previously noted, the elements were grouped into five major areas. For most of the elements, the toolkit provides: 1) a rationale for including the element in a manual or workbook based on the values expressed in the element; 2) what experts have theorized or observed about the element; 3) any evidence about the element's efficacy and effectiveness in influencing consumer outcomes; and 4) exemplary illustrations for most of the elements.

I. Introduction to the Manual or Workbook

The purpose of the first two elements is to provide readers with an introduction to the manual or workbook. In these two elements the manual or workbook authors will spell out what they are trying to accomplish with the manual or workbook. It is also important that authors of manuals and workbooks include a description of the planning process for the development of the manual.

I.1. Include a Description of the Purpose of the Manual.

It is essential that the authors of manuals and workbooks clearly spell out what they are trying to accomplish with the manual or workbooks.

EXEMPLARY ILLUSTRATION

The manual *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) provides a brief and concise description of the purpose of the manual. The description is exemplary because it briefly outlines the target audience and the goals of the manual (or what the reader should gain from reading the manual).

ILLUSTRATION 1.

Description of the Purpose of the Individual Placement and Support (IPS) Manual.

The purpose of this Individual Placement and Support (IPS) manual is to outline and describe a vocational service intervention that is helpful for people with severe mental disabilities. The reader should gain an overall understanding of IPS and specific information on how to set up and implement the program in a community mental health center (CMHC). The target audience of the manual is CMHC staff at all levels.

Source: Becker & Drake, 1993, p. i.

I.2. Include a Description of the Planning Process for the Development of the Manual/Workbook.

It is important that authors of practice manuals and workbooks include a description of the planning process for their development. This description should include, at least, a discussion of who participated in the development of the manual or workbook; how input was obtained from consumers, family members, and other stakeholders prior to the finalization of the manual or workbook; and how and by whom the manual or workbook was pilot tested.

Manuals and workbooks should be developed by authors who are experts in the practice or intervention and who have extensive clinical experience with the specific population to be served (Hibbs, et. al., 1997).

However, we also believe that manuals or workbooks will be more effective in meeting their purpose if drafts are reviewed by the kinds of people who will be affected by them when they are finalized. They will also be more effective if stakeholders from different cultures participate in the planning process and if authors include language that is culturally sensitive. Including a brief summary of the planning process makes the process clear to the reader and strengthens the validity of the manuals and workbooks content.

EXEMPLARY ILLUSTRATIONS

The manual *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness* (Hodge & Giesler, 1997) describes the process for developing the guidelines. The process included: 1) a series of focus groups held with people with serious mental illness, family members, and case managers from different parts of the nation; 2) an annotated bibliography of the available literature on case management along with a review of other research surveys; 3) opinion and guidance of an expert review panel and feedback from other contributing reviewers; and 4) a review of printed materials and telephone interviews with private managed behavioral health care organizations and states implementing managed care for people with serious and persistent mental illness. The manual includes: the results of the focus groups and a summary of the implications of the focus groups' opinions; a description of the results of the research review and implications for the guidelines; and the credentials of the review panel and a list of contributing reviewers. The manual also includes a description of the participants in the consumer and family member focus group. Illustration 2 below is the description of the focus groups, which is included in the manual for *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness* (Hodge & Giesler, 1997).

ILLUSTRATION 2.

Description of the Focus Groups Held in the Planning Process for the Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness.

Consumer and Family Member Focus Group Results.

NACM commissioned a total of eleven focus groups in six separate geographical areas, six of these with consumers, two with family members, and three with practicing case managers. The six consumer groups included one for people personally acquainted with homelessness, one for people living in rural areas, and one for working consumers. The remaining three groups were from urban areas. All groups were balanced for age and culture, and two of the consumer groups had participants who were currently in a state hospital. All consumer participants were severely and persistently mental ill and currently receiving CM services. All the groups were facilitated by consumers.

The two family groups were held in Lake Worth, Florida and Phoenix, Arizona. They were culturally and age balanced. Each of the family focus groups were facilitated by a family member, and all of the participants in each group had a close relative who was seriously mentally ill and receiving CM.

All of the focus groups were asked to answer identical questions and the facilitators were given identical training, workbooks, and instructions. The focus group workbook, including all the questions and instructions, can be requested from NACM.

Source: Hodge & Giesler, 1997, pp. 45-46.

Illustration 3 is an excerpt of a section included in the *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness* manual (Hodge & Giesler, 1997) on the implications of the focus groups for the case management practice guidelines.

ILLUSTRATION 3.

Implications of the Focus Groups Held in the Planning Process for the Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness.

Implications for Practice Guidelines.

Much of the material received from the focus groups validated current opinions and practices in the field of CM. There was not only congruence between the three case manager focus groups about situations which require differing levels of intensity of CM service, but there was also agreement with the answers to these questions given by consumers and family members. Case managers and family members saw more drastic risks without CM than did consumers, but there was concurrence among all groups that hospitalization, homelessness, and loss of income were risks faced by people without CM. Further, the focus groups all valued increased independence and decreased reliance on CM as mutual goals, while reinforcing that effective CM itself, with the appropriate level of involvement, was a critical service to maintain stability and increase wellness and independence. . . .

The three types of focus groups, consumer, family, and case manager, gave enormous guidance to the development of the levels of CM in these guidelines and tremendous support for the continuation of community support values.

Source: Hodge & Giesler, 1997, p. 51.

The two previous illustrations are exemplary because they illustrate how to provide information on who participates in planning services and how the opinions of different stakeholder groups were sought and used.

II. Elements to Predispose Providers to Offer the Practice (Why Do It)

The purpose of the following elements is to predispose providers to offer the practice or intervention. The elements provide information, such as the theory behind the practice, the principles of the practice and supporting research, which is designed to persuade others to want to implement the practice.

II.1. Include a Description of the Practice Including Theory Behind Practice and Principles of the Practice.

It is essential that manuals and workbooks describe the theoretical basis and principles of a practice (Hibbs et al., 1997). Moras (1993) believes that the most effective manuals are the ones that present the conceptual/theoretical underpinning of the treatment first and then present all the relevant technical aspects of the treatment.

★ EXEMPLARY ILLUSTRATIONS

The *Assertive Community Treatment of Persons with Severe Mental Illness* manual (Stein & Santos, 1998) explains the goals of services for persons with severe and persistent mental illness, the issues that make meeting such needs complicated, and how these goals and issues impact the theory behind the Assertive Community Treatment (ACT) practice.

ILLUSTRATION 4.

Theory Behind Assertive Community Treatment.

The goal of services for persons with severe and persistent mental illness is for that person to achieve a stable life of decent quality and to become involved in activities that promote meaningful community living. In the United States, as is true virtually elsewhere else, there has been little success in achieving this goal. There are still large numbers of persons who are unnecessarily admitted to hospitals repeatedly and live a poor quality of life between hospitalizations. They may live in isolation or have tenuous interpersonal relationships; they have little to do during the day that they see as useful; they often experience their lives as meaningless and chaotic; and their general health status is often inadequate.

Complicating the problem is the fragmented nonsystem of public mental health care that exists in the United States. Various community and hospital services operate as if others do not exist . . . In this nonsystem, even when all services are available, a few clients get more than they need, many clients get less than they need, and some get nothing at all. This nonsystem fails service recipients, frustrates families, and undermines the potential effectiveness of the professionals working in it.

The assertive community treatment (ACT) model was designed to provide a solution to this problem. ACT is best conceptualized as a service delivery vehicle or system designed to furnish the latest, most effective and efficient treatments, rehabilitation, and support services conveniently as an integrated package. It serves as the fixed point of responsibility for providing services to a group of individuals with severe and persistent mental illness identified as needing ACT services to achieve any of several desired outcomes (e.g., reduced use of “revolving door” hospital services, increased quality and stability of community living, normalizing activities of daily living such as competitive employment) . . .

Source: Stein & Santos, 1998, pp. 1-2.

Once the manual or workbook has described the theory behind the practice, it must clearly and concisely present the major principles of the practice. *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual includes a summary of the five fundamental principles of PACT: 1) being the primary provider of services and fixed point of responsibility; 2) providing services out of office; 3) providing highly individualized services to the consumer; 4) having an assertive, “can do” approach; and 5) meeting continuous long-term needs. Illustration 5 is a summary of one of the fundamental principles of PACT.

ILLUSTRATION 5.

Principle of PACT: Highly Individualized Services to the Consumer.

Individualization of treatment across clients and across time is fundamental to the PACT model given the great diversity among persons with severe mental illness and the fact that both clients and psychiatric conditions are changing. Individualized care can occur only if the staff put in the time to really know the person and his or her family. Treatment interventions are tailored to address the current needs and preferences of each individual rather than assigning clients in groups to “programs.” The content, amount, timing, and kinds of treatment, rehabilitation, and supports provided vary enormously among clients and for each client across time. Team service intensity (e.g., capacity to see a client two to five times a day in the community when the client is experiencing significant difficulties with symptoms or in life functioning) permits ongoing treatment to be carried out in the community and significantly reduces the use of hospitals.

Source: Allness & Knoedler, 1998, p. 3.

The summaries of the fundamental principles in the *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual are exemplary because they are informative about the vision behind PACT, but concise. *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual provides an explanation for each principle and describes what needs to take place in order for the principle to be carried out.

II.2. Include a Description of the Supporting Research.

In addition to providing the theory behind the practice and the principles of the practice, manuals and workbooks also should include a review of the supporting research for the practice. Torrey and colleagues (2001) conducted focus groups with clinicians and found that they must be convinced to adopt new practices. One of the factors that clinicians reported influenced them to adopt a practice is being aware of the research support for the practice. Illustration 6 is a table of supporting research included in the *Assertive Community Treatment of Persons with Severe Mental Illness* manual (Stein & Santos, 1998) manual.

EXEMPLARY ILLUSTRATION

ILLUSTRATION 6.
Supporting Research for Assertive Community Treatment.

CONTROLLED RESEARCH ON ACT				
Year	Site	Investigators	Illness Phase*	Clinical and Psychosocial Outcomes
1973	Madison, Wisconsin	Marx, Test & Stein	Unstable	ACT more effective (5 mo. trial) in reducing use of hospitals and ERs, in improving residential status, and in preserving occupational status.
1980	Madison, Wisconsin	Stein, Test & Weisbrod	Unstable	ACT more effective (12 mo. trial) in reducing use of hospitals; nursing homes, and law enforcement services; in improving residential status, socialization, instrumental functioning, and symptom profiles.
1983	Sidney, Australia	Hoult & Reynolds	Unstable	ACT more effective (12 mo. trial) in reducing use of hospitals; and ER's; in improving instrumental functioning, symptom profile, residential status, and occupational activity.
1985	Grand Rapids, Michigan	Mobray & Muldar	Stable	ACT more effective (30 mo. trial) in reducing use of hospitals; and law enforcement services; and in improving instrumental functioning and residential status.
1988	3 sites in Indiana	Bond, Miller, et al.	Stable	ACT more effective (6 mo. trial) in reducing use of hospitals in 2 of 3 sites.
1989	Santa Clara, California	Jerrell & Hu	Stable	ACT reduced use of hospitals and ER's. Improvements in functioning, and quality of life at 12 mo. no present at 24 mo.
1990	Chicago, Illinois	Bond, Witheridge, Dincin, et al.	Stable	ACT more effective (12 mo. trial) in reducing use of hospitals; and in improving instrumental functioning, satisfaction with life, and residential status.
1992	London, England	Marks, Muijen, Conolly, et al.	Stable	ACT more effective (20 mo. trial) for symptoms, social functioning; patient and family satisfaction, and reduced use of hospitals.
1994	London, England	Audinit, Marks, Laurence, et al.	Stable	ACT treated subjects in study above randomized into ACT or standard services with only significant difference at 45 mo. being increased family and patient satisfaction.
1992	London, England	Merson, Tyrer & Onyett	Unstable	ACT more effective than usual hospital and aftercare (3 mo.) regarding symptoms, satisfactions with services, and reducing use of hospitals.
1992	Madison, Wisconsin	Test et al.	Stable	ACT more effective (in first 2 of 12 year trial) in reducing use of hospitals and improving residential status.
1994	10 VA sites in Northeast	Rosenheck	Stable	ACT more effective in reducing use of hospitals (24 mo. trial).
1992	St. Louis, Missouri	Morse et al.	Mixed	For homeless sample, ACT more effective for satisfaction with program, number of days homeless, and use of community resources.
1992	New York, New York	McFarlane et.al.	Stable	ACT plus family psychoeducation more effective in reducing use of hospitals and facilitating and maintaining client employment.

* Phase of Illness at the point of recruitment into the study.

Source: Stein & Santos, 1998, p. 31.

The table in Illustration 6 is exemplary because it provides the information in an easy to read, but detailed table format. The table presents key information such as when the studies were conducted, the location of the studies, the investigators, the illness phase of the consumers at the point of recruitment, and what clinical and psychosocial outcomes were reported.

III. Elements to Predispose Providers to Set Up and Structure the Practice (How to Do It)

The elements in this section help program leaders to set up and structure the practice. In other words, the elements tell program leaders how to do the practice.

III.1. Include a Section on Eligibility/Admission Criteria.

It is important that a section on the eligibility for the practice or the admission criteria be included in manuals/workbooks. Rossi and Freeman (1993), Chambless and Hollen (1998) and others (Leff et al., under review) propose that practice eligibility and admission criteria should target those persons whose needs would best be met by the practice. At the same time, programs need to be careful about not stigmatizing people with its criteria and about not arbitrarily excluding people from the program.

Rossi and Freeman (1993), for example state “correctly defining and identifying [target population] is crucial to the success of interventions from the very early stage . . . to the extended period during which the program is authorized and implemented” (pg. 85). They note that targets are usually identified in terms of one or more of the following characteristics: social and demographic characteristics; location; and targets’ problems, difficulties and conditions (pg. 87). They also note that adequate target specification establishes rules as to who and what is included and excluded when the specification is applied.

There is also evidence that some practices are “condition-specific”; that is, they are more effective for some types of consumers than for others (The Schizophrenia Patient Outcomes Research Team, upcoming publication). This is another reason why it is important for manuals and workbooks to describe who is eligible for a practice. This information will let potential users assess whether or not the practice is appropriate for the intended population. Manuals and workbooks should be as specific as possible in describing the criteria for determining who is appropriate for the practice. It is also important that manuals and workbooks clearly identify any reasons why an intervention may not be suitable for certain persons or in certain situations. Medication manuals, for example, should specify that some patients may not be able to tolerate desired dosages or that some report adverse effects.

EXEMPLARY ILLUSTRATION

The manual *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) establishes some basic specifications for program participants. The manual states that consumers should be 18 years and older, with a major mental illness, and with an express desire to obtain paid employment (Becker & Drake, 1993: pg. 57).

The *Assertive Community Treatment of Persons with Severe Mental Illness* manual (Stein & Santos, 1998) provides more detail about who is eligible and not eligible for an ACT program. The manual includes three sets of requirements, and within the second set there are six sub-requirements. The illustration below shows how detailed ACT eligibility requirements are.

ILLUSTRATION 7. ACT Program Eligibility/Admission Criteria.

2. Other eligible individuals are those who have a major mental disorder, who by history of prognosis are likely to require intermittent acute intensive or prolonged intensive care (i.e., hospital inpatient or nursing home care), or are likely to live in a severely dysfunctional manner if ACT services are not provided, and who exhibit persistent disability or impairment in major areas of community living as evidenced by:

a. vocational impairment manifested by an inability to be consistently employed at a self-sustaining level, an ability to be employed only with extensive supports, or recurrent unemployment because of psychotic episodes, despite ability to earn sustaining income. . .

3. Individuals with a singular principal diagnosis of chemical abuse, organic brain syndrome, developmental disability, or personality disorder are not eligible. However, if a person has a primary diagnosis of a major mental illness and any of the above conditions as a secondary diagnosis, he or she will be eligible for ACT services.

Source: Stein & Santos, 1998, pp. 88-89.

Manual and workbook developers should bear in mind that more specificity is postulated to lead to better outcomes. This is because specific descriptions of practices increase the likelihood of a good fit between what consumers need and what the practice provides. It is important to note that if a practice is an evidence-based practice, the specificity is related to the researched group.

III.2. Include a Section on Boundaries: The Applicability or Use of Practice with Special Populations or the Need to Adapt a Practice.

Because people vary in their cultural characteristics and/or social context, practices appropriate for one group may need to be adapted to meet the needs of another. Practices have been modified for consumers who are from rural or frontier settings; who are members of racial, ethnic and cultural groups; who are homeless; or who use illicit drugs. Haynes, Kaholokula, and Nelson (1999) note that treatments that are evidence based differ in their effectiveness across

consumers because they differ in the degree to which they address each consumer's network of "idiosyncratic causal factors" (pg. 457).

Authors of manuals and workbooks should discuss the applicability or use of the practice with special populations or the adaptations needed to make the practice applicable to special populations.

Modifying practices to meet specific needs is consistent with the value that persons should have access to services. Modifying practices to meet specific needs in ways that do not compromise active ingredients, if known, also fits the theory and evidence that more targeted practices have better outcomes (Leff et al., under review). However, for many practices there is relatively little evidence about how group differences impact on practice efficacy, effectiveness, and safety, and how these differences can be addressed. At a minimum, there is a consensus that group differences should be assessed as a first step in responding to them (Leff et al., under review).

EXEMPLARY ILLUSTRATIONS

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual discusses key modifications and adaptations needed to implement effective programs in rural settings. Described are key differences between urban and rural ACT programs with regard to staff mobility, accessibility, communications, health expectations, attitudes toward treatment, means of transportation, and community resources.

Manuals and workbooks can utilize tables to illustrate modifications or adaptations needed to implement practices with special populations. Illustration 8 taken from the *Assertive Community Treatment of Persons with Severe Mental Illness* manual (Stein & Santos, 1998) shows how ACT programs differ from "traditional services" as well as how urban and rural ACT teams differ. The table shows that because of issues of accessibility and staff mobility rural ACT teams in contrast to urban ones: meet twice a week instead of daily; have staff available during the day time instead of 24 hours a day, seven days a week; and routinely contact consumers once a week instead of every one to three days (pg. 120). Rural ACT teams also differ by relying more on family members, the community and neighbors for providing services, medication monitoring and housing arrangements. In addition, family involvement in rural teams occurs less frequently and coincides with home visits.

Manuals and workbooks could draw a distinction between modifications supported by research and those that appear to make sense to those experienced with the practice. If modifications are done to the practice based on what makes sense, a plan is needed to evaluate the practice subsequent to the modification.

ILLUSTRATION 8. Modifications and Adaptations Needed to Adapt Practice.

TABLE 10-3

Differences between Traditional Services, Urban ACT, and Rural ACT

Service element	Traditional Services	Urban ACT	Rural ACT
Provider	individual clinician	team	team and community volunteers
Caseload Share	no	yes	yes
Caseload Size	1:50	1:10	1:10
Team Rounds	N/A	daily	twice weekly
Staff Availability	workday hours	24 hours/7 days	daytime only ^a
Site	clinics	field	field
Contact Frequency	every 1–3 months	1–3 days	once a week ^b
Family Involvement	occasional	frequent	coincides with home visit
Medication Monitoring	by family	by staff	by staff, family, neighbors, etc.
Housing Arrangements	by client and family	by staff	by staff family, neighbors, etc.
Case Management Function	broker of services	provider of services	broker and provider
Resource Mobilization	+ effort	++ effort	+++ effort

^a 24-hour-a-day telephone access-team is responsible for arranging emergency protocols^b difference in frequency due to differences in means and distances for transportation

Source: Stein & Santos, 1998, p. 120.

The next example is a tool that can be added to the assessment process to extend program boundaries to people of other cultures, race, ethnicity, etc.

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual includes as an appendix a Culturological History Form designed to obtain information about the consumer's culture and ethnicity, religious/spiritual beliefs and values, beliefs about mental illness and treatment, and problems that stem from racism or discrimination. The form also asks about cultural differences between consumer and staff. The form is used to collect information during the assessment phase and in the development of the comprehensive treatment plan. Illustration 9 is an excerpt from the Culturological History Form included in the *Assertive Community Treatment of Persons with Severe Mental Illness* manual (Stein & Santos, 1998) that shows questions related to racism and bias. The entire Culturological History Form is contained in Appendix C.

ILLUSTRATION 9. Inclusion of Cultural Competency in the ACT Manual.**Problems that Stem From Racism or Bias in Others**

1. Begin this discussion by demonstrating your understanding of how the mainstream culture oppresses people from the client's culture (e.g., an African American exhibiting the symptoms of mental illness is more likely to be arrested and jailed than taken to a hospital for treatment, etc.). Once the idea is established, ask, "Have you ever experienced prejudice, stigma, or negative reactions directed toward you because of your culture, race, gender, sexual orientation, etc.?"
2. Have you ever experienced prejudice because of being diagnosed with a mental illness, or have people related to you negatively because they know you are receiving treatment for a mental illness?
3. How have you dealt with these negative reactions?
4. Is there anything we can do to help minimize the stigma associated with receiving treatment?

Source: Stein & Santos, 1998, p. 207.

The manual *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook and Knox, 1994) provides an example of the process of “cultural mapping” intended to help NAMI affiliates extend their outreach services to African American and Hispanic families (pg. 17). The purpose of the cultural mapping is to become familiar with the characteristics of a community by visiting it to identify and record its resources and features. Once the cultural mapping is completed, a stranger to the community should be able to read the cultural maps and gain some sense of community residents, their lifestyles, common beliefs and behaviors, and use of social services (Cook and Knox, 1994). Illustration 10 is the cultural mapping exercise included in the *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook and Knox, 1994) manual.

ILLUSTRATION 10.

Inclusion of Cultural Competency in the NAMI Manual.

Creating a Cultural Map

1. On an actual map of the area, identify the boundaries of the community you are mapping. Pay attention to the possible existence of any areas within the community that have significance to community members (e.g., a business area, a high crime area). If such areas exist, note who lives there and what the area is called.
2. Next, try to identify as many organization (e.g., schools, churches, hospitals, mental health centers, clinics) in the community as possible. Locate each of these on your map. Describe what these organizations do and who runs them.
3. List the names and locations of many community leaders such as clergy/pastors, local minority legislators, city and county commissioners, business owners, school counselors/teachers/principals, agency directors, mental health professionals, musicians and other artists, and media specialists. What other leadership roles are evident in the community and who occupies these roles? How are these social organizations used by community members as resources? What needs do these formal organizations and leaders address?
4. What other, less formal patterns of social organization are evident in the community (e.g., ethnic clubs, fraternities/sororities, block clubs, gangs) and who controls them? How are these types of social organizations used by community members as resources? What need do these more informal organizations and leaders address?
5. What are some important businesses patronized by community members (e.g., grocery and clothing stores, beauty parlors/barber shops, restaurants, pharmacies, bars and night clubs)? Where are these located?
6. What are the prevailing beliefs expressed by members of the community? For example, do community members view mental illness and its causes differently from the larger culture? What kinds of symbols and ceremonies are used to expressed these beliefs? For example, are special community celebrations tied to ethnic holidays or significant events (such as Dr. Martin Luther King Day or Cinco de Mayo)? How are these values related to people with disabilities, particularly people with mental illness? How are these values related to families, especially relatives of persons with mental illness?
7. What shifts in wealth or political power have occurred historically and in the more recent past? Can these changes be expected to continue? What are their implications for people with psychiatric disabilities and their families? How has this community responded to changes that also have occurred in other nearby communities?
8. What kinds of social services are available in the community (e.g., public welfare, food stamps/WIC, public housing, mental health clinics, drug treatment facilities)? Are any of these social service agencies staffed primarily by people of color? How do community members utilize social services? What alternative sources of assistance (churches, indigenous healers, community elders, midwives, block clubs, sororities/fraternities) are available in this community and how are these utilized? Pay particular attention to this last piece of information because these sources may be crucially important in any effort to outreach people of color.

Source: Cook & Knox, 1994, pp. 17-18.

The process of cultural mapping described in the *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook and Knox, 1994) manual is designed to help affiliates learn more about the community they are targeting. Cultural mapping is also a useful tool for planning outreach strategies to be utilized with different communities.

In an upcoming toolkit from the Evaluation Center@HSRI, *Measuring Conformance to Treatment Guidelines: The Example of the Schizophrenia PORT*, the authors provide an example of how to distinguish between what is known and not known.

ILLUSTRATION 11.

Example on How to Distinguish Between What is Known and Not Known.

A word on the cultural competence of the PORT Treatment Recommendations is warranted. The recommendations do not address appropriate variations in treatment due to cultural, racial or ethnic factors because insufficient scientific data are available of these issues. The recommendations summarize appropriate care for the average consumer with schizophrenia who took part in the scientific studies reviewed . . . Should you use the recommendations, indicators, measures, and standards as provided or should you modify them to take into account cultural, racial, and ethnic factors?

Our advice is as follows:

1. Consult the bibliography at the end of this toolkit as well as any other sound scientific studies that you have available to determine if there is substantial evidence for making a change based upon demographic factors.
2. If strong evidence exists, then it may be appropriate to make adjustments to the methods for assessing quality. ADHERE TO GOOD EVIDENCE-BASED STANDARDS! One potential example is the need to lower the recommended dosing ranges for antipsychotic medications for consumers of Asian heritage.
3. If the evidence is not compelling, do not make a change. While important variations exist due to culture, race, and ethnicity, there are many more similarities than differences among people. Schizophrenia exists as a brain disorder in all cultures. Comorbid depression occurs in all groups. Most consumers are in active contact with their families. Most consumers want to be socially and vocationally productive. For these reasons the recommendations themselves are likely to hold for most groups.
4. Cultural, racial, and ethnic variations are more likely to apply to the development of specific indicators and measures for the recommendations. For example, the recommendations on family interventions emphasize that families have access to information about the illness, support, crisis intervention, and assistance with problem solving. The translation of these elements of an effective intervention for families will likely vary across demographic subgroups. The quality improvement program can take these into account in defining what types of family services meet the treatment recommendation in a given locale or consumer subgroup. These would be adaptations to the *measures* of conformance to the recommendations, *not changes in the recommendations themselves*.
5. Keep in mind that while harm can be done by ignoring cultural, racial, and ethnic differences in response to treatments, and hence the standards for quality of care, harm can also be done by assuming that different standards of care should exist for different subgroups. Hopefully, we will be better informed about these issues in the future.

Source: The Schizophrenia Patient Outcomes Research Team, upcoming publication, pp. 4-5.

III.3. Include a Section on the Relationship to and Importance of Other Services in Service System to Manualized Practice.

Individuals in the community utilize multiple types of services. It is important that authors of manuals and workbooks include a section on the relationship of the manualized practice or intervention to other services a client might be receiving and to also include a discussion of the importance of other community based services.

EXEMPLARY ILLUSTRATION

Included in the *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual is a discussion of the how the ACT team must ensure that there is good coordination among all agencies that provide services to clients. This entails working with agencies such as the Visiting Nurse Services that traditionally have not been a provider of services for clients who suffer from mental illnesses.

ILLUSTRATION 12.

The Importance of Coordinating Services.

There are many public agencies that advertise themselves as providing services to the citizens of the community, but never anticipate that they might be asked to provide those services to psychiatric clients . . . The agency will, in all probability, initially require education and support from the ACT team. We cannot emphasize too strongly that agency cooperation is not obtained by simply demanding it. Staff must provide sufficient support and education to those agencies in order to gain their cooperation.

As an example, until a few years ago the Visiting Nurse Service (VNS) of Dane County, Wisconsin, had virtually no psychiatric clients on its caseload. Now these nurses are working with a number of psychiatric clients with medical need; they change dressings, provide help to clients with diabetes, etc., and in so doing provide support to clients in their homes. Thus, the VNS has become a valuable asset to the Dane County mental health system. When VNS was first approached, they were not jubilant about the thought of doing what they are now quite happy to do. They said, “We really don’t know much about treating psychiatric clients and will probably do them more harm than good. Our staff does not have proper training.” Clearly their anxiety was overdetermined. They needed support, education and assurance. They were told that an ACT staff member would accompany their staff member until their staff felt comfortable without the presence of an ACT team member coming along with them. Further, they were told that once they got to know the client as a person, they would feel comfortable working with him or her and do a competent job. They agreed and were given the support and on-the-job training they needed. Within a short time they were comfortable enough to serve clients without the presence of an ACT staff person. An added bonus is that the VNS has become a strong advocate for community treatment. The ACT team has had the same experience with other agencies that have not had experience with seriously mentally ill people. Once they get to know the clients and work with them over a period of time, prejudices or myths that they might have had evaporate.

Source: Stein & Santos, 1998, pp. 79–80.

This illustration is exemplary because it provides an example that emphasizes the need for cooperation between a manualized practice and another service agency and describes strategies for obtaining it. These entailed the ACT team staff providing support and education to the Visiting Nurse Service in order to gain their cooperation.

III.4. Include a Section on Roles: Staffing Descriptions/Duties and Responsibilities.

It is essential that manuals and workbooks identify the key staff persons needed to carry out a practice. Staff members fill diverse roles. Some carry out the administrative and support functions of the practice, while others are engaged in providing direct care. It is important to know who is responsible for what aspect of the practice and the skills and knowledge they require to carry out their responsibilities. Logic dictates that practices require persons with appropriate skill sets and understandings of the practices in administrative, direct care, and support positions. Organizational theory and evidence from organizational studies suggest that role clarity enhances organizational performance and morale. In the human services this can be expected to reduce “burn-out” and staff turnover.

EXEMPLARY ILLUSTRATIONS

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual describes the duties and functions of individual members of the ACT team which consists of: support staff; the secretary/receptionist; social worker; nurse; psychologist; vocational specialist; drug and alcohol use specialist; and a psychiatrist. Notice that the list includes not only direct care staff but also support staff and a secretary/receptionist. The manual goes into detail as to the importance of the secretary, as the only team member who is in the office at all times and who acts as an interface between the team and the rest of the community. The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual also specifies desirable characteristics of individual team members.

An Appendix in the *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual provides position descriptions that include summaries of the responsibilities of each staff person and details as to their principal duties and responsibilities. The position descriptions also include the required education, experience, and knowledge for each staff position. Illustration 13 is the position description for the Team Leader/Supervisor included in the *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual.

ILLUSTRATION 13.

Description of Team Leader/Supervisor in PACT Manual.

Job Title: Team Leader/Supervisor.

Summary

The team leader establishes, administers, and directs the Program of Assertive Community Treatment (PACT), a self-contained clinical team which assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified clients with severe and persistent mental illnesses; supervises and evaluates the multidisciplinary team in conjunction with appropriate psychiatric support to ensure service excellence and courteous, helpful, and respectful services to program clients; and functions as a practicing clinician on the team.

Principle Duties and Responsibilities

Direct the day-to-day clinical operations of the PACT team including scheduling staff work hours to assure appropriate coverage for day, evening, weekend, and holiday shifts and on-call hours; lead the daily organizational staff meetings and treatment planning meetings; continuously evaluate the status of clients and do appropriate planning and coordination of treatment activities to ensure immediate attention to their changing needs.

Direct and coordinate the client admission process and treatment, rehabilitation, and support services of the program in coordination with the psychiatrist. Schedule the admission interview; develop and coordinate the initial assessment and initial treatment plan; assign the most appropriate staff to the individual treatment team (ITT); and provide clinical supervision of the development of the comprehensive assessment and the treatment plan for each client.

Direct and coordinate, for each client, the comprehensive assessment of psychiatric history (e.g., onset, course and effect of illness, past treatment and responses, and risk behaviors), mental status, and diagnosis; physical health, and dental health; use of drugs or alcohol; education and employment; social development and functioning; activities of daily living (e.g., self-care, living situation, nutrition, money management); and family structure and relationships.

...

Education, Experience, and Knowledge Required

The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation, or psychology, or is a psychiatrist; is licensed or certified according to the laws of the state in which the program is operating; and has strong clinical skills and experience providing treatment to persons with severe and persistent mental illnesses. Supervisory and program management experience is desirable. The person in this position must have a clear understanding of the characteristics and problems of adults with severe and persistent mental illnesses and be knowledgeable about the PACT model.

Source: Allness & Knoedler, 1998, pp. 123-124.

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual is exemplary in describing the role of both direct and non-direct care staff. The PACT manual provides exemplary illustrations of how to describe job responsibilities and requirements.

III.5. Include a Section on Training, Consultation and Supervision Requirements/Recommendations.

As previously noted, manuals alone are seldom sufficient for successful adoption of a practice (Chambless and Hollon, 1998). Usually they will need to be supplemented by additional training and supervision. Calhoun et al. (1998) outline several goals which training and training materials facilitate: an understanding of the theory beyond the practice; an acquisition of specific intervention skills associated with the practice (including when to use them); and acquisition of general skills needed to perform ongoing evaluations of the effectiveness of practice. The authors point out that manuals should include the information needed to facilitate the training goals cited above. They also note that different levels of training might be needed in order to obtain treatment competence.

With experienced therapists, training which includes both didactic seminars and supervised “practice” cases has been shown to promote more consistent provision of treatment, even with a single training case (Carroll, 1997). Piper and Ogrodniczuk (1999) found that initial training, ongoing supervision, and a weekly group seminar where taped session material was played and cases discussed enhanced adherence to therapy manuals. Illustration 14, taken from the *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual, provides an example of the need for training and consultation in order to support adoption of the practice.

EXEMPLARY ILLUSTRATIONS

ILLUSTRATION 14. Section on Training and Consultation from the ACT Manual.

Providing Sufficient Training and Access to Case Consultation

The difficulty and complexity of treating persons with severe and persistent mental illnesses require that staff be provided with considerable initial and continuous training, as well as access to trainers for case-specific consultation. Despite the fact that many staff have advanced degrees, in general professional training programs do not include courses in ACT in their curriculum. Therefore, it is important to have access to training dollars specifically for ACT training and consultation. These may include several full days of intensive training prior to project start-up, intermittent booster training sessions, consultations via conference calls with ACT experts, and on-site supervision from and ACT expert.

Source: Stein & Santos, 1998, pp. 132-133.

This illustration emphasizes the need for initial and ongoing training, case-specific consultation, and funding specifically allocated for various types of training (e.g., intensive initial training, subsequent booster sessions and consultation with experts).

Illustration 15, from the *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual, explains who is responsible for clinical supervision and how it should take place.

ILLUSTRATION 15.

Section on Supervision from the PACT Manual.

Clinical Supervision

The team leader shares with the psychiatrist overall responsibility for monitoring clinical status and response to treatment for each client as well as supervising delivery of clinical services to maintain a standard of service excellence and courteous, helpful, and respectful services to program clients. In addition, the team leader is the manager of the team. He or she carries out staff recruitment, interviewing, and hiring; schedules work hours; conducts annual performance evaluations; approves leave requests; and provides staff orientation and training.

The team leader and the psychiatrist are practicing clinicians on the team, know all of the clients, and work directly with clients and staff. Therefore, clinical supervision (i.e., continuous review of the status of each client to ensure appropriate services are provided) and assistance to the staff (to increase the staff's knowledge and skills in providing services) are provided in the context of the team's day-to-day work with individual clients as follows:

- The team leader and the psychiatrist participate in the daily organizational staff meetings to monitor each clients' clinical status and response to treatment, assess and provide feedback regarding staff performance, and give direction to staff regarding individual cases to ensure good clinical practice.
- The team leader, with the participation of the psychiatrist, leads the treatment planning meetings and supervises individual treatment teams in developing and reviewing written treatment plans. To supervise treatment planning, the team leader must master the technical and analytical aspects of individualized treatment planning.
- The team leader and the psychiatrist provide individual, side-by-side supervision to assess performance; give feedback; and model interventions by accompanying individual staff members to meet with clients in regularly scheduled or emergency meetings.
- The team leader and the psychiatrist are regularly available at office headquarters or by beeper or cellular phone to consult with team staff members.
- The team leader also may schedule regular meetings with individual staff members to review cases, evaluate performance, and give feedback.

The lead mental health professional and the lead registered nurse may, when designated by the team leader, provide clinical supervision in collaboration with the team leader and the psychiatrist in the manner outlined above and when the team leader is absent (e.g., on vacation).

Source: Allness & Knoedler, 1998, pp. 37-38.

III.6. Include a Section on Administration.

The administrative aspects of implementing a practice are essential to success. These include upper-level support such as funding, as well as the day-to-day management of financial, human and physical resources. Therefore, it is important that manuals and workbooks provide details on administrative aspects of implementing a practice.

EXEMPLARY ILLUSTRATION

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual includes a chapter that discusses administrative aspects of conducting the ACT practice. The manual makes clear that in order for ACT clinical services to fully succeed, they must have a supportive administrative environment. Several administrative principles are essential to the successful development of ACT programs: the philosophical and instrumental commitment of agency director; the recruitment of staff with the requisite characteristics; provision of sufficient training and access to case consultation; and commitment to positive interagency relations and coordinated care.

As examples of how manuals may address administrative issues, this chapter includes a discussion on financing ACT programs and current controversies for program administrators. The two current controversies for program administrators, which are interrelated, are the proper population of consumers that ACT should serve and the length of stay of consumers in the program. These two issues are usually debated prior to program start-up and often require administrative guidance and policy clarification. The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual describes a typology used by the Dane County system in Wisconsin to determine which consumers in the system require an ACT team.

III.7. Include a Section on Facility Design.

Appropriate facility design is a program component that is important for both consumers and staff. It is expected that attractive and functional spaces can contribute to consumer self-esteem and functioning. Facility décor that reflects a consumers' culture can make consumers more comfortable with seeking care (Center for Mental Health Services; Walks & Jackson, 1999). The facility design should support staff functions, morale and health status. Staff who work in an environment that is thoughtfully designed are likely to be more productive.

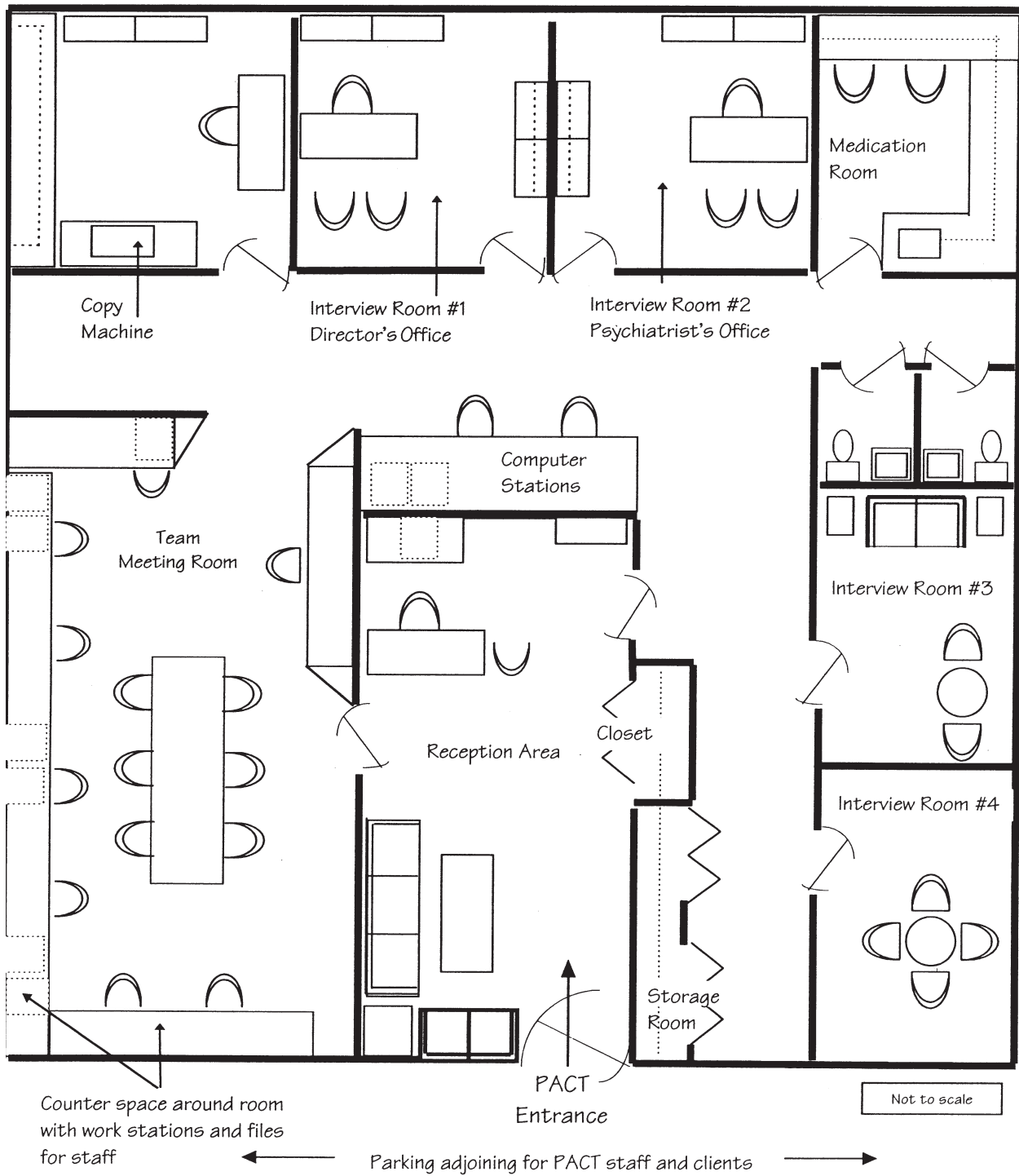
EXEMPLARY ILLUSTRATION

The *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual describes the PACT Headquarters. The manual notes that the headquarters should be in a convenient central location that is accessible directly from the street. Inside, consumers and family members should be able to immediately reach the team's reception area.

The *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual describes the layout of the PACT headquarters office as "nontraditional" (pg. 23). Central to the layout is a large common work area that allows for a free flow of conversation and ideas. This work area is also the place where phone calls are made and where record keeping takes place. In addition to the work area, the headquarters should have three to four shared interviewing offices to be used when meeting with consumers and families, a reception area, a medication room, a space for the temporary storage of consumers' possessions, a space for office machines and supplies, and parking spaces for staff. The manual also describes how the meeting and medication rooms should be furnished. The exemplary feature of this illustration is that it provides, in addition to detailed descriptions of the room, recommended floor plans for the headquarters overall and the medication room. These are shown on the next pages.

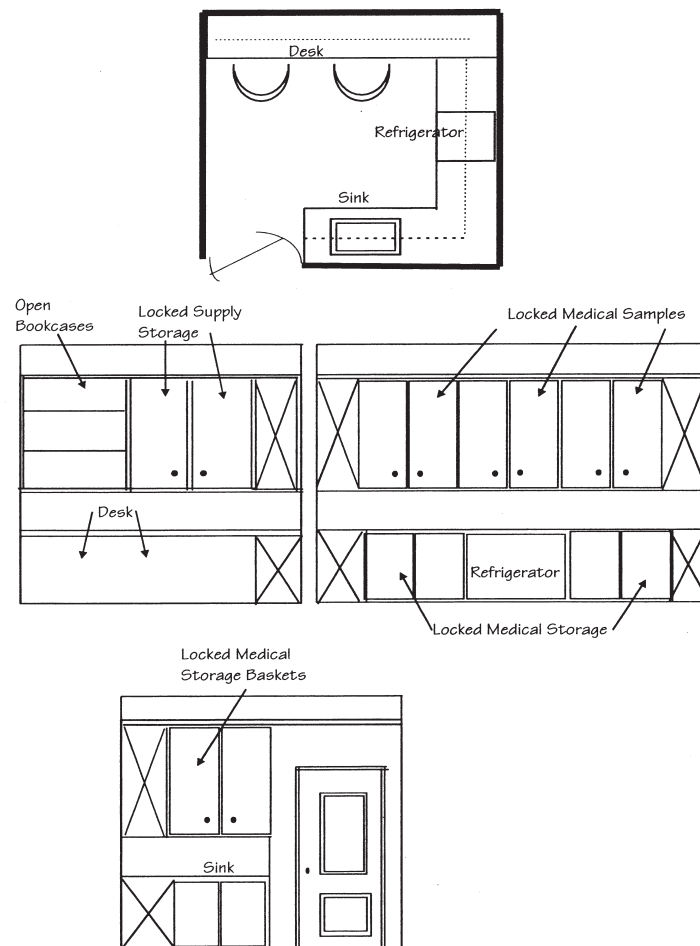
ILLUSTRATION 16:
PACT Floor Plan

Figure 3-2: Floor Plan of the PACT Headquarters



Source: Allness & Koedler, 1998, p. 24

Figure 3-3: The PACT Headquarters—Medication Room



Source: Allness & Koedler, 1998, p. 25

Where appropriate, illustrations of program features such as the office layouts make the manual less dense and easier to absorb. Illustrations also make the manual and workbook more attractive to readers, thus encouraging them to pay closer attention to details. In this case, an illustration helps readers to better visualize the facility layout.

III.8. Include a Section on Provider to Consumer Ratios or Total Caseloads, Required to Provide Services Included in the Practice.

Appropriate provider-to-consumer ratios and caseload sizes are essential to the delivery and intensity of services called for by a practice. Meeting staffing requirements for providing services as prescribed should contribute to staff morale. There is also evidence that recommendations for provider-to-consumer ratios and caseload sizes incorporated in fidelity measures are associated with improved outcomes (McGrew, Bond & Dietzen, 1994).

EXEMPLARY ILLUSTRATION

The manual for the *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness* (Hodge & Giesler, 1997) includes a section that sets staffing levels for three levels of case management. The three levels are defined in terms of the intensity of the case management service and the type of person who would benefit most from the particular case management level. The manual is clear about what should determine the appropriate provider-to-consumer ratio, namely anticipated consumer needs. The prescribed ratio increases as the appropriate level of intensity of the case management services decreases. The manual notes that an organization has administratively separate levels, with case managers serving only persons in a particular level. An acceptable modification, however, is to incorporate all three case management levels in one organizational approach. Illustration 17, from the *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness* (Hodge & Giesler, 1997), presents in table format prescribed provider-to-consumer ratios for the three levels of case management.

ILLUSTRATION 17.
Provider to Consumer Ratios and Total Caseloads.

	Level I CM	Level II CM	Level III CM
Caseload/Mode	No more than 13 persons per case manager. Except in rural areas practiced in teams for 24-hour coverage and mutual support, but caseload may be assigned to individual case managers or team as a whole. Always includes one full or part-time nurse and psychiatrist per team. Best practice: Job specialist and housing specialist included on team. In vivo practice with an average of 4 contacts per week.	20-25 persons per case manager depending on needs of persons served. Practiced in teams except in rural areas. Caseloads are individual. Best practices: Single psychiatrist and nurse for caseload of team, job specialist and housing specialist included on team. Range of contacts per month 4-11 based on individual need.	60-80 persons. Usually individual practice with some team features. i.e., group supervision, vacation backup. Largely office practice. Collaborates with medication service. Available for crisis prevention/intervention. 40 hours per week with back-up arrangements at other times. Average 4 face-to-face and 8 telephone contacts per year.

Source: Hodge & Giesler 1997, p. 31.

As noted in Illustration 17, above, provider to consumer ratios can also be dependent on other factors such as the context (e.g., rural versus urban area) within which the service is provided.

III.9. Include a Section on Specific Service Components or Approaches Comprising the Practice.

Chambless and Hollen (1998) and others emphasize that treatment manuals should provide a clear and explicit description of the techniques and services that constitute a practice. It is important that manual and workbooks clearly identify specific service components or “active ingredients” comprising practices.

EXEMPLARY ILLUSTRATIONS

The manual *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook & Knox, 1994) describes components of the process of moving towards cross-cultural awareness. The authors paraphrase the five points in this process identified by Green (1982): 1) awareness of one’s own cultural limitations; 2) openness to cultural differences; 3) willingness to learn from people of other cultures; 4) ability to utilize cultural resources; and 5) acknowledgement of cultural integrity. The authors note that the points noted above are some of the ingredients of cultural sensitivity and cultural competence. The manual also includes an exercise that helps people understand how the points discussed above relate to a person’s culture and ethnic group.

The *Schizophrenia PORT Treatment Recommendations Final Version* (September 30, 1996) specifies a number of interventions persons with schizophrenia should receive. It also provides a rationale for each recommendation and the level of evidence for each recommendation. The seven interventions covered by the Schizophrenia PORT are: 1) antipsychotic interventions; 2) adjunctive pharmacotherapies for anxiety, depression, and aggression/hostility; 3) electroconvulsive therapy; 4) psychological interventions; 5) family interventions; 6) vocational rehabilitation; and 7) community support interventions. The Schizophrenia PORT is exemplary in several respects. First, it provides a map of what interventions should be done initially and what other intervention should follow if the first one does not work out. Second, it provides a rating for the level of evidence for most interventions as well as a qualitative description of the evidence to support its recommendations. The PORT investigators adopted the criteria for levels of evidence which was utilized in the development of the AHCPR Depression Guidelines which are: Level A- good research-based evidence, with some expert opinion, to support the recommendation; Level B- fair research-based evidence, with substantial expert opinion, to support the recommendation; and Level C- recommendation based primarily on expert opinion, with minimal research-based evidence, but significant clinical experience. Illustration 18 was taken from the *Schizophrenia PORT Treatment Recommendations Final Version* (September 30, 1996) manual.

ILLUSTRATION 18.

Strategies for Implementing General Principles of a Practice.

Recommendation 17: Person who experience persistent and clinically significant associated symptoms of anxiety, depression, or hostility, despite an adequate reduction in positive symptoms with antipsychotic therapy, should receive a trial of adjunctive pharmacotherapy. A trial of benzodiazepine or propranolol is merited for persistent anxiety. An antidepressant trial should be considered for persistent depression. Adjunctive therapy with lithium, a benzodiazepine or carbamazepine should be considered for persistent hostility or manic-like symptoms. The reasons for the absence of such trials for appropriate patients should be documented. Certain adjunctive medications should be avoided in patients currently receiving clozapine to avoid synergistic side effects, for example, respiratory depression with benzodiazepine and bone marrow suppression with carbamazepine.

Rationale:

Anxiety: Anxiety and tension may respond to treatment with adjunctive *benzodiazepines*, although a few studies reported a waning effect of these agents, perhaps due to tolerance, after a few weeks of treatment.

Hostility: Disruptive, dangerous or assaultive behavior may be modified by the addition of *benzodiazepines* or *carbamazepine* to an antipsychotic regimen. Evidence of the usefulness of *benzodiazepines* for this indication comes from open or retrospective studies, and no double-blind studies have thus far addressed this. Similarly, these behaviors are cited as being potentially responsive to adjunctive *carbamazepine* by all reviewers, although most evidence is from open studies with only one positive double-blind study. Excitement and irritability (often classified as “affective symptoms”) appear to benefit from adjunctive *lithium* treatment, with a small amount of evidence that *benzodiazepines* and *carbamazepine* also might be useful.

Depression: *Antidepressants* appear to benefit patients who have episodic signs and symptoms of depressive illness in addition to schizophrenia, if they are administered in phases of illness other than the active, psychotic exacerbation phase. Antidepressants can be efficacious without exacerbating psychotic symptoms when used adjunctively with antipsychotics.

Most studies of adjunctive treatments for schizophrenia were done with patients who had chronic schizophrenia, and who were often designated as treatment-refractory. Little is known about the efficacy of adjunctive agents for first episode schizophrenia, for patients experiencing acute episodes of psychosis, or for stable patients receiving maintenance antipsychotic therapy. Little is known about the long-term effectiveness of adjunctive agents.

Review Reference: pp. 6-2 to 6-46.

Level of Evidence: B

Recommendation 18: Persons who experience persistent and clinically significant positive symptoms despite adequate antipsychotic therapy, including trials with the newer antipsychotics (clozapine or risperidone), should receive a trial of adjunctive pharmacotherapy as described in Recommendation 17.

Rationale: No adjunctive agent has demonstrated clear and consistent benefit to a majority of persons with schizophrenia. However, the most promising agents are the *benzodiazepines* (which can be useful in as many as 50% of patients with schizophrenia), *lithium*, and *carbamazepine* (which may be of mild or modest value to treatment non-responsive patients). Very little evidence supports a role for adjunctive *propranolol*. *Valproate*, *calcium channel blockers*, *antidepressants*, *clonidine*, and *dopaminergic* agents have no demonstrated utility in terms of global improvement, although they may be useful for individual symptom complexes. Positive symptoms may improve when *benzodiazepines*, *carbamazepine*, *lithium*, or *propranolol* are added to antipsychotics. Adjunctive *benzodiazepines* produced significant improvement of positive symptoms in about half of the double-blind studies that addressed this question. Adjunctive *carbamazepine* produced significant improvement in only a fraction of double-blind studies. Adjunctive *lithium* appears to alleviate, to some degree, positive symptoms in a subgroup of patients. Finally, there is only slim evidence of a therapeutic effect of adjunctive *propranolol* on positive symptoms in a minority of double-blind studies.

Review Reference: pp. 6-2 to 6-46.

Level of Evidence: C

Source: *Schizophrenia PORT Treatment Recommendations*. Final Version (September 30, 1996), p. 14-15.

III.10. Include a Section on Program Costs, Financing and Financial Management.

Program planners need to know what programs will cost and how they can be financed. Programs also need to do budgetary planning and cost control to stay fiscally solvent.

Manuals and workbooks should provide a general description of the cost of running a program and a step-by-step guide to arriving at the costs. They should explain how regional differences need to be considered in planning for costs and revenues. They should also describe how different revenue streams (e.g., Medicaid) can be tapped to pay for practices. This information can be used in fiscally managing a practice.

EXEMPLARY ILLUSTRATIONS

The *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual points out that the major cost of the practice is for qualified personnel, which includes both salaries and fringe benefits. In order to arrive at the cost of serving PACT consumers and to plan for financial and clinical success, administrators need to first determine: the number of team members that need to be employed by disciplines; the percentage of staff time (i.e., billable service hours) during which staff can see and treat consumers; and the program's indirect costs necessary to support the clinical staff. Once the above information is collected and decisions are made, then it is possible to compute the cost of providing services.

Illustration 19 is a spreadsheet included in the *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual that illustrates the cost of running a PACT program in Madison, Wisconsin. Also included in the manual are the directions for determining staff hourly rate.

Illustration 20 discusses funding issues that ACT programs face and what financing changes have taken place that have helped in their implementation.

ILLUSTRATION 19.
Program Costs .

Figure 11-1: PACT Staff Direct Hourly Rate Determination Staffing Costs to Serve 130 Clients

Staff Position	Salary & Fringe	Direct Service FTE	Direct Service Salary & Fringe	Total Hours	Vacation & Sick Leave Hours	Available Hours	¹ Billable Service Hours Percent	Billable Service Hours	Direct Service Cost per Hour	Indirect Cost per Hour	Total Cost per Hour
MD- Program Director	\$140,257	0.6	\$84,154	1,248	192	1,056	70%	739	\$189.74	\$26.01	\$215.75
RN	56,071	1	56,071	2,080	264	1,816	67%	1,217	46.08	\$26.01	72.10
RN	56,071	1	56,071	2,080	264	1,816	67%	1,217	46.08	\$26.01	72.10
RN	56,071	1	56,071	2,080	264	1,816	67%	1,217	46.08	\$26.01	72.10
RN	56,071	1	56,071	2,080	264	1,816	67%	1,217	46.08	\$26.01	72.10
RN	56,071	1	56,071	2,080	264	1,816	67%	1,217	46.08	\$26.01	72.10
OTR	47,057	1	47,057	2,080	264	1,816	64%	1,162	40.49	\$26.01	66.50
Lead Clinician	45,339	1	45,339	2,080	264	1,816	50%	908	49.93	\$26.01	75.94
Mental Health Profession	45,339	1	45,339	2,080	264	1,816	50%	908	49.93	\$26.01	75.94
Mental Health Profession	45,339	1	45,339	2,080	264	1,816	50%	908	49.93	\$26.01	75.94
Mental Health Profession	45,339	1	45,339	2,080	264	1,816	50%	908	49.93	\$26.01	75.94
Mental Health Profession	45,339	1	45,339	2,080	264	1,816	50%	908	49.93	\$26.01	75.94
Mental Health Profession	45,339	1	45,339	2,080	264	1,816	50%	908	49.93	\$26.01	75.94
Paraprofessional	37,568	1	37,568	2,080	264	1,816	35%	636	59.11	\$26.01	85.12
Subtotal		13.6	721,168	28,288	3,624	24,664			14,069		

Indirect Service Rate Determination^{2,3}

MD-Program Director (.4 FTE)	56,103
Comm Placement SPI (.6 FTE)	24,995
Program Assistant	40,147
Program Assistant (.2 FTE)	8,332
Insurance	1,120
Post/Supplies	26,000
Telephone	4,200
Training/Conf	2,000
Travel	33,980
Other (medical, client services money)	136,100
Rent/Util/Maint	22,000
Subtotal	\$354,997
Total	\$1,076,145

Notes:

¹ Actual costs for October 1995 projected for 12 months.

² Administrative costs from PACT proposed budget for 1996.

³ Administrative costs include PACT research personnel who would not be a part of the regular program start-up.

Indirect Rate Determination=Indirect Costs/(Direct Service Hours x (1 minus turnover rate))=\$354,977/(17,490 (1 minus .03))=\$26.01
Source: Allness & Knodler, 1998, p. 109.

ILLUSTRATION 20.
Financing an ACT Program.

Public Policy and Financial Support

A primary reason for the incomplete dissemination of ACT throughout the United States is the inertia of the existing systems of community and hospital care. Financing streams, which have both shaped and been shaped by the historical emphasis on hospital and office-based care, have not been altered to facilitate and thus promote the provision of ACT-based care. No third parties provide specific coverage for ACT. Only under Medicaid can a portion of the cost of ACT be recouped through the insurance mechanism. Even for Medicaid-covered populations, the considerable start-up costs of launching an ACT program, combined with the state share of Medicaid expenditures, represent barriers to state mental health agencies interested in its development. Although Medicaid has modified its rules so that it covers some ACT practices, it is essentially a fee-for-service arrangement and does not cover many crucial ACT services. The financial strategy that best fits an ACT model is one where the program is funded using a modified capitated system, for example, an ACT program would be funded to provide services for a hundred clients. The staff would then be able to do whatever was necessary to help the client without having their activities shaped by whether what they did was reimbursable service.

Broad dissemination of ACT within a state cannot occur without the support of state agencies responsible for the care of the population targeted. The broad dissemination of ACT in several states has been the result of the recognition of its effectiveness by the state-level human service directors, who have initiated policies and incentives to spur statewide development. New and reallocated state funds have been directed toward the development of ACT programs and Medicaid coverage (for which the majority of individuals in the needs of these services are eligible) has been specifically tailored to the program models. . .

Source: Stein & Santos, 1998, pp. 133-134.

III.11. Include a Section on Recommendations for Promoting Change in Practice Settings.

Simply making information about new practices available does not result in their adoption. The implementation and success of practices requires knowledge of organizational strategies for promoting change in settings (Senge, 1990). More specifically, changes in practice require support from the top-level administrators and other caregivers who are in positions to facilitate or thwart new practices. These individuals must change their behavior and influence others in ways that modify the organizational culture. Practice manuals should address strategies for changing the organizational cultures of practice settings.

EXEMPLARY ILLUSTRATION

The manual *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook and Knox, 1994) specifies how NAMI promoted change by creating a national program with the primary objective of increasing the participation of persons from diverse racial and ethnic backgrounds in NAMI. The Illustration below shows why promoting change in NAMI was necessary and what strategies were adopted by NAMI.

ILLUSTRATION 21.

Promoting Organizational Change in NAMI Affiliates.

Adoption of minority outreach as a goal of NAMI. A final reason for minority outreach efforts by affiliates is that the national organization of NAMI has adopted and officially encourages such efforts among its membership. In 1984, at the urging of its membership, NAMI prioritized outreach to minority families coping with mental illness and established an ethnic minority concerns committee to accomplish this goal (Kane, 1984). The committee identified several barriers to participation of families of color in NAMI. One of these was limited economic resources preventing potential members from joining the organization, attending support group meetings, and participating in local and national conferences. Another barrier consisted of stigma attached to minority status coupled with mental illness, leading to reluctance among some relatives to publicly acknowledge a family member's mental illness. Also identified was a lack of cultural sensitivity within NAMI to the special needs of ethnic minorities with lower levels of formal education and less familiarity with a self-help group format and organizational structure.

To address these issues, the memorandum suggested the development of a national program under the auspices of NAMI. The primary objective was to increase ethnic minority participation in NAMI and its affiliates. This was to be achieved by employing more ethnic minorities in the national office, by including outstanding people of color as plenary speakers at national meetings, by creating culturally sensitive brochures in English and Spanish, and by sponsoring press releases and public service announcements on ethnic television and radio stations. In essence, this national program required that the NAMI board and membership acknowledge the importance of ethnic minority participation, recognizing the potential of minority group members to enhance the organization through increasing its membership and broadening its perspective.

Source: Cook & Knox, 1994, pp. 5-6.

III.12. Include Case Examples.

The purpose of case examples in manuals and workbooks is to facilitate the discussion of key principles of the practice. Torrey et al. (2001) found in focus groups with clinicians that compelling vignettes influenced them to adopt new practices.

★ EXEMPLARY ILLUSTRATIONS

Through our review we identified two uses of case examples in manuals. One approach is to use case examples to practice problem solving. The manual *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook & Knox, 1994) uses case examples to help NAMI affiliates do outreach planning. The case examples consist of vignettes with “typical” problems faced by affiliates who attempt to reach out to racial and ethnic communities. The manual notes that reading and discussing the vignettes will help affiliates clarify which components they want to include in their project, as well as potential barriers that affiliates may need to overcome. Illustration 22 shows how manuals can utilize case examples to strategize about the issues.

ILLUSTRATION 22.

Case Example for Strategizing.

Case #4: Your small city affiliate has been trying to start a minority outreach program for about four months. You have started a monthly lecture series on minority issues. Affiliate members have posted signs announcing each month’s speaker and topic at various mental health agencies around the city in the hope that a wide range of people would attend. This is not working out as planned because no minorities have attended the first four lectures.

What is your next step?

What barriers are you facing?

What are you going to do next?

Source: Cook & Knox, 1994, p. 30.

The other use of case examples is for illustrative purposes. Illustrative case examples provide details about a practice. Throughout the *A Working Life: Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual case examples are provided to illustrate aspects of the practice. Illustration 23 shows how the *A Working Life: Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual utilizes a case example to illustrate the process of obtaining employment.

ILLUSTRATION 23.

Illustrative Case Example from IPS Manual.

Example #5: Paul

Paul dresses carelessly in badly fitting, mismatched clothes. His hair is scraggly and dirty, he is usually unshaven, and he walks with an odd, hesitant shuffling gait. When he talks, it is in a very quiet voice without emotion and with no eye contact. He is 32 and has been in a tailspin since his mother died two years ago, drinking more heavily and showing severe symptoms of schizophrenia for which he is taking medication.

He is a client at a small community mental health center which assigns each client to a treatment team that manages all aspects of his treatment. After a review of Paul's case, the team decided to refer him to IPS. When meeting with the employment specialist Paul was reluctant but compliant, and expressed more interest in cooking at a restaurant, a job he held for a year when he was 22.

Paul and Tim, the employment specialist, began eating lunch several times a week at a local restaurant which Tim felt was a good prospect. Tim made a point of chatting with the owner, talking about downtown business in general and the restaurant in particular.

He introduced Paul to the owner but did not mention that Paul was a client. His purpose was to simply establish a connection with the owner and to let the owner become familiar with Paul. Tim knew that Paul's appearance would tend to put people off on first encounter. He felt that his regularly appearing with Paul in the restaurant would help the owner see Paul less as a patient with mental illness and more as an individual.

After a few weeks Tim approached the owner with the possibility of paying Paul to work for a few hours for purposes of assessing his skills and work habits. The owner agreed, and afterward offered a candid evaluation of Paul, saying that Paul lacked the necessary speed but seemed to have an adequate knowledge of cooking.

As the weeks went by, Paul began to take a little more interest in the possibility of working, and Tim arranged to have him work for several days as a cooks' helper in a group home. Although the pace there was slower, it was still too much for Paul, who seemed to need three hours to do an hour's worth of work.

But now Paul began actively looking for jobs. He started taking a little more care with his appearance. Still, his emotional flatness and disheveled look seemed to prevent him from finding a job for several months. In the spring, however, Tim found a job opening for Paul at a summer camp for people with mental impairments, and Paul landed that job. The job went well, and the employer was able to give Paul a good reference when the camp closed at summer's end.

It wasn't until December, however, that Paul found another opening, this time for a cook at a nursing home. Tim wrote a cover letter introducing Paul and speaking of his work experience, but making only vague reference to his mental illness, at Paul's request.

The first visit was successful, and the director of the nursing home called Paul to schedule an interview. For the first time in the nine months he'd been working with Tim, Paul showed some excitement. He got a haircut and bought a tie. Tim tied the tie for him, and he took it home that way so all he'd have to do in the morning was slip it over his neck.

After the interview, the director called Tim and asked for an explanation. He was interested in Paul, but put off by his peculiar, detached manner. Tim downplayed Paul's mental illness, again, because that's what Paul wanted, and emphasized his dependability and skill.

"To put it simply," said Tim, "I told the Director that Paul cooks a lot better than he interviews." Paul got the job and did well. He continued to need quite a bit of support outside of the job, which the treatment team made sure that he got.

Source: Becker & Drake, 1993, pp. 31-32.

The narrative illustrates the strategies utilized by the employment specialist which include making judgments about how much to push Paul versus remaining in the background and letting Paul do the work, developing strategies for establishing connections with potential employers, and enabling Paul to gain real work experience in a kitchen. *A Working Life: Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual demonstrates that the essential strategy for finding a job is to simply meet and talk with people. The employment specialist does the work by building networks and constantly deepening and expanding them.

Case examples should portray diversity in clinical areas such as in diagnoses and in demographic ones such as gender, ethnicity and racial backgrounds of consumers. Case studies may be particularly useful in communicating to persons such as consumers, politicians, and advocates who may be more concerned about the outcomes of mental health programs than their technical aspects.

The *Personal Assistance in Community Existence (PACE)* (Ahern & Fisher, 1999) manual developed to reach consumers and express a consumer perspective, utilizes actual cases to illustrate points of its practice. Illustration 24 is a case example describing two young men who had many of the same issues such as early trauma, substance abuse, and psychiatric symptoms, but who took two different approaches to treatment. The case illustration shows how their respective approaches to treatment led to different results. The case example from the *Personal Assistance in Community Existence (PACE)* (Ahern & Fisher, 1999) manual is presented in a relaxed, story-like style that engages the reader.

ILLUSTRATION 24.
Using Actual Cases for Case Example.

A Tale of Two Boys

This is a tale of two boys- two young men to be completely truthful. One is well known to me-the son of a close friend of mine- we'll call him Jack. And the other, well, he is not so well known to me- only through a few anonymous phone calls to the National Empowerment Center. We'll call him Karl. (The names have been changed for this tale to protect the innocent, and I'm sorry to say the not so innocent anymore). And for anyone who might wonder, this is a very true tale.

Once upon a time, there were two wonderful, happy, smart young men. Both were in college, living on their own—testing the waters—testing themselves. New friends, new freedoms, new loves, new ideas, new temptations—new everything. Both had the world at their feet and were limited only by their own imaginations of what their lives might be about, might become. Then crash.

Well, as I said, Jack is a child I have known for his entire lifetime. I watched him grow inside his mother, I watched him take his first steps and say his first words. I watched and I'm still watching.

Karl I met just months ago- via the NEC 800-line. Karl I don't know—yet I do. The parallels between these two young men are eerie- yet the outcomes so different—so frighteningly different.

Crash, crash, crash. It seems to happen at that age, doesn't it? Eighteen to mid-twenties. And it happened to Jack and Karl.

Jack was at a college in New England and Karl was in school out on the West Coast. I remember when Jack was fifteen years old, he and a friend were car-jacked at knife-point. Even though they caught the man- and he was sentenced to seven years in prison- Jack never seemed to quite get over it. He would not stay alone in his house at night, always locked his car doors no matter where he was going, and would not travel without a cell phone.

When Karl called me at NEC, he told me about a time when he was an exchange student in high school, how he had been held up- mugged- alone in a foreign country—and had never been so terrified in his life.

I tell you these things for a reason.

Jack had always wanted to be a journalist, and Karl told me that music has been his passion as long as he could remember. Both had such high hopes, such big dreams. Only one dreamer remains. The other dreamer died with his dreams when was labeled “mentally ill.”

Each experimented with drugs for the first time in college- Jack went to a concert and tried LSD. Karl started smoking marijuana with the band he formed in college. Pandora's box was now open. Paranoia and fear tickled in, replacing logic. Men were after them, people were talking about them. They could not sleep, they could not eat. Fear was the dominating factor in their lives. The drugs were gone, the high was over, the trip had ceased- but the demons remained.

Jack called home and Karl's friends called his parents. This is where the road divides. This is where the similarities end. This is where one has a breakdown and the other has a breakthrough.

Jack's mother knew he was frightened. She told him to leave college and come home. She felt she needed to help him feel safe again—the only way to bring him out of this deep paranoia.

Karl's parents told him to come home. They too knew that he was frightened and needed help. They brought him to the best psychiatrist. He was hospitalized. He was medicated. He was told he had a chemical imbalance of the brain. He was labeled. He was told that college was too stressful for him, he could never return. He tried to commit suicide. He lived, but his dreams, his dreams died.

Jack's mother and friends stayed home with him, listened to his fears. He went off caffeine, ate healthy foods and took long, warm baths. He had acupuncture, massages, and found a therapist who did not label him. They took walks together, they talked. Slowly, very slowly, he felt safe enough to come back. And then they worked on why he left, why this reality was so frightening that he needed to leave it in the first place.

Jack- well, Jack is back living at college. He started working out and volunteers in a home for mentally retarded adults. He told me several things since his breakthrough: “This is the most painful thing I have ever experienced in my life and I would not wish it on anyone—but I would not change a thing. Better I deal with these issues now than wait until I'm forty of fifty. I feel stronger than I ever have. I've learned so much about myself, I still have fears but I control them—they no longer control me.”

Karl called me after he walked home from his last day at the day treatment program. “I saw a sign on a restaurant window—they were looking for a dishwasher. Do you think I could handle that?”

I cried.

—Laurie Ahern

Source: Ahern & Fisher, 1999, pp. 24-25.

III.13. Include Illustrations.A

We believe that manuals and workbooks that include graphic illustrations can present some points more clearly and reach certain populations better. More specifically, it seems likely that graphic illustrations have greater power to capture attention and motivate behavior. This possibility is expressed in the maxim “one picture is worth a thousand words.”

EXEMPLARY ILLUSTRATION

The manual *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook & Knox, 1994) includes an excerpt from the fotonovela “Que Le Paso a Ricardo?” (“What Happened to Ricardo?”). This excerpt is presented on the following page. The authors note that knowledge about informal aspects of communications can be useful in planning the development of culturally sensitive materials. They recommend utilizing “*fotonovelas*” with Latinos because in Latin America many adults read them. Fotonovelas can be adapted and used to educate Latinos about mental illness, types of treatment and rehabilitation services, and where to go for support. The excerpt that follows is about a young man named Ricardo who suffers from a mental illness. The young man’s mother is seen telling her mother how concerned she is about her son who she thinks is not improving despite attending therapy and being on medication. The mother decides to seek the help of a *curandero* or natural healer. The mother goes to the natural healer for an herbal remedy. When the mother gives the son the herbal remedy he is seen thinking to himself “I knew it — they want to poison me!”

Illustrations can make a manual more interesting to read and make certain points easier to understand. The illustration on the next page is exemplary because it illustrates in a graphic and culturally sensitive way the point that treatment for mental illness in some Latino families might combine traditional and non-traditional techniques.

ILLUSTRATION 25: A
NAMI Excerpt of FotonovelaA

Excerpt from "Que Le Paso A Ricardo?"



Source: Cook & Knox, 1994, pg. 9a

III.14. Include Flowcharts/Logic Models and Algorithms.

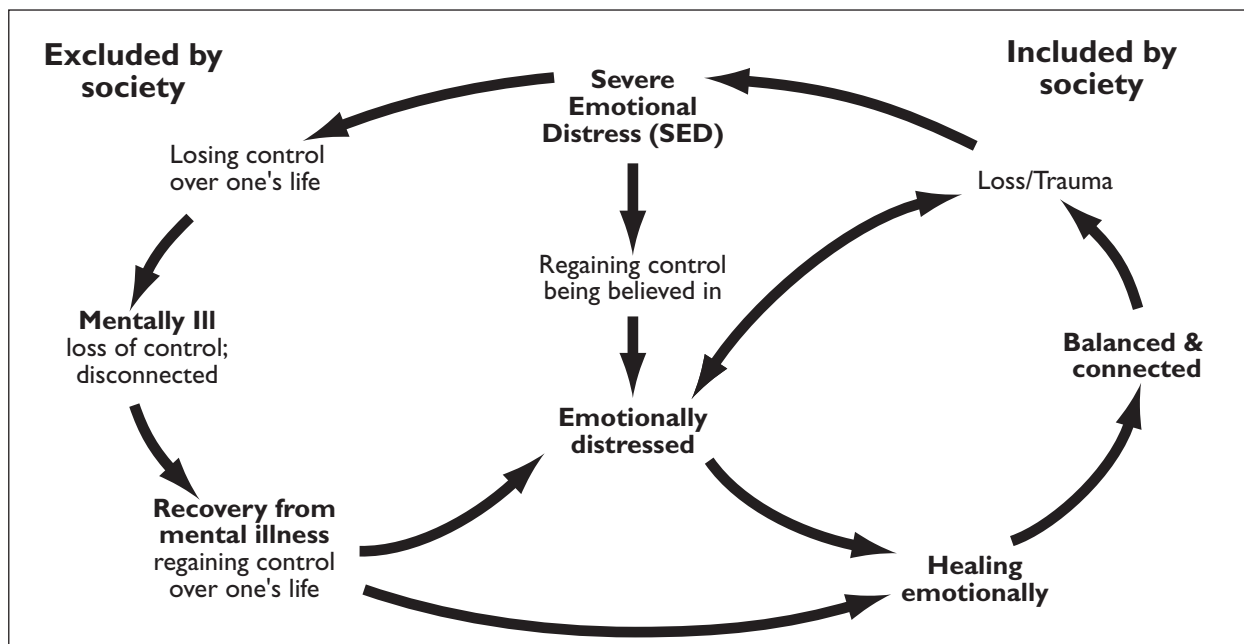
Flowcharts and logic models provide diagrammatic representations of the service processes embedded in practices. In a related manner, algorithms present the discrete steps in making a decision or providing a service. Medication algorithms, for example, are intended to guide clinicians in the selection and trial of medications. Flowcharts, logic models, and diagrams of algorithms are other examples of graphic materials that we believe capture attention, and are helpful in understanding and motivating behavior. Consumers may achieve better outcomes when services adhere to logic models and algorithms for efficacious and effective practices.

EXEMPLARY ILLUSTRATION

The *Personal Assistance in Community Existence* (PACE) manual (Ahern & Fisher, 1999) contains a flowchart that describes the practice model of recovery. The flowchart, presented on the next page, describes each step in the process through which people are first labeled as mentally ill and then recover.

ILLUSTRATION 26. A
PACE Flowchart A

PACE is based on the Empowerment Model of Recovery



Empowerment Model of Recovery from Mental Illness

by Daniel B. Fisher, M.D., Ph.D. and Laurie Ahern
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EXEMPLARY ILLUSTRATION

Individual medication treatment plans may result in better outcomes for consumers. The *Texas Implementation of Medication Algorithms (TIMA)* identifies treatment steps, which guide physicians in determining medication treatment plans.

The *(TIMA): Schizophrenia Procedures Manual, TIMA Physician Manual* (Miller et. al., January 2000) presents the schizophrenia algorithm in a form suitable for posting on a wall, which makes it very accessible and consequently more likely to be followed. The reader can then refer to the manual for a more detailed discussion of the algorithm.

ILLUSTRATION 27. A Medication Algorithm in TIMA Manual.A

AT-A-GLANCE

SCHIZOPHRENIA MEDICATION ALGORITHM

Visit Frequency: Weekly until stable when changing medications. No less often than every three months when stable.

Assessment Frequency: One at each visit.

Duration of Treatment: At least three weeks at therapeutic doses with new antipsychotic (three months with clozapine). (See CDP flow sheet).

Response: Stages 1-4, positive symptoms score less than or equal to 6. Negative symptom score less than or equal to 12. See manual for stages 5, 5a, and 6 discussion of partial response.

Criteria for Medication Change: Persistent positive or negative symptoms or unacceptable side effects (see manual for discussion).

Evaluations: At each visit an MD assessment of core symptom severity, overall functional impairment, other symptoms. Algorithm Coordinator assessment using brief positive and negative symptom scales and patient global self-rating of symptom severity and side effects.

Medication Switching: Unless the clinical situation dictates the need to abruptly stop the 'old' medication, taper it over 1-3 weeks (or longer), while titrating the dose of the 'new' medication.

Medication Doses: Doses outside of the recommended ranges should have a chart note indicating the reasons for going outside the range.

Source: Miller, et al., January 2000, p. Algorithms 2-3.

III.15. Include Checklists- Exercises and Assessments. A

Checklists provide individuals with tools for reviewing important actions or components in a practice and recording their completion. In instructional situations checklists elicit active learning by requiring learners to rehearse steps or assess whether criteria have been met. An example is Appendix E of this toolkit, which is a checklist for developing a manual for a practice or intervention.

★ EXEMPLARY ILLUSTRATION

Keys to Quality: Conducting a Performance Improvement Project for Behavioral Health in Managed Care Based on the Principles of QISMC (SAMHSA, Office of Managed Care, October, 2000) is a workbook designed to provide technical assistance to persons conducting or reviewing behavioral health quality improvement (QI) projects in managed care. The workbook provides a checklist of steps needed to plan a quality improvement study. Within each step are sub-tasks that need to be carried out and criteria that should be met. The checklist includes boxes so that readers can check off sub-tasks or criteria as they are addressed. The authors also include a comment section for users to document qualifications or considerations pertaining to items in the checklist. An excerpt from a checklist included in the *Keys to Quality: Conducting a Performance Improvement Project for Behavioral Health in Managed Care Based on the Principles of QISMC* (SAMHSA, Office of Managed Care, October, 2000) workbook follows.

ILLUSTRATION 28. A Checklist.A

Step 3: SELECT PERFORMANCE INDICATORS AND MEASURE THAT ADDRESS IMPORTANT IMPACTS AND HAVE A DESIRED SCIENTIFIC PROPERTIES.A

- ☐ 3.1 **Public payers and MCOs** contribute to selection of performance indicators (QISMC standard)
- ☐ 3.2 Performance indicators are **objective, clearly defined, evidence based** (QISMC standard)
- ☐ 3.3 Indicators measure changes in **health status, functional status, satisfaction or valid proxies** (QISMC standard)
- ☐ 3.4 **Process measures are used** as proxies for outcomes **only when validity has been established** in literature or by expert consensus (QISMC standard).

Source: *Keys to Quality: Conducting a Performance Improvement Project for Managed Care Based on the Principles of QISMC Quality Improvement Systems for Managed Care (QISMC)*.

III.16. Include Sample Plans or List of Components. A

Program or treatment plans are key ingredients for the implementation of a practice. There are two types of plans that a manual can include: 1) components needed to carry out program planning; and 2) details on how to plan for the treatment of individuals. Program developers need instruction on how to plan practices. Program staff need instruction on how to create individual service plan for consumers that realize the practice. Logic dictates that manuals providing planning guidance will result in more efficacious and effective practices.

EXEMPLARY ILLUSTRATIONS

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual includes guidelines on how to plan a new ACT team. The manual indicates the steps that should be taken in order to start a new team. Some of the steps include: 1) hiring the team leader and then other staff (e.g. part-time psychiatrist, nurse, and a clinician); 2) finding a well functioning ACT program willing to have the staff visit to see firsthand how an ACT team operates and to establish a consultative relationship with the team leader; 3) making available resources to meet the physical requirements of the team (e.g. adequate space, telephones, office furniture, office equipment, etc., development of forms and record system); 4) accepting consumers (at a rate not to exceed five, at most six per month); and 5) hiring other team members such as the secretary and a drug and alcohol treatment specialist and a vocational specialist, depending on the needs of the consumers admitted to the program.

The *Personal Assistance in Community Existence (PACE)* manual (Ahern & Fisher, 1999) includes the components of the PACE recovery plan for consumers. The recovery plan tells the consumer what he or she has to do to be an agent in the process of recovery. Illustration 29 illustrates how individuals are expected to plan in order to be active in their recoveries.

ILLUSTRATION 29. A Program Plan.A

The PACE Recovery PlanA

1. What you do for yourself: self-help, coping, healing

Recovery at your own pace

- a. Believing in one's capacity to recover through use of self-help manuals, tapes, and videos by people who have recovered, on topics such as coping with voices
- b. Dreaming dreams of what one most wants
- c. Developing one's own plans for exercise, diet, meditation, biofeedback, visualization, self-care
- d. Exploring self-expression through writing, music, arts, dance
- e. Cultivating a personal spirituality, philosophy, and/or religion

Source: Ahern & Fisher, 1999, p. 28.

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual is exemplary in how it goes about giving details for planning for an ACT program. The manual has a section titled "Guidelines for Starting a New ACT Team" containing many details about initial planning steps such as: the importance of consulting with existing ACT programs when staff are hired and once the program is operating; the need to accept consumers at a slow rate in order to have a great deal of time available for consumers and because the assess-

ment and treatment planning activities are very time consuming; and to analyze the need for additional staff based on the needs of the admitted consumers as well as the availability of the needed staff.

The PACE Recovery Plan is helpful in showing how consumers can be instructed in planning for their recovery. Direct care staff can be taught to plan with consumers by similar descriptions of desired planning processes.

III.17. Include Sample Assessment Forms or List of Assessment Items. A

Key to planning services for a consumer is knowing the needs of the consumer. Manuals and workbooks should include sample assessment forms or a list of assessment items for planning and providing adequate consumer services.

EXEMPLARY ILLUSTRATION

The manuals we reviewed offer a great variety of assessment forms. We were struck by those in the *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual. The IPS assessment form links the assessment to the intervention and to outcomes. For each objective, the form lists an intervention, staff person responsible, the date the objective is achieved and what the achievement was. Illustration 30 is an example of the assessment form in the *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual.

ILLUSTRATION 30. A Sample Assessment Form.A

ppendix III. Individual Employment Plan

Overall Vocational Goal: A to work in a competitive job in the computer field using my typing skills and interest in computers.

Date: A/9/92

Objective 1: A seek a job that will use my clerical skills and will have opportunities for computer work.

Intervention: A meet with J. Conway at least weekly to identify job leads. Update resumé. Attend job interviews as scheduled.

People Responsible: A Jill Conway, employment specialist.

Target Date: 12/9/92

Date Objective Achieved: A 1/15/92 Employed at Miller and Associates for data entry. 10 hrs/wk at \$5/hr.

Objective 2: A stay on my medication as a way to help me keep a job.

Intervention: A attend medication group (led by T. Williams) and work group (led by J. Conway) at least 2x/mo each to discuss how medication affects my ability to work. Meet with case manager and psychiatrist at least 1x/mo.

People Responsible: A Helen Howard, psychiatrist; Tom Williams, case manager; Jill Conway, employment specialist.

Target Date: A/9/93

Date Objective Achieved:

Source: Becker & Drake, 1993, pp. 77-78.

III.18. Include Sample Schedules for Staff and Consumers.A

The effective and efficient use of staff requires knowing consumer needs and staff responsibilities and making sure that staff schedules are consistent with both. This can be a complicated task in the case of community support programs that provide services for more than 8 hours a day, 5 days a week. We believe that manuals are helpful in this regard if they provide guidance for and examples of schedules both for staff and consumers.

EXEMPLARY ILLUSTRATIONS

The *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual includes sample staff and consumer schedules. Illustration 31 is the example included in the manual of staff work schedules/time sheets. The authors note that sometimes competing criteria must be satisfied when scheduling staff. They also point out that schedules need to accommodate unexpected staff absences as well as variations in the skills of the individual staff. The manual specifies who should be responsible for creating the schedules: initially the team leader and then the program assistant. Time off is inserted into the routine schedule and adjustments are made to maintain minimum coverage. The majority of the staff is assigned to peak hours (i.e., daytime weekdays), with the entire staff rotating to cover evening, weekends, and holidays. Staff schedules are posted in a place accessible to all staff.

ILLUSTRATION 31. A Staff Schedule.A

Figure 3-1: Example of Staff Work Schedule/Time Sheets

PACT STAFF WORK SCHEDULES

Week of: July 21-July 27, 1996

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
FTE Psych Nurse		1:30-10				11:30-8	10-6:30
FTE Psych Nurse		8-4:30		8-4:30	8-4:30		
FTE Psych Nurse	D0	8-4:30	8-4:30	8-4:30	1:30-10	8-4:30	D0
FTE Psych Nurse	10-6:30	D0	8-4:30	1:30-10	VAC	VAC	D0
FTE Psych Nurse	D0	8-4:30	1:30-10	8-4:30	8-4:30	8-4:30	D0
FTE Psych Nurse	D0	8-4:30	1:30-10	8-4:30	8-4:30	8-4:30	D0
FTE MH Prof.	D0						D0
FTE MH Prof.	D0	VAC	VAC	VAC	8-4:30	10-6:30	D0
FTE MH Prof.	D0	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	D0
FTE Occ. Therap	D0	8-4:30	8-4:30	8-4:30	DO	11:30-8	10-6:30
FTE MH Prof.	D0	8-4:30	8-4:30	8-4:30	1:30-10	8-4:30	D0
FTE MH Prof.	D0	8-4:30	8-4:30	1:30-10	8-4:30	8-4:30	D0
FTE MH Prof.	D0	1:30-10	8-4:30	8-4:30	8-4:30	8-4:30	D0
FTE MH Prof.	D0	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	D0
FTE Paraprof.	10-6:30	8-4:30	8-4:30	8-4:30	8-4:30	DO	D0
FTE Prog. Asst.	D0	7-3:30	7-3:30	7-3:30	7-3:30	7:3:30	D0
.2 FTE Prog. Asst.	D0	8-12			8-12		D0

Source: Allness & Knoedler, 1998, p. 20.

Illustration 32 is of a weekly consumer schedule included in the *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual. The consumer schedule is a written schedule of the specific interventions or service contacts the consumer will have. The schedule is practical in that it is placed on a five by eight index card, making it easy to carry around. It is written in pencil so that changes can be easily made. Schedules are stored in a central location so that every team member will be able to readily assess what services consumers will be receiving in a given week.

ILLUSTRATION 32. A
Consumer Schedule.A

Figure 6-3: WEEKLY CLIENT SCHEDULE

ITT: N. Wiley, R.N.. L. Richter, MD, A. Panser,							
Name: <u>Karen Landry</u>				Staff: <u>RN, G. Dalton, MSW</u>			
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
M	8 am call to prompt to follow parenting schedule	8 am call to prompt to follow parenting schedule	8 am call to prompt to follow parenting schedule	8 am call to prompt to follow parenting schedule	8 am call to prompt to follow parenting schedule	8 am call to prompt to follow parenting schedule	8 am call to prompt to follow parenting schedule
	11:30 am Wiley 1:1 for SX and SE assessment grocery store	10:30 am Dr. Richter at PACT q 2 week	11 am Wiley from social services ADL contact	10:30 am Dalton vocational contact at PACT			
PMA			Lab work at GML on own		12:30 Panser bring 7 day meds and ADL contact at home		
	5-7 work rec dept. (Goes on own)		5-7 work rec dept (Goes on own)	7 pm enhancement parenting class (ride)			

Source: Allness & Knoedler, 1998, p. 52.

III.19. Include a Section on Components of Service Records or Sample Medical Records and other Administrative Databases/Record Keeping. A

Service records are used to record information about a consumer's mental illness, assessment results, treatment plans, actual treatment or services received and progress towards recovery. Records need to provide enough information to communicate a consumer's service plan to the staff responsible for implementing it and to monitor the quality of the care that is delivered.

EXEMPLARY ILLUSTRATION

The *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual describes the process for reviewing each consumer's status and most recent staff contact. This review takes place during a daily organizational morning staff meeting attended by all PACT team members who are on duty. Illustration 33 is the description of the review process.

ILLUSTRATION 33. A

Review of Consumer Status and Outcome of Most Recent Staff Contact.A

Step 1: The Client ReviewA

With all staff present and listening, one of the team members reads the alphabetically organized log of client contacts and activities, referred to as the *daily log* or *cardex* (see Figure 4-1). After a client's name is read, the member who saw the client the previous day reports on the client's status and his or her response to the service contact. Team members who are not at the morning meeting but who worked the previous day have entered brief summaries of their work in the log so that the information can be communicated to the members of the team on duty. Information from the on-call staff from the previous night should also be reported.

All team members are free to add information, make comments, and initiate discussion. Team members who do not usually see the client can ask questions so that they can function effectively when they are called on to assist him or her. They also may offer a perspective not recognized by those who work with the individual more frequently. Clients who are reported as needing more attention are allocated more discussion time until a course of action is established. The staff person assigned to read the log also writes brief notes in the log regarding the information presented and then moves on to the next client.

The team leader and the psychiatrist can make sure that sufficient discussion occurs and that the meeting is well paced to end on time. Both of these supervisory staff solicit information and opinions from the staff, present their clinical perspectives, and focus discussion when immediate action is necessary to help a client. When a problem requires more consideration than the meeting time allows, the team leader will suggest a separate meeting of the client's individual treatment team later in the day. At the end of the client review, the team leader and the psychiatrist should have a good sense of how all the clients are doing and be able to pinpoint actual or potential problems that must be monitored throughout the rest of the day.

The daily reading of the log and discussion, as just described, is the primary process to fine-tune and carry out each client's treatment plan so that it meets his or her day-to-day needs. This client review also makes it possible to determine when a treatment plan needs substantial revision and to assign team members immediately to make necessary changes, rather than waiting until the plan is due for review.

Source: Allness & Knoedler, 1998, p. 31.

III.20. Include a Section on Start-up Experiences. A

When setting up a new practice *program developers* may experience many of the same issues faced by other developers. Manuals and workbooks should include a section that details experiences faced by new programs. The manual and workbook should also provide possible solutions or answers to the problems or barriers faced.

EXEMPLARY ILLUSTRATION

The manual *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) includes a chapter on “Problems and Questions” that staff and clients in new IPS programs frequently raise. These range from questions pertaining to the employment specialist and the treatment team to questions specific to the client. Illustration 34 is an excerpt from this section of the IPS manual.

ILLUSTRATION 34. A Problems and Questions Faced by New IPS Programs.A

What if the employment specialist gradually takes on too much responsibility for the client?A

Because of her active role, the employment specialist may tend to deal with a wider and wider range of issues in the client’s life. And the client may naturally come to the employment specialist for help and advice on aspects of his life beyond employment. But this defeats the point of the treatment team. Each member must know the boundaries of his area of expertise, and know when to share concerns with another team member. Team meetings should be used to clarify ambiguous situations.

What if the treatment team develops conflicts over approaches to treatment?A

For many people, the concept of work as treatment is not easy to understand, and that understanding comes gradually and only after months and months of watching things work. Conflicts are inevitable. One advantage of the IPS model is that these can be resolved in team meetings so the client doesn’t suffer as a result of the misunderstandings that develop between staff. Resolving differences about treatment often leads to better understanding of the goals of the program.

When the client seems to go through the motions of getting a job, but doesn’t follow through, what can be done?A

What the employment specialist expects or wants a client to do must fit with what the client is able to do. But, on the other hand, the expectations of the employment specialist often push the client slightly. Find out what the client is afraid of. Adjust your approach to help overcome that fear in small steps.

Source: Becker & Drake, 1993, p. 69.

III.21. Include a Section on Common Difficulties, Obstacles, or Problems thatA Occur When Conducting the Practice. A

When conducting a practice certain common difficulties, obstacles, or problems may occur. In order to help those implementing the practice best deal with these, manuals and workbooks should identify what they might be and offer some recommendations for how to deal with them (Moras, 1993; Hibbs et al., 1997).

Calhoun et al., (1998) note that early versions of manuals often failed to provide strategies for engaging consumers who are noncompliant with the practice. The authors emphasize the need for general training in coherent, theoretically relevant responses to vexing clinical problems. Castonguay and colleagues (1999) point out that future manuals could (and should) address the following difficulties that often confront clinicians: hostile consumers, consumers who are unable to control self-destructive patterns, consumers who are unwilling to accept personal responsibility for the impact of their actions on others, and consumers who are resistant to change.

EXEMPLARY ILLUSTRATION

A section of the *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual discusses linkages with local vocational rehabilitation offices. The authors point out the ways that the vocational rehabilitation approach sometimes is at odds with the goals of IPS, which can create complications for program staff and consumers. Illustration 35, taken from the *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual, shows some of the ways of working with local vocational rehabilitation offices.

ILLUSTRATION 35. A Dealing with discrepancies between interventions.A

While IPS sees work as part of the ongoing treatment program for a client, VR professionals often see a client's ability to find and hold permanent work as a goal, an end result of successful treatment and training. VR staff tend to measure success by the number of people they don't see again, in other words, permanent placements. And the IPS people tend to feel that they are successful when clients are spending more time working and less time in the hospital or otherwise troubled by symptoms or other difficulties. The approach and even methods may be different, but the goal is the same—helping consumers to find and hold jobs, thereby increasing their independence and self-esteem.

As you begin to plan for your IPS program, you should consider ways of building a relationship with VR, a relationship that will emphasize the understanding of shared goals rather than poor communication and work done at cross-purposes. Involve VR early on. Arrange for a VR counselor to meet with clients regularly so that she can be familiar with their progress and their needs. Add the expertise and knowledge from the established VR system to the work your employment specialists are doing with consumers. You'll find that there will be many ways to use the training and funding available for your consumers, and that a productive relationship can open up many opportunities otherwise unavailable.

Source: Becker & Drake, 1993, pp. 51-52.

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual outlines three examples of how ACT staff can deal with common problems that arise when carrying out the practice. The problems are: keeping consumers from dropping out of the program, focusing on consumers' strengths; and relating to consumers as responsible citizens. Illustration 36 is an excerpt from this section of the ACT manual.

ILLUSTRATION 36. A
Problems Which Arise in Practices.A

Keeping Clients from Dropping Out of the Program A

ACT programs must be assertive in keeping clients involved. If someone does not show up for an appointment or for a job, it will be highlighted to be discussed at the daily meeting. The person who has a good relationship with the client at that moment in time (it might or might not be the primary contact person) is given the assignment of going out and finding the client. The staff person may have to go to his home or drive along the street where the client frequents. When he is found, he is invited to go for a cup of coffee (the staff person will be willing to pay for it) where the staff person tries to learn why he missed the appointment and to find out from the client how the ACT program can help him make his appointments in the future. The client may insist that he wants no help and that the ACT team should just leave him alone. The staff then acknowledges that the client appears angry with the team and then tries to find out what is bothering him. This must be done in a nondefensive manner. The staff person may say that the ACT team really wants to be helpful and that, if the team offended the client in some way, the team would like to know what happened and to explain or, if the situation warrants it, apologize. The staff person stresses that the team wants to be of continued help. The main message, given over and over is that the team really does care about what happens to the client and is there to help the client. The client may respond by saying he doesn't want any help from the team. The staff person responds by saying he understands that is how the client is feeling today, but he will be back tomorrow to check in with the client.

Source: Stein & Santos, 1998, p. 100.

Manuals and workbooks should have readily identifiable sections devoted to common obstacles, difficulties and problems. These discussions should make program staff aware of the likelihood of encountering certain problems, but also provide them with strategies for overcoming these problems. As much as possible, these strategies should be individualized to the types of problems commonly encountered in that particular practice.

IV. Elements to Help Program Leaders Maintain and Extend Gains

It is essential that elements that help program leaders to maintain the practice and extend the gains made by the practice be included in manuals and workbooks. Some of the elements that help maintain a practice and extend the gains are: having fidelity measures, simple outcome measures and designs, and a quality improvement process.

IV.1. Include a Section on Fidelity Measures. A

The literature has shown that the effectiveness of practices or interventions is determined in part by their fidelity to program models. Bond et al., (2000) provide the following definitions for fidelity, program model and fidelity measures:

Fidelity refers to the degree to which a particular program follows a program model. In turn, a *program model* refers to a well-defined set of prescribed interventions and procedures. Program models specify such things as the types and amounts of services persons should receive, the manner in which services should be provided, and the administrative arrangements necessary to support service delivery. *Fidelity measures* are tools to assess the adequacy of implementation of program models. In essence, fidelity measures quantify the degree to which the elements in a program model have been adequately implemented (pg. 1).

Measuring fidelity, therefore, is part of monitoring and promoting quality, efficacy and effectiveness. Manuals should include such measures, along with a discussion of how they can be used in quality improvement, to the extent that measures are available or that databases with standards and benchmarks can be developed.

Investigators are developing an increasing number of fidelity measures. To promote this goal, the Evaluation Center@HSRI has issued a toolkit on developing fidelity measures for psychosocial programs, Psychiatric Rehabilitation Fidelity Toolkit (Bond et al., 2000).

EXEMPLARY ILLUSTRATION

The *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual details some of the dimensions of the domains in the ACT fidelity scale. The three domains are: the structure and composition of human resources, the organizational boundaries of the program, and the nature of the services it provides. Illustration 37 is not a fidelity scale but an excerpt showing some of the dimensions of the “Nature of Services” domain of the ACT fidelity scale

ILLUSTRATION 37. A

Dimensions of the “Nature of Services” Domain of the ACT Fidelity Scales.A

Nature of Services

1. The team spends most of its time, optimally 80 percent, working in the community, monitoring client status and helping clients develop community living skills in vivo rather than in the office.
2. The ACT program has no dropout policy; 95 percent or more of the case load is retained in a twelve-month period.
3. The team is assertive in keeping clients engaged in the program and consistently demonstrates well-thought-out strategies, including legal mechanisms when appropriate, to keep clients engaged with the program.
4. The ACT team provides intensive services, in terms of time spent with clients, optimally an average of two hours per week or more per client.
5. There is a high frequency of contact with clients, optimally an average of four or more contacts per week per client.
6. The ACT team provides supports for client’s support network—family, friends, landlords, employers, etc.—optimally one contact per week or more per client, with support system in the community.
7. The ACT program uses a stage-wise treatment model that is nonconfrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence. Optimally, clients with substance abuse disorders spend twenty-four minutes or more per week in substance abuse treatment; at least 50 percent of the clients with substance abuse attend at least one substance abuse treatment group meeting during the month and the above treatments are provided by ACT staff.

Source: Stein & Santos, 1998, pp. 107–108.

Dimensions that are presented represent the highest degree of fidelity, and noted in the *Assertive Community Treatment of Persons with Severe Mental Illness* (Stein & Santos, 1998) manual is that most ACT programs do not reach the highest degree of fidelity specified in all areas. To be effective, however, ACT programs must come close to as many of them as possible.

IV.2. Include a Section on Simple Performance and Outcome Measures andA Evaluation Designs. A

It is important that practices include an evaluation of services. Although randomized clinical experiments, which provide the most rigorous test of a practice, are rarely feasible, time series data can be collected for analysis using statistical modeling or quality improvement techniques. The use of such data will be greatly enhanced if practices use the same valid and reliable method. If different organizations use the same measures, standards and benchmarks for interpreting findings can be developed. These measures should address clinical outcomes, functional outcomes and satisfaction (Chambless & Hollon, 1998; Leff et. al., under review).

Manuals that contain performance and outcome measures help practices implement outcome systems and contribute to the creation of databases of norms and standards.

EXEMPLARY ILLUSTRATIONS

The *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook and Knox, 1994) manual provides suggestions on how NAMI affiliates can plan and conduct an evaluation of their outreach efforts. It recommends that an evaluation of outreach efforts include consumer or participant satisfaction and outcome assessment. Specific to outcome assessment, NAMI affiliates need to measure the degree of change that occurs as a result of the outreach efforts. In order to assess change, however, it is important to measure desired performance and outcomes prior to beginning (“pre”) the project, and then after (“post”) activities. Illustration 38 is an example included in the *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates* (Cook and Knox, 1994) manual.

ILLUSTRATION 38. A Describing how to Evaluate a Program Component.A

For example, suppose one of your project’s goals is to increase the number of calls from African Americans or Hispanics before you begin your outreach efforts and then after your efforts are underway. One way to do this is to use a telephone log. The person taking every call would record the date, minority status, and nature of the request for a month or two before you begin your efforts and then perhaps six months after activities commence. Better yet, you might track calls throughout the entire period that your project is operating, so that you can monitor changes in calling volume from month to month. The minority outreach project of AMI/GC used this method and found that the proportion of minority callers rose from 5% before their project began to 10% after one year of operation, 15% after two years of operation, and 25% at the end of their third year of operation.

Source: Cook & Knox, 1994, p. 77.

The NAMI manual gives affiliates guidance and encouragement on using performance and outcome measures to evaluate whether or not the efforts have created change. However, they leave it to the affiliates to try to figure out the best way to measure these. But, the manual does suggest that the simplest type of evaluation would be to count the number of people reached by the efforts and the number of different types of activities that occur as a result of the project.

The IPS manual (Becker & Drake, 1993) provides a minimum data set that programs should collect to assess employment outcomes. If multiple providers followed this guide, norms and benchmarks could eventually be developed.

Illustration 39 is a guide to outcomes evaluation included as an appendix of the *A Working Life: The Individual Placement and Support (IPS) Program* (Becker & Drake, 1993) manual. The manual recommends that enough information be collected to show whether or not consumers are working in the types of jobs which satisfy program goals. The authors note that programs should avoid collecting too much information and overwhelming staff with record keeping. The man-

ual recommends that programs keep the minimum consumer data noted below and that they establish a regular schedule for the analysis and review of data.

ILLUSTRATION 39. A
ppendix 1: Guide to Outcomes Evaluation.A

Collect enough information to be able to show whether or not your clients are working in the kinds of jobs which satisfy your program goals. But don't try to collect too much information or overwhelm your staff with record-keeping. We suggest keeping the following data on each of your clients and establishing a regular schedule for analysis and review of data.

1. Weekly hours worked
2. Start and end dates, and inactive periods
3. Hourly wages
4. Type of job (see Work Definition, Appendix II.)
5. Brief account of how client acquired job
 - on own
 - on own with IPS support
 - IPS negotiated job directly
6. Reason for job ending
 - time-limited job
 - quit
 - quit to begin another job
 - fired
 - promoted
 - laid off, etc.
7. Supports provided, frequency, and by whom
 - supportive counseling
 - telephone calls
 - transportation
 - employer support
 - vocational groups
 - other, specify

Source: Becker & Drake, 1993, p. 75.

IV.3. Include a Section on Quality Improvement Process.A

Manuals and workbooks should include a section that outlines a quality improvement process for the intervention. The process of quality improvement entails measuring the performance of a program, making changes to improve the performance of the program, and conducting a follow-up to assess the effectiveness of changes made.

EXEMPLARY ILLUSTRATION

The toolkit *Measuring Conformance to Treatment Guidelines: The Example of the Schizophrenia PORT* (The Schizophrenia Patient Outcomes Research Team, 2001), includes a chapter on how to use the toolkit for improving the quality of care of persons with schizophrenia. Illustration 39 includes excerpts from this chapter.

ILLUSTRATION 39.

Quality Improvement Process in the Schizophrenia PORT: A Toolkit for Assessing Quality of Care For Persons with Schizophrenia.

The assessment procedures described in this toolkit can be used to generate information for users about how treatment being provided measures up to the PORT Treatment Recommendations and whether treatment is improving as quality improvement interventions are instituted. Such information can be used in a quality improvement feedback loop to identify aspects of treatment that warrant improvement efforts and to monitor improvement. For aspects of treatment that are deficient based upon quality of care standards, quality improvement interventions should be initiated, and the process repeated. Inherent in this iterative process will be the ongoing reevaluation of the quality of care standards themselves and the methods for assessing outcomes. It is expected that for a certain percentage of cases deviations from standards will be appropriate, indeed necessary, to optimize outcomes. The iterative process will serve to refine the standards in regard to such appropriate variations (pg. 1).

A key aspect of a quality improvement based upon the recommendations is establishing standards. It must be stated up front that no definitive (empirically proven) standards exist for the recommendations. This can be the case even for evidence-based treatment guidelines. The standards presented here aim at a theoretical optimum of care, but at this time it is not known when a program can be judged as having maximized the quality of care relative to any treatment recommendation or when a program should be judged as clearly deficient. For example, while the PORT recommends particular dose range for antipsychotic medications, it is understood that some consumers will do best with doses outside of these ranges. We do not know what proportion of consumers under optimal care will fall outside of these ranges. Standards should be used to move treatment toward the optimum. If only 30% of consumers are receiving recommended doses at a point in time, a quality improvement goal may be to raise this to 50% within 6 months. Once this is achieved, the standard would be raised further. It will also be important to review cases that do not conform to the recommendation to identify appropriate variations from the standard. For example, it may be determined that in 20% of cases the dose of medication should be out of the recommended range, and therefore the "ultimate" standard for the recommendation would be an 80% conformance rate. Standards should be set to be achievable within a defined time period. Once the interim standard has been achieved, the bar can be raised again (pg. 3).

Source: The Schizophrenia Patient Outcomes Research Team, August, 2001.

IV.4. Evaluating the Manual or Workbook.A

Manual or workbook authors need to conduct cognitive and impact testing. Cognitive or pilot testing is conducted in order to test the understandability of the manual or workbook. Cognitive testing can be done through the use of individual interviews or focus groups.

Impact testing evaluates the impact of the manual or workbook. There are three ways that authors of manuals or workbooks can do impact testing. The first method would be to select a

comparison method such as readings, didactic training or supervision, with and without the use of a manual. Another method of testing the impact of a manual or workbook would be to assign persons to receive packages with and without manuals. A final method of testing impact would be to ask or observe whether the use of a manual or workbook for a practice leads to more adoption of the practice, more fidelity to the practice and better outcomes.

V. Supporting Elements. A

Manuals and workbooks should include elements that make it easier to use the materials and assist users in obtaining additional information. Examples of supporting elements that manuals and workbooks should include are: a glossary of terms; and references to other materials, activities, and resources to facilitate the adoption and implementation of the practice.

V.1. Include a Section on Definitions/Glossary. A

Manuals and workbooks need to identify key terms important for implementing the practice. A Definitions/Glossary section helps to prevent ambiguity in the use of the manual or workbook.

EXEMPLARY ILLUSTRATION

The *PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* (Allness & Knoedler, 1998) manual includes a glossary of key terms as an appendix. Illustration 40 is an excerpt.

ILLUSTRATION 40. A Appendix 2: Glossary.A

Case Management is an organized process of coordination among the multidisciplinary team to provide a full range of appropriate treatment, rehabilitation, and support services to a client in a planned, coordinated, efficient, and effective manner.

Case Manager is the team member who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the treatment plan, to provide individual supportive therapy, to ensure immediate changes are made in the treatment plan as the client's needs change, and to advocate for the client's rights and preferences. The case manager is the first staff person called when a client is in crisis and provides primary support and education to the client's family. The case manager shares these tasks with other members of each client's individual treatment team, who are responsible to perform them when the case manager is not working.

Source: Allness & Knoedler, 1998, p. 117.

V.2. Include References to Other Materials, Activities, and Resources to A Facilitate Adoption and Implementation. A

Additional or supporting materials can be utilized to gain the attention of consumers and providers, motivate them to adopt practices, illustrate specific principles of practices and describe how to conduct certain aspects of the practice.

Suggested Readings

Manuals and workbooks for practices should include references to additional readings and other sources where readers could get more detailed information about specific aspects of a practice. Torrey et al., (2001) learned from clinician focus groups that individuals who have mastered the basic elements of the practice and want to expand their understanding and skills often find Internet resources helpful.

The Assertive Community Treatment of Persons with Severe Mental Illness (Stein & Santos, 1998) manual includes at the end of each chapter, suggested readings on the topic discussed in the chapter (e.g., act research and dissemination, act administration and financing, etc.).

Pamphlets/Brochures/Booklets

Other materials might be more applicable for providing information to some stakeholders such as consumers and family members. For example, Torrey et al. (2001) recommend that pamphlets, brochures and booklets be developed for consumers and families to establish reasonable expectations about services and outcomes and to refer them to organizations that advocate for the practice.

Videos

Torrey et al. (2001) also recommend videotapes as a useful tool for predisposing stakeholders to work on restructuring services in a variety of ways. Videotapes can be utilized to describe the practice, review the scientific support, and provide testimony from consumers and clinicians who have participated in the practice. They can also serve as a medium for linking the research evidence for a practice with personal experiences of people who have benefited from a practice, thus bringing the practice to life for stakeholders.

Videotapes can be utilized to illustrate how to conduct central components of a practice (Calhoun et al., 1998). Moras (1993) points out that videotapes of experts conducting a treatment or aspects of a treatment are a great training aid. The videotape can include a narrative that indicates which intervention and related principles are being illustrated. Moras (1993) adds that videotapes may be used to illustrate common ways in which interventions are misapplied or done incorrectly.

Videotapes can also be utilized for supervision purposes (Calhoun et al. 1998). Videotapes give supervisors the most accurate information on the correctness and completeness of a trainee's implementation of the practice.

Posters

Torrey et al. (2001) suggest using strategically placed posters listing practice principles or relevant slogans to support learning and reinforce supervision.

Web-Based Technologies

McQueen and Demakis (November, 2000) observe that the use of interactive computer programs and website is a popular strategy for disseminating evidence-based practices. As noted, in Torrey et al. (2001) clinicians find the Internet useful for expanding their understanding and skills. They recommend establishing a web site for a practice that will link providers with other relevant research, training opportunities, and materials. Materials for other stakeholders such as consumers and family members also can be posted on the web.

Frequently Asked Questions and Answers (FAQs)

A manual and workbook should include a list of frequently asked questions and answers (FAQs). FAQs can also be distributed in brochures and posted on the web. The *Personal Assistance in Community Existence (PACE)* (Ahern & Fisher, 1999) manual includes a section on frequently asked questions and answers regarding PACE and recovery. Illustration 41 is taken from the PACE manual.

ILLUSTRATION 41.

Frequently Asked Question Regarding PACE and Recovery

Do people still have symptoms after they recover from mental illness?A

People who have recovered still go through periods of emotional distress, but these are no longer symptoms of mental illness because they have learned to retain control of their life. Hearing voices is a good example. Hearing voices was always thought to be a symptom of mental illness. Recently, however, Sandra Escher and Dr. Marius Romme's research (Romme and Escher, 1993) has shown that many people who were never labeled with mental illness are voice hearers. Furthermore, they have found that many people who have fully recovered from schizophrenia still occasionally hear voices. They found that people who have recovered feel stronger than their voices, and have developed coping strategies. They can remain involved in caring and supportive relationships despite the voices. It also seems necessary for these people to experience the voices as meaningful. People need to feel they can understand what the voices are telling them about their life. Then they can take steps to cope. These authors suggest that the chemical imbalance explanation offered by biological psychiatry is not helpful in recovery because it leaves no room for the person to learn to understand or to control their voices by their own thought or actions.

Research at NEC has reinforced these finding, as the following history illustrates. John was first labeled with severe mental illness when he was in college. He was very frightened by his thoughts and voices. He withdrew. He was afraid to tell people what he was experiencing. He was hospitalized several times and given heavy medication. Gradually through positive relationships, sensitive therapy, and meaningful work he recovered and came off his medication. Several years later the voices and negative thinking recurred. This time, however, he dealt with the distress at home, without medication. The difference was that through his previous experiences he learned that he could take steps to cope. He retained hope and did not slide into fear and despair. He felt that his voices helped him to understand himself better. Also he was not afraid to share the experience with his wife and coworkers. They were able to help him make the adjustments in his work and life to accommodate his temporary state of distress.

Source: Ahern & Fisher, 1999, pp. 30-31.

Conclusions

There are logical and empirical reasons to believe that manuals and workbooks that contain the elements described in this toolkit have the potential for improving care. There are also issues related to how prescriptive manuals and workbooks should be. These issues should be addressed through research and evaluation as manuals and workbooks are produced and used. The use of manuals and workbooks should be thought of as a process in which initial efforts are improved over time by new knowledge about both effective clinical practices and the best ways to describe and disseminate these practices.

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APPENDIX A. GLOSSARY

Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve client outcomes (Drake, Goldman, Leff, et al., 2001).

Fidelity Measures are tools to assess the adequacy of implementation of program models. In essence, fidelity measures quantify the degree to which the elements in a program model have been adequately implemented (Bond et al., 2000).

Manuals and/or workbooks are materials that provide sufficient detail to allow trained personnel to replicate practices.

Practices are a complex of services designed to improve service recipient outcomes.

APPENDIX B. INFORMATION ON OBTAINING MANUALS/WORKBOOKS

Ahern, L., & Fisher, D. (1999). Personal Assistance in Community Existence. Lawrence, MA: National Empowerment Center, Inc. (National Empowerment Center, Inc., 599 Canal Street, Lawrence, MA 01840, or 800-POWER-2-U or www.power2U.org).

Allness D.J., & Knoedler WH. (1998). The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up. Arlington, VA: NAMI. (NAMI, P.O. Box 753, Waldorf, MD 20604, www.nami.org,

specify book number NAMI RDS no.145).

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APPENDIX C. RESOURCES ON ACADEMIC DETAILING AND SOCIAL MARKETING

WHAT IS SOCIAL MARKETING:

Center for Social Marketing

<http://www.csm.strath.ac.uk/smchapter.html>

Novartis Foundation for Sustainable Development

http://www.foundation.novartis.com/leprosy/social_marketing.htm

Ontario Government: Social Marketing for Organizations:

<http://www.gov.on.ca/OMAFRA/english/rural/facts/92-097.htm?>

Social Marketing Institute

<http://www.social-marketing.org/sm.html>

The Social Marketing Network

<http://www.hc-sc.gc.ca/hppb/socialmarketing/smintro.htm>

Weinreich Communication

<http://www.social-marketing.com/whatis.html>

SOCIAL MARKETING TOOLKITS:

Center for Social Marketing

<http://www.csm.strath.ac.uk/smchapter.html>

Culbridge Marketing and Communications

<http://www.outilsdechangement.com/English/firstsplit.asp>

Novartis Foundation

http://www.foundation.novartis.com/leprosy/social_marketing.htm

Ontario Government, Social Marketing for Organizations

<http://www.gov.on.ca/OMAFRA/english/rural/facts/92-097.htm?> (the social marketing process)

The Social Marketing Network

<http://www.hc-sc.gc.ca/hppb/socialmarketing/tutorial/smtue01.htm>

Weinreich Communications

<http://www.social-marketing.com/building.html>

EXAMPLES OF SOCIAL MARKETING IN ACTION:

Center for Social Marketing (Research and consultancy projects on issues such as smoking, drugs, diet, traffic safety, health services, etc.) <http://www.csm.strath.ac.uk/projects.html>

Florida "Truth" Campaign (Anti-smoking campaign)

<http://www.social-marketing.org/success/cs-floridatruth.html>

Social Marketing Institute: Success Stories (List a variety of successful social marketing campaigns on issues such as reducing infant mortality, AIDS awareness, disease control, promotion of breast feeding, and seatbelt usage)

<http://www.social-marketing.org/success.html>

Sunsmart (Encouraging youth to protect against skin cancer by using proper sun protection)

<http://www.sunsmart.co.nz>

Tools of Change (Examples of projects in the United States and Canada dealing with Health and Environmental issues)

<http://www.outilsdechangement.com/English/firstsplit.asp>

U.S. Public Health Service's Title X family planning program

("Don't Kid Yourself" campaign to reduce unintended pregnancies) <http://www.social-marketing.com/dky.html>

MISCELLANEOUS INFO ON SOCIAL MARKETING:

Center for Social Marketing (Other related organizations)

<http://www.csm.strath.ac.uk/links.html>

Novartis: Social Marketing A to Z

http://www.foundation.novartis.com/atoz/social_marketing.htm

Social Marketing Institute (related sites)

<http://www.social-marketing.org/relatedsites.html>

Weinreich Communications

(additional info about social marketing)

<http://www.social-marketing.com/library.html>

4(links)

<http://www.social-marketing.com/links.html>

APPENDIX D. ACT CULTUROLOGICAL HISTORY FORM

CULTUROLOGICAL HISTORY

Name _____ Date _____

Interviewer(s) name _____

I. CROSS CULTURAL DIFFERENCES

1. Discuss cultural differences with the client. Begin by pointing out some of the differences you have with the client (e.g., race, religion, ethnicity, socioeconomic class, sex, sexual orientation, etc.). Ask, "Is there anything about me or my background you'd like to know more about?" Then ask, "Do you think our differences will cause any problems, or is there anything about yourself you think I may not understand or appreciate because I'm a European American male, Latina, etc.)?"

2. Do you have any ideas about how we might overcome these potential problems?

3. Have you ever been in a (cross cultural) counseling situation before? What were the circumstances? Was that comfortable for you? What made it comfortable/uncomfortable?

4. Do you have any suggestions about how we might provide services in a way that takes your culture into account? How can we provide services to you in a way that is culturally acceptable to you?

II. CULTURE

A. Culture of Origin and Ethnicity

1. Tell me about your ethnic background. (If necessary, model for the client by describing your own ethnic background.)

2. Where did your mother and father come from/grow up?

Mother (Name: _____) _____

Father (Name: _____) _____

3. Where did your grandparents come from/grow up?

Mother's Mother (Name: _____) _____

Mother's Father (Name: _____) _____

Father's Mother (Name: _____) _____

Father's Father (Name: _____) _____

4. How many generations ago did your family/ancestors come to the U.S.?

Mother's Ancestors _____

Father's Ancestors _____

5. Why did your family/ancestors leave their homeland?

6. How does that affect you now and your view of your life?

7. Who raised you?

8. Where were you raised?

9. Who was the head(s) of your family (or made the rules in your family)?

10. Who in your community, outside of your family, had some influence on you?

11. Who had the most status in the community you grew up in?

12. How did you fit in when you were growing up (at school, with family and friends, etc.)?

School

Family

13. Do you relate to the culture you were born into?

14. Is there another culture you see yourself relating to more? Why?

15. Does this present any problems for you?

16. What are your culture's expectations of what it means to be a woman/man? Are you comfortable with fitting/not fitting that expected role?

B. Current Culture/Community

1. Who would you include in defining your family now?

Name and relationship _____

Name and relationship _____

Name and relationship _____

Name and relationship _____

Name and relationship _____

2. Describe your current community or support system:

3. Is there an organization or individual in your community to whom you could go to for help?

4. How does your community view those with a mental illness? How do they view treatment with medications?

5. Who has the most status in your community now?

6. Who are your heroes/heroines? Why?

7. What kind of music/movies/books/TV shows do you like?

Music _____

Movies _____

TV shows _____

Books _____

8. What do you do for fun (sports, crafts, arts, etc.)?

C. Religious/Spiritual Beliefs and Values

1. What religious or spiritual beliefs were you raised with?

2. What were the beliefs of your parental figures (people who raised you)? Did they have the same beliefs (if there was more than one parental figure)? If they didn't, was there conflict?

3. Did you attend services when you were growing up? If so, what churches, temples, synagogues, cathedrals, etc., did you attend and how often?

4. What are your beliefs now? Do you have any particular spiritual or religious beliefs that provide support for you?

5. Do you attend services now? If so, where and how often? If not, would you like to start attending services? If so, where? Could we be of any assistance with connecting you to a congregation?

6. Are there any special practices you observe because of your religious/spiritual beliefs that might be important for me to know about (e.g., special diets, important days of celebration, sweat lodges, etc.)?

7. Do you have any religious/spiritual beliefs that influence how you view mental illness or medication?

8. Is there any tension between your religious/spiritual beliefs and your behavior/lifestyle (e.g., your sexuality, chemical use, etc.)? Between the beliefs you were raised with and your behavior/lifestyle?

D. Language (Clarify unfamiliar terms, e.g., clinical terminology, cultural or generational slang, used by either client or therapist.)

1. What do you prefer to be called?

2. Are you offended by any specific words/terms?

3. What is your communication style (e.g., lots of gestures/body language, rapid loud speech, high context vs. low context communication style)?

4. What language do you speak at home? What language do you prefer to communicate in? Will it be a problem for you to communicate in the language of the therapist?

E. Social, Economic, Environmental, and Political Factors

1. Describe the neighborhood you grew up in. What did it look like, sound like, smell like, feel like? Would you describe it as a wealthy, middle-class, working-class, or poor community?

How did/does this affect you?

2. How did you perceive your parents' (or parental figures') status? Was your parents' status different from your friends' parents' status?

Was your parents' status different from the community or neighborhood you lived in?

3. What is your status now compared to your parents' status? Is your status different than your parents' status when they were your age?

4. Where are you compared to the friends you grew up with?

5. We live in a society which often attributes personal value to monetary success. Does this affect your self-concept? How?

6. Are you involved in the political process in any way? Are you aware of current legislation about areas that affect you?

III. VALUES OF THE CLIENT AND THE CLIENT'S COMMUNITY VIS-À-VIS MENTAL ILLNESS AND TREATMENT

1. How does your community view mental illness (e.g., is it all right to tell people in your community that you have a mental illness or is it best to keep this a secret)?

2. What do people in your community generally view as the cause of mental illness (e.g., a difficult childhood, biochemical, environmental stress, etc.)?

3. What is the generally accepted form of help for your problem from your community's point of view?

4. What is the generally accepted view in your community about the use of medications to treat mental health problems?

5. What would your friends say about your being here today asking for help?

6. Would you be embarrassed to tell family members or friends that you came for help today? (How accepting is the community?)

7. If your son, daughter, brother, sister, etc., had this kind of problem, what would you recommend that he or she do?

8. What do you think causes mental illness?

9. What do you think caused your problems?

10. How do you feel about the use of medications to treat your problems?

11. How have you dealt with this problem before? (What are your coping mechanisms?)

12. How has your community intervened before with regard to this problem?

13. Is there any way that your community might be helpful to you now?

IV. PROBLEMS THAT STEM FROM RACISM OR BIAS IN OTHERS

1. Begin this discussion by demonstrating your understanding of how the mainstream culture oppresses people from the client's culture (e.g., an African American exhibiting the symptoms of a mental illness is more likely to be arrested and jailed than taken to a hospital for treatment, etc.). Once the idea is established, ask, "Have you ever experienced prejudice, stigma, or negative reactions directed toward you because of your culture, race, gender, sexual orientation, etc.?"

2. Have you ever experienced prejudice because of being diagnosed with a mental illness, or have people related to you negatively because they know you are receiving treatment for a mental illness?

3. How have you dealt with these negative reactions?

4. Is there anything we can do to help minimize the stigma associated with receiving treatment?

APPENDIX E. CHECKLIST FOR CREATING A MANUAL/WORKBOOK

PHASE 1:

Planning Your Manual or Workbook

Step 1: Determine expertise of authors.

- ☐ The manual or workbook will be developed by experts of the practice.

Comments:

- ☐ Manual or workbook authors have extensive clinical experience with the specific population to be served.

Comments:

Step 2: Involve consumers and other stakeholders in the development phase.

- ☐ The manual or workbook was reviewed by consumers, family members, and other stakeholders to ensure usefulness of product.

Comments:

- ☐ Input was obtained from individuals from diverse cultural backgrounds.

Comments:

Step 3: Ensure the manual is user friendly.

- ☐ Manual or workbook is written in simple language.

Comments:

- ☐ Manual or workbook provides as much detail as possible.

Comments:

- ☐ Manual or workbook was field tested with the types of providers that will utilize the manual.

Comments:

PHASE 2:
Creating Your Manual or Workbook

Step 1: Include elements to introduce the manual or workbook.

- ☐ 1. Description of the purpose of the manual or workbook.

Comments:

- ☐ 2. Description of planning process.

- ☐ a. Names of those who participated in the development of the manual or workbook.

Comments:

- ☐ b. Description of how input was obtained from consumers, family members, and other stakeholders prior to the finalization of the manual or workbook.

Comments:

- ☐ c. Description of how the manual or workbook was pilot tested.

Comments:

- ☐ d. Description of who pilot tested the manual or workbook.

Comments:

Step 2: Include elements to predispose providers to offer the practice (why do it).

- ☐ 1. Description of the practice.

Comments:

- ☐ 2. Description of the theory behind practice.

Comments:

- ☐ 3. Principles of the practice.

Comments:

- ☐ 4. Description of the supporting research for the practice.

Comments:

Step 3: Include elements to help program leaders to set up and structure the practice (how to do it).

- ☐ 1. Eligibility/admission criteria for practice.

Comments:

- ☐ 2. A discussion on boundaries- the applicability or use of practice with special populations or the need to adapt practice

Comments:

☐ 3. A discussion of the relationship to and importance of other services in service system to manualized practice

Comments:

☐ 4. A discussion of roles: staffing descriptions/duties and responsibilities.

Comments:

☐ 5. Training, consultation, and supervision requirements/recommendations.

Comments:

☐ 6. A discussion on administrative aspects of implementing a practice.

Comments:

☐ 7. A discussion on facility design.

Comments:

☐ 8. A discussion on provider to consumer ratios, or total caseloads, required to provide services included in the practice.

Comments:

☐ 9. A discussion on specific service components or approaches comprising the practice.

Comments:

☐ 10. A discussion on program costs, financing and financial management.

Comments:

☐ 11. A discussion on recommendations for promoting change in practice settings.

Comments:

☐ 12. Case examples.

Comments:

☐ 13. Illustrations.

Comments:

☐ 14. Flowcharts/logic models and algorithms.

Comments:

☐ 15. Checklists- exercises and assessments.

Comments:

- ☐ 16. Sample plans or list of components.

Comments:

- ☐ 17. Sample assessment forms or list of assessment items.

Comments:

- ☐ 18. Sample schedule for staff and consumers.

Comments:

- ☐ 19. Components of service records or sample medical records and other administrative databases/record keeping.

Comments:

- ☐ 20. Discussion of start-up experiences.

Comments:

- ☐ 21. Discussion of common difficulties, obstacles, or problems that occur when conducting the practice.

Comments:

Step 4: Include elements to help program leaders maintain and extend gains.

- ☐ 1. Fidelity measures.

Comments:

- ☐ 2. Simple performance and outcome measures and evaluation designs.

Comments:

- ☐ 3. A discussion on quality improvement process.

Comments:

- ☐ 4. Evaluation of manual or workbook.

Comments:

Step 5: Include supporting elements.

- ☐ 1. Definitions/Glossary.

Comments:

- ☐ 2. Reference to other materials, activities, and resources to facilitate adoption and implementation.

Comments:

APPENDIX F. MODEL OF ESSENTIAL ELEMENTS OF MANUALS AND WORKBOOKS

Essential elements of Manuals and Workbooks

