Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance

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Table of Contents

INTRODUCTION 4

PROGRAM SUPPORTS 12
- Inpatient Program Development 12
- Multimodal Biopsychosocial Case Formulation Strategies 13
- Progress and Outcome Data 13
- Social Learning Program Assessment System 13
- Comprehensive Inpatient System for Assessing Clients, Staff, and Programs 13
- Forensic Services 15
- Assertive Community Treatment 15
- Psychiatric Advance Directives 16
- Education 16
- Consumer Operated Services 16
- Cross-Cultural and Ethnic Issues 16
- Gender Issues 18
- Young Adults/Youth in Transition Support Systems 19
- Development of Compensatory and Environmental Supports 19
- Recovery Program Development 19

THERAPEUTIC INTERVENTIONS 23
- Skills Training 23
- Workplace Social Skills Training 23
- Client-Directed Treatment Planning 24
- Cognitive Rehabilitation 24
- Compensatory Environmental Supports 26
- Cognitive Behavior Therapy 27
- Trauma Interventions 28
- Supported Socialization 29
- Psychotherapy 29
- Illness/Wellness Management 30
- Family Psychoeducation 30
- Substance Abuse and SMI 33
- Role Recovery 34
- Tools For Enhancing Self-Determination 36
- Integrated Health Care 38
- Supported Housing 38
- Supported Employment 39
- Community Integration 40
- Spirituality 40
- Forwarding the Recovery Paradigm 41
- Pathways in Living 41

ASSESSMENT METHODS 43
- Responsiveness to Skills Training Interventions 43

Progress and Outcome Data 43
Functional Assessment 44
Social Skills Assessment 45
Rehabilitation and Recovery-Oriented Assessments 45
Acquiring the Life History of Clients to Individualize Treatment Planning 47
Neuropsychological Assessment 47
Symptom Assessment 48
Assessment of Geriatric Schizophrenia 48
Mental Health Workplace Safety Assessment and Risk Management 48

TRAINING AND DISSEMINATION METHODS 46
Program Development 49
Ethics in Psychiatric Rehabilitation 49
Training in Family Education/Psychoeducation 50
Behavior Contracting 50
Training in Recovery-Based Approaches 51
Implementing Evidence-Based Practices 51
Training Members of the Public in Better Recognition And Support 51
Moving State Systems into Psychosocial Rehabilitation 52
Improving the Quality of Decision-Making Regarding Medications 52

TRAUMA-INFORMED SERVICES 53
Integrated Substance Abuse and Trauma Treatment Programs 53
Training in Family Education/Psychoeducation-PTSD 53
Client-Directed Treatment Planning 54
Other Services 54
Integrating Trauma Treatment into Mental Health Programming 54
Trauma Assessment 56
Staff Training in Sexual Abuse and Trauma 56
Centers and Web-Based Resources 56

INTERVENTIONS EFFECTIVE IN REDUCING THE USE OF RESTRAINT, SECLUSION, AND OTHER COERCIVE INTERVENTIONS 62
Training Programs 62
Multimodal, Biopsychosocial Case Formulation Strategies and Techniques 62
Forensic Services 64
Advance Crisis Management 64

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APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance[1]

Introduction

This Introduction will address several issues related to the development, rationale, intent, structure, and content of the *Catalog of Clinical Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness*. This document should assist providers in identifying appropriate interventions for their settings and those they serve, identifying needed advanced clinical training initiatives, and obtaining access to those clinicians and researchers who have developed, implemented, and/or studied the outcomes of the interventions and instruments described.

Development of the document The Catalog of training opportunities grew out of discussions promoting mental health system reforms as part of the work of the American Psychological Association (APA), specifically, the Committee for the Advancement of Professional Practice's (CAPP) Task Force on Serious Mental Illness and Severe Emotional Disturbance (TFSMI/SED). Objectives for its development included compiling the best clinical practices known to improve outcomes and quality of life for adults with serious mental illness, identifying advanced clinical training initiatives that were immediately available without further development costs, and providing access to experts involved in the development or research of these state-of-the-art interventions. The 2003 publication of The President's New Freedom Commission on Mental Health Report, *Achieving the Promise: Transforming Mental Health Care in America* outlining the need for mental health system reforms and emphasizing "science to service" initiatives as an important step in the reform process, brought increased attention to this project. This also led to the recognition that the then current version of the document needed to be revised to contain information on more than just interventions if it was to achieve its objective; it also needed to convey information about tools and methods that could be used to help implement program change or to support ongoing programming. Therefore, the current version of the document contains the following sections, in this order: 1) Program Supports; 2) Therapeutic Interventions; 3) Assessment Methods; 4) Training and Dissemination Methods; 5) Trauma-Informed Services; and 6) Interventions Effective in Reducing the use of Restraint, Seclusion and other Coercive Interventions. Inclusion of all of these sections has maximized the degree to which the *Catalog* addresses the needs outlined in the President's New Freedom Commission on Mental Health Report, in terms of containing information and resources necessary for reforming mental health systems.

[1] The task force would like to acknowledge the contributions of Richard H. Hunter, Chairman, Task Force on SMI/SED, and Steven M. Silverstein, Chairman, Training Committee, for their extensive work on this project. To provide input, or to obtain further information regarding the training grid, contact Dr. Hunter or Dr. Silverstein at rich.hunter@clinicaloutcomes.us or Steven.Silverstein@att.net, respectively.

Earlier versions of the catalog, previously referred to as the *Training Grid* were distributed and critiqued by members of the Training Subcommittee of the APA/CAPP TFSMI/SED. After revisions, several versions were reviewed by the full TFSMI at annual meetings and by the full TFSMI and observers on the web-based listserv maintained by the task force. Input was also sought from experts in the field who are not involved with the TFSMI, including experts from other disciplines such as psychiatry and social work.

We did not include a section on psychopharmacology. While we recognize that pharmacologic interventions may manage symptoms and reduce distress, there is little evidence at this point that medication reduces disability, enhances level of functioning, or builds on a person's assets, strengths, interests, or aspirations. Moreover, as the number of existing medications is far fewer than the number of psychological interventions designed to promote recovery and resilience, and as multiple textbooks are available on psychopharmacology, whereas a compendium of best practices for psychological interventions for serious mental illness is lacking, we did not see the necessity to include a section on medication in this document.

Rationale While reviews of the literature and summaries of evidence-based practices have appeared in the literature, these papers aim to summarize research findings and to report average effect sizes, as opposed to giving information about specific interventions themselves. Therefore, a further rationale for developing the *Training Catalog* was to produce a document that differed in intent and content from prior narrative reviews and meta-analyses by providing intervention-specific information. Also, while detailed information about specific interventions and instruments can be found in single publications and on agency and center web sites, these sources of information typically focus only on the interventions or products studied or offered by the group that writes the text. In contrast, the rationale behind the *Training Catalog* was to compile a comprehensive listing of information about multiple interventions and instruments into a single, user-friendly document.

Intent The original intent of the *catalog* was to provide a resource for public and private mental health systems and individual agencies that would inform them of state-of-the-art interventions and practices to enhance their efforts to improve client outcomes, and to transform their culture to one that was more rehabilitation, recovery, and resiliency-oriented. This version of the document provides a catalogue of interventions, brief descriptions of the interventions and instruments listed, and contact information for those who can provide advanced clinical training and/or facilitate acquisition of materials. With the publication of the President's New Freedom Commission Report, there is a clear mandate to transform mental health service systems in the direction of being more recovery and consumer- (and family-) friendly. In order for this to occur, user-friendly summaries of available interventions, instruments, and other services, such as the *catalog*, should be helpful in informing and guiding decisions about how to proceed and about what the outcomes of reform should look like. In its current form, the document may also serve as an educational tool to inform mental health policy makers, advocates, staff, consumers, and students about the nature of work being done in the area of clinical practice related to serious mental illness.

Structure The *catalog* is divided into five sections, with a page break between each section. Each section uses the same format. The left-hand column lists subheadings,

in bold typeface, under the general heading (e.g., "Family Psychoeducation" under "Therapeutic Interventions)." The middle column lists the names of specific interventions contained under the subheading. Immediately under the names are descriptive summaries of each intervention, instrument, or other service. In most cases, these summaries were provided by the clinicians and/or researchers who developed the intervention, instrument, or service listed. Where we could not obtain this information directly from the developer, we used available treatment manuals, articles, and websites to obtain the necessary information, and then summarized it ourselves. The right-hand column in each section lists the names and e-mail addresses of contact people who are associated with the intervention, instrument, or service. In many cases, multiple people are listed. This occurs for several reasons. First, in some cases, several variants of an intervention have been developed (e.g., Family Psychoeducation; Cognitive Behavior Therapy for Psychosis). In these cases, key people involved in the development of each variant are listed. In addition, in some cases, people who have conducted extensive research and/or advanced clinical training on an intervention have become associated with it in general. In such cases, the names of these researchers/clinical trainers are listed alongside the people who originally developed the intervention.

Content The content of the *catalog* comes from multiple sources. First, extensive reviews of the research and clinical literature generated clear candidate interventions, instruments, and other services for inclusion in the document. Second, discussions among TFSMI/SED members at meetings and over the listserv and consultations with other experts, both within and outside of psychology, generated additional candidate entries. Consensus among TFSMI/SED Training Subcommittee members formed the basis for the ultimate decision about what to include and exclude.

Several issues were considered in reaching decisions about inclusion/exclusion. None created more heated discussion than the issue of an intervention's "evidence base." In considering this issue, our explicit decisions were to: 1) include any intervention for which there was a clear evidence base (e.g., The Social Learning Program originally developed by Paul and Lentz for behavioral inpatient treatment) but 2) not to exclude any potential entry *a priori* solely on the basis of its not having an extensive evidence base. The latter decision was made for two reasons. First, some of the entries in the *catalog* reflect assessment instruments and program supports which represent important components of successful programs, yet one would not expect that they would be individually subjected to research. Second, a number of interventions reflect new technical developments (e.g., consumer-run services that facilitate empowerment) or treatment philosophies (e.g., they are recovery-oriented) that are value-driven and appear to be important and innovative for humanitarian reasons. In a number of cases, such interventions are being used and studied at or through major research centers, even though to date, little, published controlled data exist on their effectiveness. In our opinion, exclusion of such developments solely on the basis of a lack of evidence would be counterproductive to the field and therefore, ultimately, to consumers.

A potential problem with criterion #2 above is that, if taken to its logical extreme, no intervention would be excluded - leading to an overly cumbersome document which purports to be user-friendly but which in fact does not help the user discriminate between the myriad of existing possibilities. Therefore, a third criterion used to determine inclu-

sion in the document was consensus among TFSMI/SED members and outside experts as to usefulness and feasibility (and history) of adoption outside of the development site. Using criterion #3 to filter the options accumulated by criteria 1 and 2 led to the development of a comprehensive yet discriminating list of available clinical services for people with serious mentally illness. Stated perhaps more explicitly, the entries contained in the *catalog* are those which the APA/CAPP TFSMI/SED considers to be best practices or emerging best practices. By definition then, the *catalog* is one version or one view of best practices for improving services and outcomes for people with serious mental illness. We recognize that another group charged with the task of developing such a document might produce something that differs somewhat in content from ours. Given the source of our data, however, we believe it is unlikely that any such differences would be significant. Moreover, even with the recognition that there can never be 100% agreement about the content of a best practices statement, we believe it is critical to produce such a document to inform clinical care and mental health policy at the federal, state, and local levels.

Below, each section of the *catalog* will be described briefly.

Program Supports By this heading, we refer to developments that are not therapeutic interventions per se but can be used to provide information needed to deliver effective treatment interventions. Examples of entries included in this section are cross-cultural training programs for mental health professionals and psychiatric advance directives that can be used to guide treatment in cases when consumers are unable to make decisions on their own behalf. We also include in this section assessment tools that are meant to be used on a daily, or other regular basis to routinely inform decisions about treatment and/or future program development and staff training needs (e.g., The Staff-Resident Interaction Chronograph).

Therapeutic Interventions The largest section of the *catalog*, this section lists and describes a wide variety of interventions whose aim is to reduce disability, improve functioning in one or more domains, and promote recovery and resiliency. The interventions listed include skills training approaches, cognitive rehabilitation, dual disorder interventions, vocational services, family interventions, and consumer run services, to name just a few. Specific interventions within each subheading are grouped together.

Assessment Methods This section provides information about instruments that can be used to generate information to drive clinical decision making. A variety of formats are represented here, including self-report, other-report, and observational measures. All of the measures listed are rehabilitation and/or recovery-oriented. We do not list assessment measures which are not related to these themes. Thus, for example, a list of traditional neuropsychological tests is not included, whereas a new measure of assessing readiness to engage in skills learning interventions is included, as is a widely-used cognitive screening battery.

Training and Dissemination Methods Numerous studies now indicate that despite the availability of effective interventions, only a small percentage of people who could benefit from them typically receive them. Moreover, data also indicate that workshops and didactic presentations typically lead to little change over the long term. This speaks to the need for effective training methods, as well as techniques for transforming

institutions, agencies, and larger systems to ensure that best practices are actually used. This section of the *catalog* documents a number of such methods, ranging from those that train staff in specific interventions, to those that target organizational barriers to the effective implementation of rehabilitation, recovery, and resiliency-based services.

Trauma-Informed Services It is becoming increasingly evident that much physical, psychological, and sexual abuse goes unreported, and that psychiatric inpatients in general, and people with severe mental illness in particular, have alarmingly high rates of experiences of abuse. Moreover, histories of abuse predispose people to later victimization. This has led to an acceleration of service development for people with abuse histories and those exposed to other life-threatening and traumatic experiences. This section of the document lists interventions, assessment tools, and staff training materials to assist mental health agencies to better address issues experienced by people with abuse histories and the treatment of those suffering from post-traumatic stress disorder (PTSD).

Interventions Effective in Reducing the use of Restraint, Seclusion and other Coercive Interventions The final section of the document describes interventions that have demonstrated usefulness in reducing the need for seclusion and restraint. Note that procedures *for* seclusion and restraint are not discussed in this section. Rather, the inclusion of this section reflects beliefs, experience, and data indicating that most, if not all, instances of seclusion and restraint can be avoided if functional assessment of inappropriate behaviors and hypothesis- and data-driven treatment are provided. It is important to note that while the entries listed in this section have specifically been targeted to reduce seclusion and restraint, many of the assessment, training, and intervention items listed in other sections can also help reduce seclusion and restraint as a result of their generating information about the functional triggers for aggression, improving staff communication skills, and/or teaching new behavioral skills so that aggressive responses become less likely.

Future Development of the Catalog Because new interventions, procedures and instruments are continually being developed, and new evidence on the effectiveness of existing ones appears on a daily basis, a document such as the *Catalog* must be updated and revised frequently. The TFSMI/SED plans to review and revise this document on a regular basis. The latest version of the catalog will be available at: http://www.apa.org/practice/resources/grid/index.aspx.

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PROGRAM SUPPORTS		
TYPE	**SPECIFIC INTERVENTION**	**CONTACT PERSON/PEOPLE**
Inpatient Program Development	The Social Learning Program (including a token-economy structure & all tools for assessment, intervention, and data reporting) This is a highly structured, ward-wide, inpatient approach to rehabilitation for individuals with the most severe problem behaviors and skills deficits. It consists of a comprehensive integrated network of skills training techniques and supports based on learning theory, individually tailored to client needs. It includes a post-discharge declining contact community aftercare component. A premium is placed on staff training and competency assessment, including paraprofessional staff. As appropriate to the level-of-functioning of clientele, this program can incorporate most evidence-based individual and group interventions listed below.	Gordon L. Paul - gpaul@uh.edu Tony Menditto - anthony.menditto@dmh.mo.gov
	Other structured inpatient/residential behavioral programs Comprehensive, data-oriented multimodal rehabilitation approaches that incorporate individual behavior contracting and contingency management, skill training, cognitive-behavioral therapy; designed especially for people with the most severe, persistent and disabling conditions in residential or inpatient settings.	Will Spaulding - Wspaulding@neb.rr.com Mary Sullivan MESullivan@neb.rr.com Steven Silverstein - silvers1@umdnj.edu Sandra Wilkniss – swilkniss@thresholds.org

Multimodal, Biopsychosocial case formulation strategies and techniques	Multimodal Functional Model (MFM) (including methods for functional assessment, and treatment hypothesis generation and testing) MFM is biopsychosocial case formulation and intervention model that has demonstrated effectiveness with treatment-refractory clients and people with comorbid behavior disorders. The model integrates progress and outcome data to guide functional behavioral assessments and clinical hypothesis testing leading to more precise causally-based intervention strategies. The MFM leads to efficiency since the impact of all interventions are measured and ineffective treatments are terminated. This case formulation model moves beyond diagnosis-driven interventions to specific interventions based on causative factors. Multidisciplinary Algorithm for the Assessment of Persistent Schizophrenia (MAAPS) This is a comprehensive set of assessments, whose goal is to provide information for more effective treatment planning for chronically disabled people with schizophrenia.	Rich Hunter – rich.hunter@clinicaloutcomes.us Sandra Wilkniss – swilkniss@thresholds.org Courtenay Harding - charding@bu.edu
Progress and Outcome data	Functional assessment instruments – Context, Antecedent, Behavior, Consequence (CABC) cards; Patterns and Trends Data Sheet Simple data observation and collection instruments for generating case-specific diagnostic/causal hypotheses, evaluating the impact of various intervention strategies, advising when interventions should be discontinued, and in providing timely input for altering treatment strategies.	Rich Hunter – rich.hunter@clinicaloutcomes.us
Social-Learning Program Assessment System	Clinical Frequencies Recording System (CFRS) The CFRS consists of a set of forms on which observational data are recorded by clinical staff as part of ongoing clinical operations as well as computerized summarizing procedures. It documents ongoing event data for clients and staff to ensure proper conduct of Social-Learning Programs.	Gordon L. Paul – gpaul@uh.edu Tony Menditto – anthony.menditto@dmh.mo.gov Paul Stuve – mbstuvp@mail.dmh.state.mo.us
Comprehensive Inpatient System for Assessing Clients, Staff, and Programs	The Computerized TSBC/SRIC Planned-Access Observational Information System. The complete TSBC/SRIC System is an objective assessment and information system providing practical support of ongoing clinical, administrative, and regulatory decision-making in any adult inpatient or	Gordon L.Paul – gpaul@uh.edu Mark H. Licht – mlicht@DARWIN.PSY.FSU.EDU Tony Menditto – antho-

	residential treatment program. Technician-level observers monitor all clients, staff, & programs, time-sampling 16 hrs/day on the Time Sample Behavior Checklist (TSBC) & the Staff-Resident Interaction Chronograph (SRIC). An integrated set of procedures and computer reports combine data from TSBC, SRIC, and other sources (biographical, financial, medical) to provide continual gathering, processing, analyzing, & distribution of most data needed for clinical decision-making, staff competency assessment, and comparative program evaluations. It is a fully manualized and computerized system with documented cost-effectiveness.	ny.menditto@dmh.mo.gov Paul Stuve – mbstuvp@mail.dmh.state.mo.us

Forensic Services	Social Learning Program within a forensic hospital This is an adaptation of the original SLP (see description in "Inpatient Program Development" section) for individuals with severe mental disorders residing in forensic hospitals.	Tony Menditto – anthony.menditto@dmh.mo.gov
	Forensic services for adolescent sex offenders This is a highly structured cognitive-behavioral approach that emphasizes relapse prevention and working to develop empathy towards victims. It ideally begins in a residential setting with step-down through lesser levels of structure. Not all adolescents who enter such programs will successfully graduate from them. Those who don't graduate will require alternate risk management approaches.	Joe Alford – joe.alford@mail.state.ar.us
	Continuum of care program for dually diagnosed (SMI + substance abuse) forensic patients A public-private partnership involving a sequence of: 1) residential treatment building coping and life skills in a hierarchical fashion; and 2) assertive community treatment.	Tony Cimino – tony.cimino@mail.state.ar.us
Assertive Community Treatment	Assertive community treatment Multi-disciplinary continuous treatment teams provide individualized services, skills training and support in community settings for people with serious mental illness. Clinical trials have shown reductions in hospital use and symptoms, and improved satisfaction with services. National performance monitoring data have confirmed these effects as well as improvements in alliance, functioning and quality of life with maintenance of program fidelity over seven years. Successful teams have served as mentor-monitors for new programs.	Mary Ann Test – matest@facstaff.wisc.edu Len Stein, Michael Neale – Michael.Neale@med.va.gov Gary Bond – gbond@iupui.edu ACT Center Indiana (IUPUI) link: http://www.psych.iupui.edu/act/HOME%20PAGE/actalternativo.html
Psychiatric Advance Directives	Psychiatric Advance Directives Psychiatric advance directives are an emerging tool for documenting patient treatment preferences in advance of acute symptomatology that can limit decision-making abilities. Advance directives provide a mechanism to include the choices of individuals with mental illnesses during mental health crises, when their meaningful participation in treatment decisions is otherwise unlikely.	Judith Cook - cook@ripco.com Debra Srebnik – srebnik@u.washington.edu

Education	Supported education for people with SMI Supported education provides preparation, assistance and support to adults with SMI who wish to pursue post-secondary education or training and follows psychiatric rehabilitation principles. Program Manual for Planning and Implementing a Supported Education Program This includes curriculum modules to use in delivering the program, plus a specification of fidelity criteria. The manual provides an overview of the supported education process. It details the procedures for implementing and operating support services to help people with a psychiatric disability who want to be students choose, get, and keep an academic setting and program of study. Activities related to each of the phases are detailed, with examples and forms for each, such as goal-setting, decision-making, identifying barriers and academic supports and adjustments, and skill and resource development.	Judith Cook – cook@ripco.com Ann Sullivan-Soydan Anna.sullivansoydan@verizon.net
Consumer Operated Services	Consumer Organization and Networking Technical Assistance Center (CONTAC) Contac serves as a resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States, promoting self-help, recovery and empowerment**.** Contac was developed utilizing research on ideal consumer self-help programs, successful consumer-run programs, community support service philosophy about service delivery, descriptions of mature mental health systems, and management and leadership skills.	http://www.contac.org/ Crystal Blyler – cblyler@samhsa.gov Betsy McDonel Herr - bmcdonel@samhsa.gov
Cross-Cultural and Ethnic Issues	Cross-cultural training for mental health professionals Intensive eight-day, 12 hour training sessions focusing on African-American, Hispanic, and American Indian cultures with didactic and experiential components. Post-workshop evaluation showed significant improvement in knowledge, attitudes, social distance, values, and world view. Pre-post videotapes of cross-cultural interviewing skills showed significantly improved therapeutic effectiveness. Long range evaluation of agencies (6-18 months later) showed significantly increased minority utilization rates, and decreased dropout rates with significant cost-benefit.	Harriet Lefley – hplefley@aol.com

	Outreach to African American and Hispanic/Latino Families of Adults with mental Illness This manual was created to assist affiliates of the National Alliance for the Mentally Ill (NAMI) in providing outreach to African American and Hispanic/Latino consumers and families. Chapters cover the needs for minority outreach, techniques for enhancing cultural sensitivity and cultural competence, steps to take in formulating an outreach program, four basic outreach strategies, evaluation of outreach efforts, and ways to disseminate successful projects.	Judith Cook – cook@ripco.com
	SAMHSA National Standards for Cultural Competence The Western Interstate Commission for Higher Education (WICHE) has been known for its work in cultural competence across the last 2 decades, long before the concept was popularized. WICHE with Marie Sanchez (now executive director of the Latino Behavioral Health held many conferences and meeting with panels from across the country which created the SAMHSA National Standards on Cultural Competence (USDHHS, 2000). The 72 members of these panels represented academics, clinicians, administrators, family members, and consumers from across the nation and the 4 underrepresented groups: Native American, African, Latino, Asian and Pacific Islanders descent. These panels met at Georgetown University and created a core set of competencies for agencies serving the mentally ill. There are benchmarks, outcome measures, and standards. These are the only national standards of any kind approved by SAMHSA.	Courtenay Harding – charding@bu.edu

Gender Issues	Training for MH Professionals A series of manuals exist that can be used by professionals (and peers) to provide gender-informed services and supports. "Hope for Healing: Recovery and Empowerment for Women Consumers/Survivors" is a support group leadership curriculum that helps women with a mental illness who are in the first stages of recovery. Some of the topics addressed include creating safety and coping with crises, managing intense emotions and flash-backs, and therapeutic limit setting skills for women survivors. "Having Our Say: Women Consumers/Survivors Identify Their Needs and Strengths" compiles self-identified service and support issues for diverse women with a mental illness, and includes service policy, and research recommendations to better meet women's needs. The curriculum "Safe, Secure and Street-Smart: Empowering Women with Mental Illness to Achieve Greater Independence in the Community" helps women with a mental illness to enhance their community safety, independence, and self-advocacy skills. "Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups". This manual guides group leaders through the trauma recovery process, and includes discussion questions, typical responses, and experiential exercises. The manual, "Assessing the Needs of Women with Psychiatric Disabilities: Needs Assessment Protocol and Documentation Manual" is based on the National Women Consumers/Survivors Needs Assessment Survey and includes instructions for administering and interpreting the assessment. "Training on Evidence-Based Best Practices for Gender-Responsive Services to Address Mental Health, Trauma & Substance Abuse" includes modules related to evidence-based practices in gender-responsive services delivery with an emphasis on integrating treatment for trauma/abuse, mental health, and substance abuse Special Needs of Mothers with Mental Illness Recommendations for mothers with serious mental illness, based on longitudinal research. Key service delivery principles include services that are family-focused; contain a mix of treatment, rehabilitation and support; are not time-limited; are sensitive to stigma; focus on custody concerns; understand that parenting serves as a foundation for mothers' recov-	Judith Cook – cook@ripco.com Jessica Jonikas – jonikas@psych.uic.edu Lisa Razzano – razzano@psych.uic.edu Maxine Harris Judith Cook – cook@ripco.com Joanne Nicholson – jnichols@sghms.ac.uk Alexis Henry – Alexis.Henry@umassmed.edu

	ery; and involve inter-agency collaborations.	

Young Adults/ Youth In Transition Support System	Transition to Independence Process A system to engage youth and young adults in their own futures planning process, provide them with developmentally-appropriate services and supports, and involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains -- employment, career-building education, living situation, personal-effectiveness and quality of life, and community-life functioning.	Hewitt B. Rusty Clark clark@fmhi.usf.edu
Development of Compensatory and Environmental Supports	Personal Assistance Services Personal assistants to help with daily tasks. Note that this is not supported by all states. Building Natural Supports Intervention model developed to build and strengthen the consumer's natural support network while supporting the goal of employment. Intervention consists of a "social integration specialist" trained in, and implementing the *Texas EARNS Social Network Enhancement Curriculum*, which had been adapted from Biegel & Tracy's curriculum (1993). Intervention also includes a peer advocate staff member trained in, and implementing the *Self-Advocacy Curriculum: A Guide for Living and Working in Your Community*, which was develop by consumers through consumer focus groups. A companion fidelity measure assesses faithfulness to the model.	Marianne Farkas – mfarkas@bu.edu Carolyn Russell – Carolyn_Russell@FloridaSDC.info Steve Onken – so280@columbia.edu
Recovery Program Development	Developing a recovery-oriented system of care Recommendations and tools to assist mental health programs in developing a recovery orientation. The University of Illinois at Chicago (UIC) Center on Mental Health Services Research and Policy (CMHSRP) provides a number of resources to introduce concepts of self-determination and self-directed care into the traditional mental health system. These resources include conference papers and journal articles on federal, state, and public systems as sources of cash-outs and other fiscal opportunities; how to translate concepts of "patient-centered care" to behavioral health care; and current knowledge about self-determination at individual, human service systems, and societal levels.	William Anthony – wanthony@bu.edu Courtenay Harding – charding@bu.edu Judith Cook – cook@ripco.com Jeanne Dumont – jdumont@lightlink.com Marianne Farkas – mfarkas@bu.edu Dori Hutchinson – dorih@bu.edu

	Forwarding the Recovery Paradigm Recovery is difficult to define. Recovery means different things to different people. Yet, research has shown us that there are common elements that help us define the experience of recovery and indicators that help us recognize the degree to which a mental health system is recovery oriented. This series approaches the topic of recovery by examining benchmarks for a recovery oriented system, considerations for designing services that promote recovery, developing skilled practitioners, and supporting people as they undertake the task of recovery. The series concludes with outcome measures that assess people's recovery rather than program success. Each of these five sessions is co-presented by recognized leaders in the recovery movement, with at least one presenter per session being a person with the lived experience of recovery	Dr. Wm. Anthony Dr. Lori Ashcraft Dr. Mark Ragins Peter Ashenden Dr. Peggy Swarbrick Annette Backs Dr. Larry Davidson Jim McNulty Larry Fricks Larke Huang 7.5 hr. Training CD Produced by United States Psychiatric Rehabilitation Association ebussema@uspra.org
	Recovery Enhancing Environment measure (REE) A psychometrically sound assessment of stage of recovery and recovery markers for people with psychiatric disabilities that also assesses 24 elements of a recovery enhancing mental health program, 12 elements of a resilience engendering organization climate, and special needs (e.g., trauma, substance abuse).	Priscilla Ridgway – priscilla.ridgway@yale.edu
	Assessing Fidelity to the Recovery Model The Recovery Oriented System Indicators (ROSI) Measure evolved from collaborative efforts among a team of consumer and non-consumer researchers, state mental health authorities and a consortium of federal and state sponsors working to operationalize a set of system orientation performance indicators for mental health recovery. The findings of a grounded theory guided, multi-site qualitative study (N=115) of person-in-environment factors that help or hinder recovery for people experiencing severe and persistent mental illness were used in crafting the initial set of indicators. The findings of a multi-site prototype test (N=219) resulted in the selection of 42 of the initial 73 self-report items (i.e., the ROSI Adult Consumer Self-Report Survey) and a survey of nine participating SMHAs resulted in the selection of 23 if the ini-	Steve Onken – so280@columbia.edu

	tial 30 administrative-data items (i.e., the ROSI Authority/Provider Profile). A factor analysis of the 42 self-report items resulted in domains of Person-Center Decision-Making & Choice, Invalidated Personhood, Self-Care & Wellness, Basic Life Resources, Meaningful Activities & Roles, Peer Advocacy, Staff Treatment Knowledge, and Access. The 23 administrative-data items also include the domains of Peer Support, Staffing Ratios, Consumer Inclusion in Governance, and Coercion. The ROSI measure is undergoing pilot testing, no data is available yet for evidence-based ratings. <u>Developing a recovery center within a n existing setting</u> An adult education program that offers holistic education and wellness interventions in conjunction with rehabilitation interventions to assist in recovery. <u>Implementing Recovery Oriented Ingredients into existing Mental Health Practices</u> In-service training for administrators who are interested in implementing recovery oriented practices into their existing mental health services. (upon request). The training and consultation process currently is available upon request and plans are being developed to offer it electronically. The content is derived from research in organizational change as well as recovery process and outcomes research. An article related to the content is in press: Farkas, M., Gagne, C., Anthony, W.A.A. , Chamberlin, J. "Implementing Recovery Oriented Evidence Based Practices ", (in press) Community Mental Health Journal. <u>Hiring Consumers as MH Service Providers; Managing Accompanying Organizational Change and Conflict</u> There are two training manuals that address this topic. "Positive Partnerships: How Consumers and Non-Consumers Can Work Together as Service Providers" addresses issues that arise when current or former consumers of mental health services work as service providers. Topics include the benefits of hiring consumers, discrimination and other barriers to consumer hiring, strategies for creating an inclusive work environment, ways to avoid tokenism and co-optation, the transition from client to provider, methods for managing mental illness in the workplace,	Judith Cook – cook@ripco.com Jessica Jonikas – jonikas@psych.uic.edu Marianne Farkas – mfarkas@bu.edu Sam Shore – sam.shore@mhmr.state.tx.us

	and disclosure and consumer rights under the ADA. "Managing Workplace Conflict: A Skills Training Workbook for Mental Health Consumers and Supervisors" addresses the ways in which consumer and non-consumer service providers can resolve disagreements and manage conflict at work. Tips for effective negotiation and communication strategies leading to improved job performance and supervision are included. <u>Intentional Care: Employee Performance Standards That Support Recovery and Empowerment</u> Tools and standards to support a recovery orientation within an agency. This includes a set of standards and decision making tools that can be used by staff and supervisors to support clients' recovery; a set of evaluation tools with which supervisors can assess employee performance in supporting clients recovery; a set of competency tests through which supervisors can assess staffs' understanding of the Intentional Care Performance Standards; a method for teaching staff to intentionally and purposefully use their relationship with clients to support recovery and empowerment; training tool that includes role-plays for staff to practice the Intentional Care Performance Standards; and an on-line learning community where field sites have adopted and modified the Intentional Care Standards and posted their findings so that they can be reviewed and integrated into organizations.	Patricia Deegan; Advocates - patricia.deegan@comcast.net, http://www.intentionalcare.org/index_2.html

THERAPEUTIC INTERVENTIONS		
Skills Training	Social and Independent Living Skills (SILS) modules: Medication Management, Symptom Management, Basic Conversation Skills, Interpersonal Problem Solving Skills, Friendship and Intimacy, Community Re-entry, Recreation for Leisure (see below for others) Evidence-based skills training groups designed to teach psychiatrically disabled persons critical life skills needed to improve quality of life, and reduce stress and risk of relapse. Each group uses a therapist's manual with instructions for all group exercises, in addition to a videotape for in-group exercises, and pre-post assessment measures. These groups follow a cognitive-behavioral format, and involve frequent use of motivational interviewing, modeling, feedback, behavioral rehearsal with coaching and corrective/positive feedback, problem-solving exercises, in-vivo exercises, and homework assignments.	Robert Liberman – rpl@ucla.edu Chuck Wallace – cwall886@concentric.net Psychiatric Rehabilitation Consultants – www.psychrehab.com
	Self-Esteem Module This module consists of 24 hourly sessions which aim at helping individuals consolidate the five components of self-esteem: security, identity, belonging, purpose, and competence. Demonstrated effectiveness with inpatients as well as outpatients with a long history of psychosis.	Tania Lecomte – lecomte@interchange.ubc.ca
	Social Skills Training Role-play based social skills training, guided by selection of themes relevant to group members, and then choice of role-play exercises most suited to each person's level of functioning and disability. Treatment duration varies from a few weeks to 6-months or longer, depending on level of functioning and number and complexity of topics selected for training.	Alan Bellack – alan.bellack@med.va.gov Kim Mueser – Kim.T.Mueser@Dartmouth.edu
Workplace Social Skills Training	On-the-Job Curricular Series: Vol 1. Stress Management at Work, Vol 2. Workplace Social Skills, Vol 3. Avoiding Substance Abuse at Work Created to enhance the social skills of people who have secured or are currently seeking community employment, "Sustaining Employment: Social Skills at Work" includes information and role-play	Judith Cook – cook@ripco.com Jessica Jonikas – jonikas@psych.uic.edu Carol Petersen – cpetersen@psych.uic.edu

	activities for a variety of job-related situations, such as socializing with co-workers, requesting a raise, getting along with supervisors, employee rights and the ADA, and friendships or romances at work. The curriculum "Methods for Managing Stress in the Workplace: Coping Effectively on the Job" helps mental health consumers/survivors learn effective methods of stress management to cope with the pressures of employment. Techniques include identifying and coping with job-specific stressor, physical relaxation, deep breathing exercises, and assertiveness training. "Dealing with Difficult Choices about Drinking and Drug Use: Abstinence and Achievement on the Job": This curriculum addresses substance abuse and medication issues in the workplace. Sessions focus on general information regarding addiction and psychotropic medications, the consequences of mixing alcohol and drugs with prescribed medications, peer pressure to use substances during or after work, occurrence of relapse, and the use of self-help, twelve-step recovery groups.	
Client-Directed Treatment Planning	Therapeutic Contracting A system for therapeutic contracting whereby clients participate in developing their own treatment contracts. This method of case formulation and treatment planning improves treatment participation and improved outcomes for people with histories of distrust or negative experiences with providers. It empowers clients and expands choice.	Philip Levendusky – Levendp@mcleanpo.Mclean.org Rich Hunter – rich.hunter@clinicaloutcomes.us Robert Heinssen – rheinsse@mail.nih.gov
Cognitive Rehabilitation	Attention Process Training (APT) An individually administered form of cognitive rehabilitation originally developed for people with traumatic brain injury. Four modules are presented in sequential order: sustained attention, selective attention, alternating attention, and divided attention.	Mckay Moore Sohlberg & Catherine Mateer – www.lapublishing.com/AttentionMemoryTraining-TBI.htm
	Integrated Psychological Therapy (IPT) Group-administered cognitive rehabilitation originally developed in Switzerland by Hans Brenner and colleagues. Modules cover cognitive flexibility, social perception, verbal communication, basic conversation skills, and interpersonal problem solving.	Will Spaulding – Wspaulding@neb.rr.com

	Cognitive Enhancement Therapy (CET) Cognitive Enhancement Therapy is a small group, developmental approach for patients in the post-stabilization (recovery) phase of illness. It integrates computer assisted training in attention, memory and problem solving with a social cognitive curriculum. CET attempts to facilitate the attainment of adult cognitive milestones (e.g., perspective taking and social context appraisal) by shifting an early developmental reliance on effortful, serial processing to a more "gistful" abstraction of social themes.	Gerard Hogarty – hogartyje@msx.upmc.edu Sam Flesher – Smfgrappa@aol.com Deborah Greenwald – greenwald@upmc.edu
	Neurocognitive Enhancement Therapy (NET) A form of cognitive rehabilition that combines individualized computer training and other cognitive skill practicing, in addition to group work focusing on self-esteem and communication skills.	Morris Bell – rehab.javanet@rcn.com
	Thinking Skills for Work Program In the cognitive rehabilitation programs section of Therapeutic Interventions, the Thinking Skills for Work program should be added: The Thinking Skills for Work program is a cognitive remediation program designed to improve employment outcomes in persons with severe mental illness. The program is provided in the context of supported employment and includes four components: a) cognitive and work history assessment; b) 24 sessions of computer cognitive training exercises over approximately 4 months using Cogpack 6.0 (Marker software), a commercially available software program, facilitated by the cognitive specialist; c) collaborative job search planning with the client, employment specialist, and cognitive specialist; and d) job support consultation in which the cognitive specialist provides consultation to the employment specialist and client to address any work-related problems or unmet needs. Collaborative job search planning takes place at any point during the program, depending on the client's preference. Variations of the Thinking Skills for Work program have been implemented in other vocational rehabilitation programs.	Susan McGurk: susan.r.mcgurk@dartmouth.edu Karin Feldman: Kfeldman@bbcs.org
	Cognitive Remediation Therapy (CRT) Intervention to increase metacognition in people with schizophrenia.	Til Wykes – t.wykes@iop.kcl.ac.uk
	The Neuropsychological Educational Approach to	Alice Medalia – ameda-

	Remediation (NEAR) Developed specifically for psychiatric patients, NEAR emphasizes the importance of increasing both motivation and cognitive skills, to achieve a positive functional outcome. NEAR has been successfully implemented in a variety of outpatient and inpatient settings. As per the treatment manual, groups of 3-10 clients meet twice a week to work on individually paced, specially designed computer-assisted learning exercises, as well as a once weekly verbal group to facilitate transfer of learned skills to everyday life tasks. Goals of treatment include improvement in: neuropsychological functions, awareness about learning style, independent learning skills, confidence, and functional outcome.	lia@aol.com Nadine Revheim – revheim@nki.rfmh.org
	Errorless Learning Approaches Errorless learning is a theoretically- and empirically-based approach to training and intervention dating back to the mid 1960s in the experimental psychology literature. The approach is based on the premise that learning is stronger and more durable if it occurs in the absence of errors. Training includes several components: (a) the to-be-learned task is broken down into a set of hierarchically ordered components, (b) training begins on the simplest components and proceeds in a step-wise manner to more complex ones, maintaining high levels of performance proficiency by including multiple teaching aids during the transition from one step to another, (c) each component is over-learned through repeated practice, (d) previous used prompts, cues, and guided instruction are slowly faded to help ensure maintenance of previously attained high levels of performance proficiency.	Robert Kern – rkern@ucla.edu
	Attention Shaping Attention shaping uses individualized goal setting, frequent feedback, and specific prompts and reinforcers for goal attainment, to increase duration of specific attentive behaviors, reduce frequency of inattentive behaviors, and increase learning of psychoeducational and skills training content, in group settings.	Steven Silverstein – silvers1@umdnj.edu Tony Menditto – anthony.menditto@dmh.mo.gov
Compensatory Environmental Supports	Cognitive Adaptation Therapy (CAT) Cognitive Adaptation Training uses environmental supports such as signs, checklists, alarms, special medication containers, and the organization of the home or work environment to cue and sequence adaptive behavior. Supports are based upon cogni-	Dawn Velligan – velligand@uthscsa.edu

	tive testing to identify relative strengths and weaknesses, level of executive functioning and behavioral style in completing goal-directed behavior. Supports are established and maintained by brief weekly home (workplace) visits from a CAT trainer.	
Cognitive Behavior Therapy	Cognitive Behavior Therapy for Psychosis The premise of CBT is that cognition, the process of acquiring knowledge and forming beliefs, can influence mood and behavior. CBT techniques help patients to identify and correct thoughts and misinterpretations of experiences that are at the root of aberrant behavior. Schizophrenia patients typically have information processing biases and deficits in abstract reasoning and cognitive flexibility that may contribute to maintenance of delusional beliefs. CBT modifies these cognitive processes and challenges beliefs underlying delusions, hallucinations and negative symptoms. Patients are introduced to the general concepts of CBT, including the relationship between thoughts, actions and feelings (generic cognitive model), automatic thoughts, thought challenging by examining evidence for beliefs, and mistakes in thinking (e.g., jumping to conclusions; mind reading; all-or-none thinking). Patients are taught to identify thoughts, identify relationships between thoughts, feelings and behaviors, and identify mistakes in thinking. Behavioral experiments are conducted inside and outside of sessions (homework), in order to gather evidence to evaluate beliefs. Alternatives therapy, Socratic questioning, thought chaining, and thought records are used to help patients examine the logic of beliefs underlying positive and negative symptoms and generate more adaptive alternatives to mistakes in thinking or thoughts without sufficient evidence.	USA : Eric Granholm – egranholm@ucsd.edu Aaron Beck – abeck@mail.med.upenn.edu David Penn – dpenn@email.unc.edu Steven Silverstein – silvers1@umdnj.edu Canada : Neil Rector – Neil_Rector@camh.net UK : Paul Chadwick – paul.chadwick@wht.nhs.uk Max Birchwood – M.BIRCHWOOD@bham.ac.uk Nick Tarrier – Nick.Tarrier@man.ac.uk David Kingdon – D.Kingdon@soton.ac.uk Douglas Turkington – douglas.turkington@ncl.ac.uk
	Group CBT for Psychosis Manualized intervention to address psychotic symptoms in a group format.	Tania Lecomte - lecomte@interchange.ubc.ca
	Dialectical Behavior Therapy Dialectical Behavior Therapy (DBT) was originally developed as a broad array of cognitive and behavior therapy strategies addressed to the problems of	Marsha Linehan – Linehan@u.washington.edu Website: http://faculty.u.washington.

	Borderline Personality Disorder, including suicidal behaviors. More recently, it has been increasingly used for people with schizophrenia. Stylistically, DBT blends a matter-of-fact, somewhat irreverant, and at times outrageous attitude about current and previous parasuicidal and other dysfunctional behaviors with therapist warmth, flexibility, responsiveness to the patient, and strategic self-disclosure. Emotion regulation, interpersonal effectiveness, distress tolerance, core mindfulness, and self-management skills are actively taught. In all modes of treatment, the application of these skills is encouraged and coached. Throughout treatment, the emphasis is on building and maintaining a positive, interpersonal, collaborative relationship between patient and therapist. A major characteristic of the therapeutic relationship is that the primary role of the therapist is as consultant to the patient, not as consultant to other individuals.	edu/linehan/
	Cognitive-Behavioral Therapy for PTSD in SMI The CBT for PTSD in SMI program is a 12-16 week individual program focusing on the treatment of PTSD in persons with severe mental illness. The program is primarily based on cognitive restructuring and does not include therapist directed exposure therapy. The program includes the following components: a) Orientation to Program; b) Developing a Crisis Plan; c) Breathing Retraining; d) Education about PTSD; e) Education about Associated Symptoms and Problems; f) Cognitive Restructuring I: Common Styles of Thinking; g) Cognitive Restructuring II: The 5 Steps of Cognitive Restructuring; e) Generalization Training; and f) Termination.	Kim Mueser: kim.t.Mueser@dartmouth.edu Stan Rosenberg: Stanley.d.Rosenberg@dartmouth.edu Jessica Hamblen: Jessica.l.hamblen@dartmouth.edu
	Trauma Recovery and Empowerment Model (TREM) TREM is a 24-29 session treatment that addresses areas of empowerment, the impact of trauma events, and skills building. Skills such as self-soothing, self-awareness, emotional modulation, development of safe and mutual relationships, and consistent problem solving are aimed at active substance abuse treatment and relapse preventions. TREM utilizes cognitive-behavioral, psychoeducational, and skills training approaches. Versions are available for use with men, adolescent girls and for Spanish language and culture.	Rebecca Wolfson Berley – rwolfson@ccdc.org

Supported Socialization	Partnership Project Supported socialization seeks to increase the involvement of individuals with psychiatric disabilities in naturally occurring social and recreational activities in community settings of their choice. Consumers are paired with either another consumer or a non-consumer. Results of a controlled study indicated significant increases in socialization as well as improvements in quality of life. Compeer The Compeer Program matches community volunteers in friendship relationships with children and adults who are receiving mental health treatment. Consumers are are referred to the program by mental health professionals. Community volunteers, who are trained and screened, visit their friend for a minimum of one hour per week for a year and provide rehabilitative social support, advocacy, educational and vocational mentoring, and access to community resources. On-going training, supervision and support are also provided.	Larry Davidson - Larry.davidson@yale.edu http://www.compeer.org/1/contact-us.asp
Psychotherapy	Personal Therapy Evidence based form of psychotherapy for people with schizophrenia and related disorders.	Gerard Hogarty - hogartyje@msx.upmc.edu

Illness/Wellness Management	Illness/Wellness Management and Recovery Program The Illness Management and Recovery (IMR) program (also called Wellness Management and Recovery) teaches people how to manage their psychiatric disorder in collaboration with others in the context of setting and pursuing personally meaningful goals. IMR is one of the evidence-based practices identified by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundation of IMR is the setting and pursuit of personally meaning goals, which the client identifies at the beginning of the program and which are continually supported and followed up throughout the program. The IMR curriculum consists of 10 modules: Recovery Strategies, Practical Facts about Mental Illness, The Stress-Vulnerability Model, Building Social Support, Using Medication Effectively, Drug and Alcohol Use, Reducing Relapses, Coping with Stress, Coping with Problems and Persistent Symptoms, and Getting Your Needs Met in the Mental Health System. Each module consists of a detailed educational handout (including discussion questions and worksheets) and a practitioner's guide. Practitioners are expected to use a combination of teaching strategies in IMR sessions: motivational enhancement strategies, educational strategies and cognitive-behavioral strategies. The IMR program can be provided in an individual or small group format and usually takes 6-10 months to complete, depending on frequency of sessions. The IMR toolkit consists of a workbook (with written materials including an introduction, practitioners' guidelines, educational handouts, and information sheets), a short introductory videotape, and a practice demonstration videotape showing examples of clinicians working with clients using each of the modules. The original workbook is available online at www.samhsa.gov. Susan Gingerich and Kim Mueser have revised the workbook and SAMHSA will post it on their website.	Kim Mueser – kim.t.mueser@dartmouth.edu Susan Gingerich – gingsusan@yahoo.com Michelle Salyers – mpsalyer@iupui.edu Piper Meyer – psmeyer@email.unc.edu Lindy Fox – melinda.b.fox@dartmouth.edu Harry Cunningham – cunningh@mhcgm.org
Family Psychoeducation	Multiple Family Group Treatment Evidence-based intervention for treating patients and their families in a group format.	William McFarlane – (207) 662-2091
	UCLA Involving Families in Services for the Seriously Mentally Ill Module	Shirley Glynn – Sglynn@ucla.edu

	This program is designed to provide the skills necessary for mental health professionals to collaborate successfully with relatives of persons with serious psychiatric illnesses, and for relatives to collaborate effectively with professionals. Seven core competencies are covered in two manuals—one directed at professionals and one directed at relatives. An accompanying video demonstrating the skills is also available. The curriculum covers information about serious mental disorders, their treatments, resources available in the community and how to access them, communication and problem-solving skills, and overcoming special problems relevant to minority groups and dual diagnosis. This group can be used by staff of inpatient units, crisis units, assertive community treatment teams, mental health centers, private practitioners, and psychosocial clubs.	Robert Liberman - rpl@ucla.edu Psychiatric Rehabilitation Consultants – www.psychrehab.com
	Evidence Based Family Education/Psychoeducation (patient outcome focused) Family psychoeducation is a post-acute stabilization phase intervention that addresses the increased processing demands of family life through the formation of a family alliance, provision of an educational seminar, (including survival strategies), and a collaborative, step-wise plan for reintegrating the patient into the family and community.	William McFarlane – (207) 662-2091 Kim Mueser – Kim.T.Mueser@Dartmouth.edu Robert Liberman – rpl@ucla.edu Ian Falloon Carol Anderson – andersoncm@msx.upmc.edu Gerard Hogarty – hogartyje@msx.upmc.edu
	Brief Family Psychoeducation and other family interventions (family coping focused) Brief family interventions include family consultation, family support groups, and family education. As a group, these interventions are designed to meet the needs of families for support, skills, and education. There is some evidence that these relatively brief and cost-effective interventions do meet family needs, although there is insufficient research to meet the standards for evidence-based interventions. On the other hand, evidence-based family psychoeducation involves intensive and long-term intervention by a multidisciplinary team, which may not be feasible for some families, providers, and/or settings. Educating Patients and Families about Mental Ill-	Diane Marsh – dtm3@pitt.edu Harriet Lefley – hplefley@aol.com Susan Gingerich Sue Pickett-Schenk – pickett@psych.uic.edu Judith Cook - cook@ripco.com Cynthia Bisbee – cibis-

	ness 475-page manual includes course outlines, masters to make slides or transparencies, homework, hand-outs, for topics related to serious mental illness, and general information on models and methods for educating both patients and families. While this specific manual & set of classes has not been the subject of research studies, the method of patient and family psychoeducation has been well researched and is considered an evidence-based practice.	bee@aol.com
	Family to Family A 12 week course taught by trained family members focusing on schizophrenia, bipolar disorder, clinical depression, panic disorder and OCD. The course discusses the clinical treatment of these illnesses and teaches the knowledge and skills that family members need to cope more effectively.	Joyce Burland joyce@nami.org Lisa Dixon – ldixon@umaryland.edu
	Journey of Hope Family Education Course (for families of adults, and for families of young adults JOH is an 8-week course for families of adult relatives with mental illness. JOH is a family-led course: all trained volunteer instructors have a relative with a mental illness. Course curricula covers the biological causes and treatments of schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and obsessive-compulsive disorder. Symptom complexes and relapse warning signs for each of these illnesses are discussed. Problem-solving and communication skills training also are taught. Families are taught how to work with professionals, and how to best facilitate their relatives' recovery. The course itself and all course materials are free to participants. Results from the recently-completed controlled study of JOH indicates that long-term course participation benefits include increased knowledge of the causes and treatment of mental illness, improved relationships with ill relatives, decreased depressive symptoms, and increased satisfaction with mental health services.	Sue Pickett-Schenk – pickett@psych.uic.edu Linda Zweifel – lzweifel@att.net
	Behavioral Family Therapy/Behavioral Family Management/Family Focused Therapy for Bipolar Disorder is a single family psychoeducation model designed by develop collaborative working rela-	Shirley Glynn – sglynn@ucla.edu Robert Liberman - rpl@ucla.edu

	tionships between a client's treatment team and his or her family, including the client, in order to better manage the psychiatric disorder, reduce stress in the family, help the client make progress towards personal recovery goals, and improve the well-being of everyone in the family. The program includes the following components: a) assessment of each family member and the family as a whole; b) psychoeducation about the nature of the psychiatric disorder and the principles of its treatment; c) communication skills training; d) problem solving training; and e) special problems. The family program is usually provided over a 9 to 24 month period.	David Miklowitz - Miklowitz@Colorado.EDU Kim Mueser – kim.t.mueser@dartmouth.edu Susan Gingerich – gingsusan@yahoo.com Lindy Fox – melinda.b.fox@dartmouth.edu
Substance Abuse and SMI	Overcoming Addictions: Skills Training for People with Schizophrenia Teaches groups of individuals with schizophrenia how to avoid drugs and alcohol, recognize signs that they may be headed toward relapse, and build healthy habits and healthy pleasures into their daily routine. Each chapter includes suggested scripts for use in training sessions. Most of the sessions focus on teaching specific skills (e.g., how to say "no" to a pushy dealer) using the Substance Abuse Management Module (SAMM) Skills Illustration Videotape (available from W. W. Norton). Integrated Dual Disorders Treatment This model specifies that that concurrent treatment should be provided for severe mental illness and substance use disorders (dual disorders) by the same clinician or team of clinicians, with the treatment team assuming responsibility for integrating the treatment of the two disorders. Integrated treatment emphasizes: the use of assertive outreach to engage clients in treatment and provide as needed assistance in the community; motivational enhancement to address one's substance use problems and better manage one's mental illness; reduction of harmful consequences related to substance use; cognitive-behavioral therapy strategies to help people develop skills for refusing offers to use substances, prevent substance abuse or mental illness relapses, and cope with symptoms or cravings; collaboration with significant others; comprehensiveness to address the broad range of social, health, housing, and medical needs; and long-term treat-	Andrew Shaner – ashaner@ucla.edu Lisa Roberts Thad Eckman Kim Mueser – kim.t.mueser@dartmouth.edu Doug Noordsy - Douglas.l.noordsy@dartmouth.edu Robert Drake – Robert.e.drake@dartmouth.edu Lindy Fox – melinda.b.fox@dartmouth.edu Patrick Boyle – patrick.boyle@case.edu Marc Bono - dualrecovery@comcast.net Rusty Foster – Alan Bellack -

	ment when needed. Multiple treatment modalities are employed, including individual, group, and family approaches. Behavioral Treatment for Substance Abuse by people with Severe Mental Illness (BTSAS) BTSAS is administered to small groups (4-6) twice per week for 6-months. It is a highly structured social learning intervention that was designed to accommodate the cognitive deficits endemic to schizophrenia, but that are common in other patients with SPMI as well. Behavioral rehearsal, repetition, minimal demands on memory, and low levels of abstraction are central features. Each session adheres to the same basic structure: a) A urine sample is secured and the results are announced to the group. Subjects with negative samples receive social reinforcement from the therapists and group members (applause is typical) and financial reinforcement. Subjects who have positive samples are engaged in a non-accusatory discussion of situational factors that contributed to use, and rehearse coping strategies to increase the likelihood of abstaining in the situation in the future. b) Each subject is then assisted in setting realistic goals for decreased drug use until the next session, and signs a goal contract. c) The remainder of each session follows a structured curriculum for drug abuse education, skills training, and relapse prevention. The content varies somewhat according to the needs of the particular set of patients in the group and how well they are doing. More time is devoted to goal setting and problem solving if group members are actively using drugs. Conversely, if most group members are doing well more time is available for teaching, and more curriculum units can be covered. Enrollment is open (rolling), and the curriculum is recycled as members graduate and all required curriculum units are completed.	alan.bellack@med.va.gov
Role Recovery	Rehabilitation Readiness This curriculum teaches providers the skills they need to involve individuals with serious psychiatric disabilities in an assessment of their willingness and preparedness to commit to a long term process of change. The content is derived from empirical principles identified in the literature (e.g. motivation, learning, change theory etc).	Marianne Farkas – mfarkas@bu.edu

	Recovery Education Program (Workbook, Leader's Manual, and Book – in English and Spanish) Can be run by consumers or professionals or both. The purpose of the workbook is to help people with mental illnesses to understand the possibilities and process of recovery. No significant research.	LeRoy Spaniol – leroys@bu.edu
	Workbooks and other resources for facilitating self-determination (3 in the set) "This is Your Life! Creating Your Self-Directed Life Plan". This easy-to-use workbook helps people with psychiatric disabilities think about, choose, plan for, and act on a life goal, with supports of their own choosing. The workbook has as it foundation both person-centered planning and the stages of change model. It guides people in mental health recovery to see that life change is a process, with natural twists and turns along the way. "Raising Difficult Issues with Your Service Providers": This booklet provides "conversation starters" for people to use when they wish to begin an empowering dialogue with mental health service providers. Ways to raise issues in ten important life areas cover education, employment, history of abuse and trauma, intimate relationships, control over one's own money, maintaining privacy, promoting sexual freedom, honoring choices about psychiatric medications, and showing respect for service recipients. "Choosing an Evidence-Based Supported Employment Program": "Seeking Supported Employment: What You Need to Know" is an easy-to-read booklet that guides consumers through the process of identifying an evidence-based supported employment program. Using a question and answer checklist format, along with an integrated scoring system, consumers can choose the program that is right for them, and know whether the program provides services that research has shown lead to career success.	Judith Cook – cook@ripco.com Jessica Jonikas – jonikas@psych.uic.edu

Tools for Enhancing Self-Determination Among People with Mental Illness	Mentoring Young Adults with SMI A program guide and curriculum that fosters the development of mentor relationships between adults in recovery with young adults with serious mental illness	Dori Hutchinson – dorih@bu.edu
	Wellness Curricula Wellness Curricula: a 10-week Healthy lifestyle curriculum for women with psychiatric disabilities, includes a yoga curriculum, supported fitness program guide, etc.	Dori Hutchinson – dorih@bu.edu
	Connecting Skills This is a workbook for people with mental illnesses that has been piloted for four years. The purpose of the workbook is to help people with mental illnesses to understand the knowledge, skills, and support necessary to build relationships.	LeRoy Spaniol – leroys@bu.edu, Patricia Deegan – patricia.deegan@comcast.net, www.power2u.org
	Wellness Recovery Action Planning Program (developed by and for consumers) Wellness Recovery Action Planning (WRAP) is a self help life management system developed in 1997 be a group of people who had been working to recover from mental health difficulties and move forward with their lives. It includes identification of wellness tools, and using these tools to develop lists of things to do every day to maintain wellness, responding to triggers, early warning signs and signs that things have gotten much worse, and to develop Advance Directives and Post Crisis Plans. This plan, along with other recovery topics that have been identified and developed by people who have mental health difficulties such as changing negative thoughts to positive, self esteem, peer support and employment issues has been incorporated into a curriculum, Mental Health Recovery including WRAP: Facilitator Manual (Copeland, M. Revised 2002. Dummerston, VT: Peach Press). WRAP and the curriculum have been networked widely in the United Sates and around the world through groups facilitated by trained recovery educators. Many of the Recovery Educators are people who have experienced mental health difficulties. This program has become the cornerstone of mental health recovery programs in many states including Vermont, West Virginia, Illinois, Connecticut, Minnesota and	Mary Ellen Copeland – copeland@mentalhealthrecovery.com

	New Mexico. For more information contact the Copeland Center for Wellness and Recovery,	
	Consumer Organization and Networking Technical Assistance Center Consumer Curricula The three day curriculum is not about mental illness but rather citizenship wherein adult learners with psychiatric disabilities acquire the skills needed to navigate the social, political and behavioral health system.	Larry Belcher – larry-belcher@contac.org
	Manual for Delivering Peer Support in Post-Secondary Settings Peer Support for Students in Postsecondary-Education is a skills-based manual designed to help consumers who are beginning or returning to college develop their own support group. The lessons in the manual include both how to set up a support group and the information needed for students to successfully return to school. The topics included are: Developing a peer support group Being a peer mentor Helping and communication skills Problem solving skills Making decisions Developing an educational goal Advocating for resources Accommodations and services Financial aid The manual is 131 Pages, and is available through the UIC National Research and Training Center on Psychiatric Disability, 104 South Michigan Ave, Suite 900, Chicago, IL USA 60603 312.422.8180/Phone 312.422.0740/FAX 312.422.0706/TDD	Karen Unger – kvunger@easystreet.com
	Peer support Literature review on naturally occurring mutual support groups, consumer-run services, and the employment of consumers as providers within clinical and rehabilitative settings.	Larry Davidson – larry.davidson@yale.edu
	CDs About Recovery for Consumers Brief CDs of consumers speaking about recovery, to be viewed from a personal computer. "Recovery	Gene Oulvey – DHSVR30@dhs.state.il.us

	from Mental Illness: A Process of Hope, Healing, Choice, Growth" is on recovery in general. The other, "9 to 5: Recovery is Working" deals with issues such as encouragement to resume working, and how to keep benefits while working.	
Integrated Health Care	Helping Older People Experience Success (HOPES) Program In the skills training section of Therapeutic Interventions, the Helping Older People Experience Success program should be added: The Helping Older People Experience Success program is a skills training program designed to improve social functioning, community living, and health in older persons with severe mental illness. The program integrates social rehabilitation and health care management over a one year active treatment period followed by a one year maintenance period. Skills training is taught through a combination of role play practice, in vivo community trips, and engaging the support of indigenous support persons, with curriculum divided into seven modules, including Making the Most of Leisure Time, Living Independently in the Community, Communicating Effectively, Making and Keeping Friends, healthy Living, Making the Most of a Health Care Visit, and Using Medications Effectively. Teaching is guided by a leader's manual supplemented by participant handouts.	Sarah Pratt: sarah.i.pratt@dartmouth.edu Kim Mueser: kim.t.Mueser@dartmouth.edu
Supported Housing	Supported housing covers housing projects which are managed for the benefit of people who need additional support. This can mean regular support in a specifically designed project, support visits for someone who can almost live completely independently (known as floating support) or it can mean projects supplying 24 hour support to help its clients live in the wider community. A recent element of the supported housing movement is a change from reliance on a faculty-based residential treatment setting or a series of such specialized settings as the focus for treatment and rehabilitation to the need for a safe, secure home of one's own as a basis for a stable life in the community. In this new paradigm, professionals no longer select the setting or determine what type of placement is best for the patient, nor do they place a person on the basis on the basis of open beds or slots in the residential ser-	Paul Carling - http://www.cccinternational.com/contactccci.htm

	vice system. Rather, the person is helped to choose an appropriate living situation on the basis of personal criteria, preferences, resources, and needs. As such, the patient assumes the role of tenant, householder, neighbor, and mainstream community member, working together with staff on mutually agreed on goals and tasks geared toward the individual's success and stability in the home chosen. Additionally, social support, case management, crisis intervention, in-home skills training, and accessible psychiatric consultation, are flexibly wrapped around the changing needs of the patient. Financial assistance is available through subsidized rental vouchers (Section 8 grants) provided by the United States Department of Housing and Urban Development. To date, three large demonstration projects indicate that innovative, supportive housing programs do seem to allow many persons with long-term psychiatric disorders to develop a stable home in the community. However, an ambitious policy of independent housing – without consideration of such factors as substance abuse, an individual's social network, poverty, quality of housing, criminal activity in the neighborhood, and the amount and quality of ongoing, personalized support and assistance from community-based mental health teams – is not likely to maintain long-term residential stability.	
Supported Employment	Supported Employment Placement of clients in competitive jobs with using the place and train approach, with provision of supports to address obstacles to successful performance. The defining features of the IPS model are all incorporated into SAMHSA's toolkit on supported employment (downloadable at www.samhsa.gov), including the fidelity scale. Integrated SE and ACT Program. ACT subteam operates according to PACT model standards, but does not provide vocational services. The SE subteam adheres to its program model standards. Both subteams work side-by-side as a self-contained program at all times. ACT-IPS aims at reducing interference of illness symptoms while vigorously backing efforts to promote clients' efforts to succeed in the competitive labor market. Employment Specialists coordinate multiple vocational service cycles of assessment, planning, coun-	Robert Drake – Robert.E.Drake@Dartmouth.edu Debbie Becker Deborah.R.Becker@hitchcock.org Judith Cook – cook@ripco.com Lisa Razzano – razzano@uic.edu

	seling, and job development/finding, while enlisting ACT staff to help clients control illness symptoms and break through cognitive, emotional, and behavioral impairments to perform well on the job, cope with and learn from job endings, and undertake new job searches. <u>Career Development curriculum</u> The Career Planning Curriculum is a comprehensive instructional guide for helping people with psychiatric disabilities specify and plan for the attainment of vocational goals. The content is derived from the Choose-Get-Keep approach developed at Boston University Center for Psychiatric Rehabilitation.	Paul Gold – goldpb@musc.edu Marianne Farkas – mfarkas@bu.edu
Community Integration	<u>Redefining Community…Discovering the Value and Gifts of Every Citizen</u> Relationships are critical for recovery from serious mental illness. Moving from the medical model of providing services in an institution to maintaining people in the community as a result of deinstitutionalization does not guarantee community membership and interdependence. Presenters share examples of their community-building projects that can help agencies become better corporate citizens while assisting individuals to fight isolation and build their own social networks.	Dennis Rice Michael Siebold 90 minute Training CD Produced by United States Psychiatric Rehabilitation Association ebussema@uspra.org
Spirituality	<u>The Role of Spirituality in Wellness Management</u> The discussion of religion and spirituality has been a taboo topic in mental health for the greater part of	Dr. Nancy Kehoe Evelyn Bussema

	the 20th century. A growing body of research, more in relation to physical health than mental health, suggests that religion and spirituality can play a beneficial role. Following a literature review, this training focuses on working with people in recovery and the role religion and spirituality play in their lives. Pointers will be given on how to address this topic and deal with one's own issues related to religion and spirituality.	90 minute Training CD Produced by United States Psychiatric Rehabilitation Association ebussema@uspra.org
Forwarding the Recovery Paradigm	Forwarding the Recovery Paradigm Recovery is difficult to define. Recovery means different things to different people. Yet, research has shown us that there are common elements that help us define the experience of recovery and indicators that help us recognize the degree to which a mental health system is recovery oriented. This series approaches the topic of recovery by examining benchmarks for a recovery oriented system, considerations for designing services that promote recovery, developing skilled practitioners, and supporting people as they undertake the task of recovery. The series concludes with outcome measures that assess people's recovery rather than program success. Each of these five sessions is co-presented by recognized leaders in the recovery movement, with at least one presenter per session being a person with the lived experience of recovery.	Dr. Wm. Anthony Dr. Lori Ashcraft Dr. Mark Ragins Peter Ashenden Dr. Peggy Swarbrick Annette Backs Dr. Larry Davidson Jim McNulty Larry Fricks Larke Huang 7.5 hr. Training CD Produced by United States Psychiatric Rehabilitation Association ebussema@uspra.org
Pathways in Living	Pathways in Living Pathways in Living (PIL) is an 8-week peer-led recovery education course for mental health consumers. PIL was developed by consumer members at NAMI-Greater Chicago and uses the Pathways to Recovery self-help workbook. In PIL, consumers learn recovery principles, how to change negative thinking, set goals, and strengthen social supports.	Suzanne Andriukaitis, LCSW namigc@aol.com Sue Pickett-Schenk, Ph.D. pickett@psych.uic.edu

ASSESSMENT METHODS		
TYPE	**SPECIFIC INTERVENTION**	**CONTACT PERSON/PEOPLE**
Responsiveness to Skills Training Interventions	Micro-Module Learning Tests (MMLT) The MMLT is designed to rapidly assess a person's responsiveness to skills training interventions. There are 7 alternate forms of the test, making it suitable for repeated testing. Each test has 3 components, measuring responsiveness to: verbal instruction and videotaped modeling, and ability to demonstrate observed skills in a role-play. The MMLT is also a dynamic assessment measure in that it assesses whether people can benefit from instructional cues when they initially answer an item incorrectly.	Steven Silverstein – silvers1@umdnj.edu Chuck Wallace – cwall886@concentric.net
Progress and Outcome data	Functional assessment instruments – Context, Antecedent, Behavior, Consequence (CABC) cards; Patterns and Trends Data Sheet Simple data observation and collection instruments that lead to improved causal analysis and measurement of treatment outcomes will be presented. Case examples demonstrating their utility in generating case-specific functional etiological hypotheses, directing interventions at more precise targets, evaluating the impact of various intervention strategies, and advising when interventions should be discontinued thereby leading to more efficient services will be included. Integrating data collection and analysis formats as a means to improve case formulation and intervention strategies will be discussed.	Rich Hunter – rich.hunter@clinicaloutcomes.us
	Therapy, Activity, Classes (TAC) Observational Rating System; Individualized Behavior Management Plan (BMP) development The TAC system is a method for monitoring critical behaviors in a group-treatment format, and includes items such as attentiveness, participation, and disruptiveness. BMPs are individualized, data-driven behavior contracts.	Will Spaulding – Wspaulding@neb.rr.com
	Clinical Frequencies Recording System (CFRS). The CFRS consists of a set of forms on which observational data are recorded by clinical staff as part of ongoing clinical operations as well as computerized summarizing procedures. It documents ongoing client/staff event data to ensure	Gordon L. Paul – gpaul@uh.edu Tony Menditto – anthony.menditto@dmh.mo.gov Paul Stuve –

	proper conduct of Social-Learning Programs.	mbstuvp@mail.dmh.state.mo.us
	The Computerized TSBC/SRIC Planned-Access Observational Information System. The complete TSBC/SRIC System is an objective assessment and information system providing practical support of ongoing clinical, administrative, and regulatory decision-making in any adult inpatient or residential treatment program. Technician-level observers monitor all clients, staff, & programs, time-sampling 16 hrs/day on the Time Sample Behavior Checklist (TSBC) & the Staff-Resident Interaction Chronograph (SRIC). An integrated set of procedures and computer reports combine data from TSBC, SRIC, and other sources (biographical, financial, medical) to provide continual gathering, processing, analyzing, & distribution of most data needed for clinical decision-making, staff competency assessment, and comparative program evaluations. It is a fully manualized and computerized system with documented cost-effectiveness.	Gordon L.Paul – gpaul@uh.edu Mark H. Licht – mlicht@DARWIN.PSY.FSU.EDU Tony Menditto – anthony.menditto@dmh.mo.gov Paul Stuve – mbstuvp@mail.dmh.state.mo.us
Functional Assessment	Independent Living Skills Survey (ILSS) The ILSS comes in self- and other-rated forms. It contains 118 items broken into 12 areas of community functioning, including money management, job seeking, social interaction skills, and ability to care for self and living space. Independent Living Scales The ILS is an individually administered assessment of the degree to which adults are capable of caring for themselves and their property. Although the ILS is designed primarily for use with older adults, it is also useful for assessing competence in adults with brain injury, emotional disturbance, dementia, or mild mental retardation. The ILS is composed of five scales that assess the following areas: Memory and Orientation Managing Money Managing Home and Transportation Health and Safety Social Adjustment Independent Living Skills Inventory An 89-item functional assessment instrument	Chuck Wallace – cwall886@concentric.net Psychological Assessment Resources, Inc. – http://www.parinc.com/product.cfm?ProductID=142 Alice Medalia – amedalia@aol.com Will Spaulding – WSpaulding@neb.rr.com

	measuring the extent to which individuals are able to competently perform a broad range of skills important for successful community living. It contains subscales related to skills in a 11 areas critical to community living, including interpersonal skills, home maintenance, cooking, medication management, etc. Also comes in a briefer format.	
Social Skills Assessment	Assessment of Interpersonal Problem Solving Skills (AIPS) A videotape-based measure that involves viewing vignettes where there is or is not an interpersonal conflict, and then determining the best way to solve the problem, and role-playing the solution. Structured Role Play Technique *Maryland Assessment of Social Competence* (MASC). The MASC measures participants' ability to solve common problems in an interpersonal context (e.g., a job interview). It was empirically developed and has proven to be reliable in several studies, to have good discriminant validity, and to be relatively independent of changes in symptomatology. It consists of 3-4 role play scenarios and takes about 20 minutes to administer. Alternate forms are available. Unstructured Role Play Technique This is a three-minute conversation probe used to assess social skill in persons with severe mental illness.	Pete Donahoe Will Spaulding – Wspaulding@neb.rr.com Alan Bellack – alan.bellack@med.va.gov David Penn – dpenn@email.unc.edu
Rehabilitation and Recovery-Oriented Assessments	Competency Assessment Instrument (CAI) The CAI measures 15 provider competencies that are central to the provision of recovery-oriented care. Recovery Competencies for Mental Health Professionals: What Psychiatrists and Therapists Need to Know This short guide presents essential knowledge about the process of recovery from mental illness. Summaries of relevant research, first-person accounts, and clinical experiences are linked to Recommended practices and approaches. Essential helping skills are described. Recovery Competencies for Mental Health Pro-	Alexander Young – www.mirecc.org Marianne Farkas – mfarkas@bu.edu Marianne Farkas –

	fessionals: Essential Skills for Professional and Peer Helpers This training guide is focused on helping people who work closely with people who are recovering from mental illness to acquire interpersonal skills and behaviors that facilitate the process of recovery. Survey research, first-person accounts, and clinical experiences have suggested the importance of the skills of: demonstrating understanding and inspiring and behaviors that demonstrate respect are important facilitators of the recovery process.	mfarkas@bu.edu
	Client's Assessment of Strengths, Interests, and Goals (CASIG) The CASIG collects individualized data, structures how the data are used to plan and evaluate a client's treatment, and produces aggregate information relevant for research and program purposes. Two parallel versions were developed: one for the client's self-report, and one for an informant's report. The CASIG begins by assessing medium-term goals in five areas of community living: housing, money/work, interpersonal relationships, health, and spiritual activities. Other sections assess current and past community functioning, medication compliance and side effects, quality of life, quality of treatment, symptoms and performance of intolerable community behaviors. A computer program can be used to score the CASIG, and to generate a rehabilitation plan.	Chuck Wallace – cwall886@concentric.net
	Multidisciplinary Algorithm for the Assessment for Persistent Schizophrenia (MAAPS) MAAPS transfers technology learned in university research protocols to the general public clinical arena. MAAPS was designed to promote a systematic, structured and comprehensive assessment of patients with persistent schizophrenia. These persons are still symptomatic, stuck at low levels of functioning, and were not fortunate enough to have ever been included in university-based comprehensive research projects. MAAPS is laid out in a formal logical sequence for each of the five disciplines (psychiatry, neuropsychology, nursing, social work, and occupational therapy/vocational rehabilitation). Each	Courtenay Harding – charding@bu.edu

	discipline's algorithm is laid out as the critical question → tool to use → answer elicited → treatment plan recommendations (some with further step-down assessments). Each discipline has an average of 5-6 questions to pursue specific to its own natural area of training and expertise. Completion of the individual discipline-specific assessments has been timed to cover approximately 80-90 minutes each. The Manual for MAAPS consists of training materials, a presentation about outcome in schizophrenia, the MAAPS algorithm, the instruments involved, and the literature supporting the instruments as well as the treatment recommendations.	
Acquiring the Life History of Clients to Individualize Treatment Planning	<u>The LIFELINE & The LIFECHART</u> The LIFELINE is a short but effective data collection mechanism using semi-structured interview about a life lived. There are 12 domains outlined in this format: date and place of birth, living situation, family composition, schooling, friends, life events (including trauma such as witness, victim, or perpetrator of violence), dating/intimate relationships, substance use, symptom evolution, employment, coping and buffers, prodrome, medications and other treatments, and sustaining activities. This instrument was designed as a brief version of the LIFECHART. It takes about 30 minutes and data is converted to structured narrative format, which includes both history as related by the subject and subjective observations by the rater. The LIFECHART and LIFELINE are derived from the work of Adolph Meyer (1919) and Alexander & Dorothea Leighton (1949). Inter-rater trials have shown these instruments to be highly reliable with a reported kappa of 0.79 (Harding et al, 1987b). There is a standard form for converting the actual life chart into a narrative history using verbatim quotes as well as a section for the interviewers to write his or her subjective experience working with the patient participant.	Courtenay Harding – charding@bu.edu
Neuropsychological Assessment	<u>Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)</u> The RBANS is a brief (~30 minute) cognitive screening test that provides for the measurement of language, memory, visuospatial, and attentional abilities. The test has been standardized in	Jim Gold – jgold@mprc.umaryland.edu

	healthy controls, and there are two alternate forms available to facilitate repeated testing. Published re-test reliability, validity, and extensive normative data are available from patients with schizophrenia. Brief Cognitive Assessment A 15 minute assessment whose scores correlate with longer test batteries and community functioning.	 Dawn Velligan – velligand@uthscsa.edu
Symptom Assessment	Brief Psychiatric Rating Scale (BPRS) The 24-item Brief Psychiatric Rating Scale (BPRS; Ventura et al., 1993) is a modified version of the original BPRS published by Overall and Gorham (1968), that includes additional items for rating mood symptoms, suicidality, and bizarre behavior. The BPRS is one of the most widely used symptom rating scales in global psychopharmacological and psychiatric research. The BPRS allows for a rapid, reliable, and valid assessment of psychiatric symptoms that can be used to evaluate change in symptom status or to monitor symptoms over time. The BPRS has been used to evaluate the impact of various psychopharmacological agents and psychosocial interventions. Most factor analyses of the BPRS show that groups of symptoms form separate factors that can reliably be distinguished, e.g., positive symptoms, negative symptoms. Positive and Negative Syndrome Scale (PANSS) The PANSS is a 30-item scale that is typically scored using one of two systems: positive, negative, or general psychopathology symptoms; or positive, negative, cognitive (disorganized), excitement, and anxiety/depression symptoms. Like the BPRS, each item is scored on a 7 point scale, using descriptive anchor points.	Joe Ventura – jventura@ucla.edu Lewis Opler – lao1@columbia.edu
Assessment of Geriatric Schizophrenia	Social Adaptive Functioning Evaluation (SAFE) A 17 item scale for assessment of three components of adaptive behavior in geriatric psychiatric inpatients. Items are rated on a four point scale as defined in a glossary of terms and are based upon observation, care giver contact and interview with subject where possible	Phil Harvey – philipdharvey1@cs.com Leonard White – pgcnlww@omh.state.ny.us

Mental Health Workplace Safety Assessment and Risk Management	Training MH Administrators on Risk Management and Organizational Safety The manual "Safety First: Personal Safety and Risk Management for Assertive Community Treatment (ACT) providers important insight into minimizing safety risks when delivering ACT services. Areas addressed include creating a safe work environment, individual and team strategies for delivering safe services, managing critical incidents, and methods of empowering consumers to develop personal safety skills. Risk prevention is reviewed from multiple perspectives.	Judith Cook – cook@ripco.com, Carol Petersen – cpetersen@uic.edu
	Therapy, Activity, Classes (TAC) Observational Rating System; Individualized Behavior Management Plan (BMP) development A system for rating the quality and frequency of behaviors relevant to group treatment, including attentiveness, participation, and disruptive behaviors.	Will Spaulding – Wspaulding@neb.rr.com

TRAINING AND DISSEMINATION METHODS		
TYPE	**SPECIFIC INTERVENTION**	**CONTACT PERSON/PEOPLE**
Program Development	Interactive Staff Training (IST) IST represents an interaction or organizational development and educational methods that help a rehabilitation team identify service needs, develop a program that meets these needs, and evaluate the program's impact.	Pat Corrigan – pcorrigan@iit.edu Stanley McCracken smccracken@uchicago.edu
	Behavior Management Training (video/DVD self-study plus written and in-vivo examinations) These programs train staff in behavioral principles and interpersonal treatment techniques, for use in residential treatment settings.	Steven Silverstein – silvers1@umdnj.edu Will Spaulding – Wspaulding@neb.rr.com
	Training Staff to work with families A series of 5 training modules for training professionals to work with families.	LeRoy Spaniol – leroys@bu.edu
Ethics in Psychiatric Rehabilitation	Ethics in Psychiatric Rehabilitation; Ethical Dilemmas in Daily Practice This course will begin by defining ethics and describing the general principles of ethics. The presenters will clarify the key ethical issues in psychiatric rehabilitation as competence, cultural competence, self-determination, rights of people being served, and conflict of interest. Challenges to ethical practice in psychiatric rehabilitation will be discussed. Trainees will be walked through steps of ethical decision making. The program will assist experienced practitioners in responding to the complex issues they face in their work. It will also provide guidelines for supervisors and trainers in psychiatric rehabilitation.	Nora Barrett Dr. Patricia Nemec Annette Backs 3-hour training (two 90 min. CDs Produced by U.S. Psychiatric Rehabilitation Association ebussema@uspra.org

Training in Family Education/ Psychoeducation	Training in Family Education/ Psychoeducation One-day or Two-day interactive workshops; organizational consultation (drawing largely from IST approach above) and clinical supervision; ongoing technical assistance and implementation tips. Via the Family Institute for Education, Practice & Research at the University of Rochester Medical Center; and/or via Maine Medical Center. The Multi-Family Psychoeducational Support Group is an open-ended continuous service offered by a clinical facility to families/caregivers of adults with serious and persistent mental illness. This is a free service for families and friends of patients and is open to the general public. The model offers education and support on an ad hoc basis, specific to current needs of individual cases, and tailored to lifespan and illness trajectory issues. In addition to didactics and training in behavior management, the multi-family model offers shared experiences and coping strategies, resource information, social networking, and cross-parenting in terms of concrete aid for members' relatives. Members also offer living proofs of improvement and recovery. Participation serves both long-term and crisis needs and is not time-limited. Training is offered on an ad hoc basis to psychiatric residents, psychology postdoctoral students, and mental health staff who may attend the meetings. Other formats for training in Family Treatment of Schizophrenia	William McFarlane – (207) 662-2091 Tom Jewell – Thomas_jewell@URMC.rochester.edu Harriet Lefley – hplefley@aol.com Lisa Dixon – ldixon@umaryland.edu
Behavior Contracting	Training Direct Care Staff in Behavior Contracting A staff training workbook based on a classic text by William J. DeRisi and George Butz, Writing Behavioral Contracts (Research Press). This workbook expands upon the original text by using a user-friendly, hands-on format and practical, interactive exercises.	Tom Jewell – Thomas_jewell@URMC.rochester.edu Rodney Corry – rodney_corry@urmc.rochester.edu Steven Silverstein – silvers1@umdnj.edu
	Training curricula for the Recovery model.	Joan Clayton – jkcin-

Training in Recovery-Based Approaches to Treatment of People with SMI	A one-day workshop for professionals, to raise awareness about recovery issues, and promote integration of a recovery orientation into individual and agency practice. Training seminars and reading materials to train staff in recovery principles and practices. This training provides and opportunity to understand basic recovery concepts and processes. It also provides practical information on implementing specific recovery practices in an agency Personal Assistance in Community Existence (PACE). The PACE/Recovery Curriculum has been developed by Laurie Ahern and Dan Fisher MD, Ph.D. It includes a 34-page guide and a 90-minute video lecture on the PACE curriculum, featuring information on the empowerment model of recovery, PACE/Recovery principles, and recovery research. This information in useful for administrators, consumers, families, advocates, and providers who want to transform their system to one based on a recovery culture.	house@aol.com Steven Silverstein – silvers1@umdnj.edu William Anthony – wanthony@bu.edu LeRoy Spaniol – leroys@bu.edu Marianne Farkas – mfarkas@bu.edu Courtenay Harding – charding@bu.edu http://shop.store.yahoo.com/power2u/paccur.html
Implementing Evidence-Based Practices	National Evidence-Based Practices (EBPs) Project Modules for training in family psychoeducation, illness management and recovery, supported employment, ACT, and dual-disorder treatment.	Robert Drake Robert.E.Drake@dartmouth.edu Kim Mueser – Kim.T.Mueser@Dartmouth.edu (& others – contributors listed on toolkits and accompanying articles) SAMHSA toolkits link: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp
Training Members of the Public in Better Recognition and Support	Mental Health First Aid Mental Health First Aid is a training course analogous to conventional first aid, but focusing specifically on mental disorders. The course trains participants in the application of first aid steps to mental health crisis situations and to ongoing	Betty Kitchener – betty.kitchener@anu.edu.au Anthony Jorm – Anthony.Jorm@anu.edu.au

	mental disorders. The crisis situations covered include suicidal thoughts, panic attack, exposure to trauma, a psychotic person threatening violence, and substance use overdose.	
	Psychiatric Rehabilitation Certificate Program The PRCP is a 14-16 semester hour (four courses + internship) college certificate program to teach entry level staff the skills needed for psychiatric rehabilitation.	Annette Backs – backsean@umdnj.edu Daniel Giffort Stanley McCracken Pat Corrigan – p-corrigan@uchicago.edu William Anthony – wanthony@bu.edu
Moving State Systems into Psychosocial Rehabilitation	Texas Psychiatric Rehabilitation Benefit Design Project "Blazing New Trails: Using Evidence-Based Practice and Stakeholder Consensus to Enhance Psychosocial Rehabilitation Services in Texas" is an article published in the Spring 2004 issue of the *Psychiatric Rehabilitation Journal* that describes the unique initiative undertaken by the Texas Department of Mental Health and Mental Retardation to use best practices along with community consensus in designing a package of psychosocial rehabilitation services for people using public mental health services	Judith Cook – cook@ripco.com Marcia Toprac
Improving the Quality of Decision-Making regarding Medication	Texas Medication Algorithms Project (TMAP) The algorithm consists of a stepped, sequence of medications, often with choices at each step, combined with routine assessment, at each clinic visit, of symptom and side effect status, combined with a patient/family education program, and sufficient staffing to follow-up missed appointments, to educate patients/families, and to routinely assess and document outcomes achieved with each medication step.	John Rush – john.rush@utsouthwestern.edu

TRAUMA-INFORMED SERVICES		
Integrated Substance Abuse and Trauma Treatment Programs	Atrium A 12-week group treatment that addresses mind, body and spirit. Atrium incorporates psychoeducational, process, and expressive activities. It is based on cognitive-behavioral and relational theories. Helping Women Recover A 17-session group treatment. It uses an integrated curriculum that addresses trauma and addition. It is based on relational and cognitive-behavioral theories and integrating expressive arts. Curricula for adolescent girls and criminal justice settings are available. Helping Women Recover has been used in both residential and outpatient settings, and in substance abuse, mental health, and domestic violence settings. The curriculum can also be used as an individual treatment. Seeking Safety A 25-session group treatment. It is a present-focused therapy promoting safety and recovery. Seeking Safety integrates cognitive-behavioral theory with interpersonal and case management domains. It has been used in inpatient, outpatient, and residential settings, and in correctional, health, and mental health centers. The curriculum can also be used for individual treatment. Triad A 16-session group treatment that promotes survival, recovery, and empowerment using a cognitive-behavioral approach. Triad's primary treatment goals are to reduce psychiatric and trauma-related symptoms associated with histories of violence/abuse and substance abuse for those with substance abuse disorders. Triad has also been modified for use in jails.	Dusty Miller - dustymi@valinet.com Stephanie Covington – Sscird@aol.com Lisa Najavits – Info@seekingsafety.org Colleen Clark – cclark@fmhi.usf.edu
Training in Family Education/ Psychoeducation-PTSD	The Support and Family Education (SAFE) Program The SAFE Program is an 18 session day family psychoeducation curriculum. The SAFE program is distinct from other psychoeducation programs	Michelle D. Sherman - michelle.sherman@med.va.gov; http://w3.ouhsc.edu/safep

	because it is not diagnosis specific and can be used with family members from diverse home environments and relationships with clients. The program also includes one session that focuses on PTSD, an often neglected co-morbid diagnosis, including for those with schizophrenia. The program is also facilitated by mental health professionals and includes information about medication.	rogram
Client-Directed Treatment Planning	Therapeutic Contracting A system for therapeutic contracting whereby clients participate in developing their own treatment contracts. This method of case formulation and treatment planning improves participation in treatment for people lacking trust, those with negative histories with providers, or individuals who have suffered from abuse or trauma. It improved client empowerment and choice.	Philip Levendusky – Levendp@mcleanpo.Mclean.org Rich Hunter – rich.hunter@clinicaloutcomes.us Robert Heinssen – rheinsse@mail.nih.gov
Other services	Raising Difficult Issues with Your Service Providers This booklet provides "conversation starters" for people to use when they wish to begin an empowering dialogue with mental health service providers. Ways to raise issues in ten important life areas cover education, employment, history of abuse and trauma, intimate relationships, control over one's own money, maintaining privacy, promoting sexual freedom, honoring choices about psychiatric medications, and showing respect for service recipients.	Judith Cook – cook@ripco.com Jessica Jonikas – jonikas@psych.uic.edu
Integrating Trauma Treatment into Mental Health Programming	Training MH Professionals on Trauma Issues for Consumers The "Toolkit for Increasing Self-Determination Through Advance Crisis Management in Inpatient and Community Settings" contains two Advance Crisis Management tools: an instructional manual and videotape that have been described in detail in prior sections. Additional resources include "Hope for Healing: Recovery and Empowerment for Women Consumers/Survivors with Abuse Histories"; "Safe, Secure and Street-Smart: Empowering Women with Mental Illness to Achieve Greater Independence in the Community"; "Trauma Recovery and Empowerment: A	Jessica Jonikas – jonikas@psych.uic.edu Judith Cook – cook@ripco.com Maxine Harris Elaine Carmen

	Clinician's Guide for Working with Women in Groups"; and "Healing the Trauma of Abuse: A Women's Workshop."	

Trauma Assessment	Childhood Trauma Questionnaire The CTQ is a 28-item self-report questionnaire comprised of 5 subscales: physical, emotional and sexual abuse, and physical and emotional neglect.	The Psychological Corporation – http://www.psychcorp.com
	Child Maltreatment Interview Schedule-Short Form (CMIS-SF) The CMIS-SF utilizes a self-report format to assess experiences of childhood maltreatment in four main categories: sexual abuse, physical abuse, emotional abuse, and witnessing domestic violence. The measure contains sections to assess the presence, frequency, duration, and severity of each of these abuse experiences.	John Briere - http://www.johnbriere.com/cmis.htm
	Trauma Symptom Checklist (-33 and -40) Both versions of the TSC assess adult symptoms associated with traumatic childhood or adult experiences.	John Briere - info@johnbriere.com
	Traumatic Events Screening Inventory for Children (TESI-C) This inventory screens for a wide variety of traumatic events. For each trauma, it evaluates the severity of the individual's subjective emotional experience, as well as recency of exposure.	Julian Ford - Ford@psychiatry.UCHC.edu.
	Life Stressor Checklist-Revised The Life Stressor Checklist-Revised (LSC-R) was designed to screen for the occurrence of life events that meet the definition of a trauma according to DSM-IV, as well as stressful life events that may impact on symptomatology and functioning. For 30 events, respondents indicate whether or not the event has occurred, and if so, their age, the duration, their beliefs about potential harm, their emotional response, and the impact of the event in the past year. Examples of events include losing a loved one, assault, sexual abuse, and being mugged. Female veterans' endorsement of traumatic events on an earlier version of the LSC was highly correlated with PTSD diagnosis.	National Center for PTSD - ncptsd@ncptsd.org
	Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA) The Child and Adolescent version of the Clini-	National Center for PTSD – ncptsd@ncptsd.org

	cian-Administered PTSD Scale (CAPS-CA) is a structured clinical interview designed to be a developmentally adjusted counterpart to the CAPS for adults. The CAPS-CA interview assesses the seventeen symptoms for Posttraumatic Stress Disorder (PTSD) outlined in DSM-IV along with eight associated features (e.g., guilt, shame, dissociation, changes in attachment behaviors, and trauma-specific fears) and is meant for individuals aged eight through early adolescence. The CAPS-CA consists of standardized prompt questions, supplementary follow-up (probe) questions, and behaviorally anchored 5-point rating scales corresponding to the frequency and intensity of each symptom assessed.	
	<u>Clinician Administered PTSD Scale for Adults (CAPS)</u> The Clinician-Administered PTSD Scale (CAPS) is a structured clinical interview designed to assess adults for the seventeen symptoms of Posttraumatic Stress Disorder (PTSD) outlined in DSM-IV along with five associated features (guilt, dissociation, derealization, depersonalization, and reduction in awareness of surroundings). The CAPS consists of standardized prompt questions, supplementary follow-up (probe) questions, and behaviorally anchored 5-point rating scales corresponding to the frequency and intensity of each symptom assessed. It also describes clear behavioral indicators, has a time frame concordant with that of DSM diagnostic criteria, and separate frequency and intensity ratings.	National Center for PTSD – ncptsd@ncptsd.org
	<u>PTSD Checklist – Civilian Version (PCL-C)</u> This is a widely used and well-validated adult self-report measure of posttraumatic stress symptomatology that yields a total score that has been found predictive of PTSD diagnosis and severity of symptomatic impairment.	National Center for PTSD – ncptsd@ncptsd.org
	<u>PTSD Checklist for parents (PCL-C/PR)</u> This is a 17-item checklist that can be completed by the child or parent, covering the PTSD symp-	Julian Ford - Ford@psychiatry.UCHC.edu

	toms.	
	PTSD Symptom Scale-Interview The PTSD Symptom Scale—Interview (PSS-I) is a semi-structured interview. (There is also a self-report version, PSS-I-SR) The scale contains 17 items that diagnose PTSD according to DSM-III-R criteria and assess the severity of PTSD symptoms.	Edna Foa – foa@mail.med.upenn.edu
	Trauma Symptom Inventory The TSI, a 100-item test, is designed to evaluate posttraumatic stress and other psychological sequelae of traumatic events, including the effects of rape, spouse abuse, physical assault, combat, major accidents, natural disasters, and the lasting sequelae of childhood abuse. It includes 10 clinical scales that measure the extent to which the respondent endorses trauma-related symptoms. These, in turn, can be subsumed under three broad categories of distress (trauma, self, and dysphoria). Additionally, in contrast to other trauma measures, the TSI contains three validity scales (Response Level, Atypical Response, and Inconsistent Response), which assess the respondent's tendency to deny symptoms that others commonly endorse, to over-endorse unusual or bizarre symptoms, and to respond to items in an inconsistent or random manner.	John Briere - info@johnbriere.com
	Post-Traumatic Cognitions Inventory (PTCI) The PTCI is a measure of trauma-related thoughts and beliefs. The items were derived from clinical observations and current theories of post-trauma psychopathology. Due to its high specificity identifying PTSD cases and its high correlation with PTSD severity, the PTCI is useful as a clinical assessment tool for patients with PTSD. Moreover, the PTCI may be used to identify the erroneous cognitions that are targeted in cognitive–behavioral treatment	Edna Foa – foa@mail.med.upenn.edu

	Hope Scale The Hope Scale is a 12 item self-report scale that measures an individual's level of hope. The items on the scale measure the sense of successful determination in relation to the person's goals and the person's cognitive appraisals of their ability to generate means for surmounting goal-related obstacles and reaching goals.	C. Richard Snyder – http://www.psych.ku.edu/faculty/rsnyder/state.htm
	Assessing and Addressing Trauma and PTSD within Psychiatric Rehabilitation Many adults in recovery have undetected and unaddressed histories of traumatic abuse. This training will focus on assessing and addressing trauma among people in psychiatric rehabilitation programs, and will provide strategies for working with survivors of trauma and PTSD to facilitate healing. Participants will -**Learn** about rates of traumatic abuse -**Gain knowledge** about the physical and emotional impact of abuse -**Identify** key points to consider for trauma assessment at the programmatic and individual levels -**Gain recognition** of trauma triggers in PSR programs -**Prepare to offer** trauma-informed services and support service providers -**Learn** about group work and community resources for trauma survivors	Dr. Judith Cook Jessica Jonikas Julie Gibson Fran Nathanson 1 hr. Training CD Produced by United States Psychiatric Rehabilitation Association ebussema@uspra.org

Staff Training in Sexual Abuse and Trauma	Sexual Abuse and Trauma – Inquiry and Response: A Workshop for Mental Health Workers A one day training program developed by clinicians, managers, researchers, consumer consultants and Maori practitioners, which is mandatory for all mental health staff of the Auckland District Health Board, New Zealand. The morning focuses on why, when and how to take a trauma history. The afternoon deals with how to respond therapeutically to disclosures of abuse. The process involves didactic research presentations about the prevalence and effects of abuse and current (poor) clinical practice in asking and responding, as well as interactive discussion, and role plays on asking and responding. Its evaluation found it to be very effective in increasing knowledge and attitudes and moderately effective in changing actual clinical practice. Articles on effectiveness available upon request. Manuals for Implementing Interventions for People with PTSD Integrated Care for HIV and PTSD, Integrated Care for Substance Abuse and PTSD, Seeking Safety	John Read - j.read@auckland.ac.nz Terry Keane - Terry.Keane@med.va.gov
Centers and Web-Based Resources	The National Center for PTSD (NCPTSD) A rich source of information for assessment tools, intervention protocols, and the latest research and clinical developments in PTSD and trauma related issues. There are assessment measures for trauma exposure, child as well as adult trauma and PTSD, and several others. The website of the NCPTSD contains links to a wide array of information that can be used for training clinicians, including a treatment section with information on therapeutic approaches including therapeutic approaches for complex PTSD. Much of the information has been developed at the Center but there are links to information from other sources as well. The Center on Women, Violence, and Trauma This website is managed by the Center for Mental Health Services (CMHS) which is part of the Substance Abuse and Mental Health Services Administration (SAMHSA). The Center on Women, Violence, and Trauma is designed to as-	www.ncptsd.va.gov http://www.mentalhealth.samhsa.gov/womenandtrauma/

	sist trauma survivors within the contexts in which they live and work. Its focus is on the following five populations: women and adolescents with co-occurring mental health and substance abuse problems and histories of violence, women trauma survivors in the criminal justice system and women crime victims, refugee and immigrant women, men with histories of trauma, and consumer-survivor leadership. The website contains many resources, such as trauma facts, trauma-related news and research articles, and links to related websites.	

INTERVENTIONS EFFECTIVE IN REDUCING THE USE OF RESTRAINT, SECLUSION AND OTHER COERCIVE INTERVENTIONS		
Training Programs	National Technical Assistance Center Training Curriculum for the Reduction of Seclusion and Restraint Developed by The National Association of State Mental Health Program Directors (NASMHPD) and its National Technical Assistance Center for State Mental Health Planning (NTAC), the Training Curriculum is designed for mental health administrators who are interested in reducing the use of SR in their treatment settings. It consists of six Core Interventions presented over the course's 17 Modules. The Core Interventions incorporate ideas and techniques from the successful SR reducing practices that were reviewed by NTAC and the initial meeting participants. The goals of the Core Interventions are: **Leadership:** Developing and articulating a mission and philosophy toward reducing SR, developing and implementing a performance improvement plan, and holding people accountable through improved SR oversight and "witnessing." **Use of Data:** Using data in non-punitive and competitive ways, including adding analysis of facility usage by unit, shift, day, and staff member, and identifying facility baseline, setting improvement goals, and monitoring changes over time. **Workforce Development:** Creating a less coercive and conflictual treatment environment with policies, procedures, and practices based on the principles of recovery and understanding of trauma to inform care through staff training. **SR Reduction Tools:** Integrating a variety of tools and assessments into the treatment of each consumer; including assessments to identify to identify risk for violence, risk for death and injury, SR history, and trauma history, as well as de-escalation and safety tools. **Consumer Roles in Inpatient Settings:** Including consumers fully and formally in roles throughout the organization to reduce SR. **Debriefing Tools:** Gaining knowledge and informing policy toward the reduction of SR and mitigation of adverse effects of SR events, through rigorous analysis of all SR events. During the initial implementation project, facility	Kevin Huckshorn - Kevin.huckshorn@nasmhpd.org

	administrators from twenty-six states were trained with the curriculum. Initial post-training data, received from eight states have been very encouraging.	
	Nat'l Assoc of Consumer/Survivor Mental Health Administrators/SAMHSA: *Roadmap to a Restraint-Free Environment* This is a SAMHSA funded program developed in conjunction with the National Association of Consumer/Survivor Mental Health Administrators. It takes the consumer's perspective and is quite powerful. Topics covered include: ■1. The Personal Experience of Seclusion & Restraint ■2. Understanding the Impact of Trauma ■3. Creating Cultural Change ■4. Understanding Resilience & Recovery from the Consumer Perspective ■5. Strategies to Prevent Seclusion & Restraint ■6. Sustaining Change through Consumer & Staff Involvement ■7. Review and Action Plans	Contact: Joyce Jorgenson: joyce-jorgenson@earthlink.net or www.mentalhealth.samhsa.gov/publications/allpubs/sma06-4055/
Multimodal, Biopsychosocial case formulation strategies and techniques	Multimodal Functional Model (MFM) Description: MFM is biopsychosocial case formulation and intervention model that has demonstrated effectiveness with treatment-refractory clients and those with co-morbid behavior disorders. The model utilizes progress and outcome data to guide functional behavioral assessments leading to specific intervention strategies that treat the causes of unwanted behaviors. This model provides for the direct treatment of the behaviors that place a person at risk of dangerousness, teaches prosocial replacement behaviors, reduces both staff and patient injuries, and dramatically reduces the use of restraint, seclusion, and other coercive interventions. It provides a strong clinical treatment component to the NTAC model described above.	Rich Hunter – rich.hunter@clinicaloutcomes.us Sandra Wilkniss – swilkniss@thresholds.org

	The Social Learning Program (including a token-economy structure & all tools for assessment, intervention, and data reporting) This is a highly structured, ward-wide, inpatient approach to rehabilitation for individuals with the most severe problem behaviors and skills deficits. It consists of a comprehensive integrated network of skills training techniques and supports based on learning theory, individually tailored to client needs. It includes a post-discharge declining contact community aftercare component. A premium is placed on staff training and competency assessment, including para-professional staff. As appropriate to the level-of-functioning of clientele, this program can incorporate most evidence-based individual and group interventions listed elsewhere.	Gordon L.Paul – gpaul@uh.edu Tony Menditto – anthony.menditto@dmh.mo.gov
Forensic Services	Social Learning Program within a forensic hospital This is an adaptation of the original SLP (see description in "Program Supports" section) for individuals with severe mental disorders residing in forensic hospitals.	Tony Menditto – anthony.menditto@dmh.mo.gov
Advance Crisis Management	The Advance Crisis Management Program to Reduce Utilization of Restraint and Seclusion The "Toolkit for Increasing Self-Determination Through Advance Crisis Management in Inpatient and Community Settings" contains two Advance Crisis Management (ACM) tools: an instructional manual and videotape. The manual, "Increasing Self-Determination through Advance Crisis Management in Inpatient and Community Settings: How to Design, Implement and Evaluate Your Own Program" addresses 4 major topics: designing and implementing an ACM program; creating ACM plans each day; common concerns of ACM programs; and evaluating ACM plans and procedures. The videotape, "Increasing Self-Determination: Advance Crisis Management with Mental Health Consumers in Inpatient and Other Settings" demonstrates how to conduct a crisis de-escalation training. Descriptive handouts are included.	Jessica Jonikas – jonikas@psych.uic.edu Judith Cook – cook@ripco.com