

CMHS MANAGED CARE INITIATIVE: ADULT PANEL

SUMMARY OF BASIC FINDINGS, GAPS, AND FUTURE DIRECTIONS IN ADULT PRACTICE GUIDELINES, STANDARDS, AND PROVIDER COMPETENCIES

**Robert D. Coursey, Ph.D.
Psychology Department
University of Maryland
College Park, MD 20742
W 301 405-5905
F 301 314-9566
email Coursey@bss3.umd.edu**

**Center for Mental Health Policy and Services Research
University of Pennsylvania School of Medicine
Department of Psychiatry
7th Floor, 3600 Market St.
Philadelphia, PA 19104-2648
215 662-2886. F 215 349-8715**

**Center for Mental Health Studies
SAMHSA
5600 Fishers Lane, Room 15C-18
Rockville MD 20857**

January 29, 1997

BASIC FINDINGS, GAPS, AND FUTURE DIRECTIONS IN ADULT PRACTICE GUIDELINES, STANDARDS, AND PROVIDER COMPETENCIES

I. INTRODUCTION

A. Goals/Purpose Of The Study

- The overall goal of our project was to review standards of care, clinical guidelines and other relevant material in order to identify the core competencies of providers who can deliver effective services to adults with serious mental illness in a managed care environment.
- The key notion here is core competencies. By competencies I am referring to essential values, attitudes, ethical principles, knowledge, and skills that mental health providers need to function effectively. "Core" means the most important or critical competencies, or the ones that most clearly define the set of attributes we would like to see in service providers if one of our family members became seriously mentally ill.
- Of course, we are attempting to define a set of core competencies that would be necessary within a service system, not necessarily all in a single person. So the set of competencies would be the basic core skills/knowledge, etc. for any rehabilitation staff, psychotherapists, psychopharmacologist, etc.
- This overarching set of competencies will be the outcome of the whole project. It will come from integrating the adult materials into a single list of attributes which is then blended with the results from the panels on ethnicity and the developmental panels which are examining children/adolescents and older adults. These are the next steps of the CMHS Managed Care Initiative. This larger initiative is a project that includes a multi-year self study and curriculum development of mental health training among the organizations which prepare mental health service providers to work with people with serious mental illnesses in the public/private behavioral health care system of the future.

B. Content/Sources

a) Parameters of the Adult Project

Because the area was so large, it was necessary to carefully define the limits of the project. These limits include the focus on adults (18-65) with severe mental illness, but not substance abuse, mental retardation, and other co-existing disorders. Within the generic category of severe mental illness, the focus was on schizophrenia, major depression, and bipolar disorders since these three cover about three-fourths of the clients in the public mental health system. The focus was also on services within the

mental health service system (inpatient and outpatient) but not those in collateral agencies such as justice, schools, and nursing homes. These services were also limited to those which are most commonly found in the public mental health systems (e.g., psychiatric rehabilitation, self-help consumer groups, residential services, psychotherapy, etc.). We regret the limits, but we focused on areas that had an adequate literature and that were most central to the goals of the project. Finally, because there were parallel projects dealing with children and adolescents, elderly, and minority populations, we did not include materials related to these topics, even though they must be integrated in any final curriculum development.

b) Outline of material collected for both literature and competency section.

We collected material from four types of sources: (1)Generic material such as bibliographies or material that did not pertain to any specific viewpoint. (2)Views of the stakeholders such as the mental health disciplines, consumers' and families' perspectives, and the perspectives of managed care, and of the states. (3)Resource material included literature on critical Biopsychosocial Services, Practice Guidelines, Standards of Care, and Outcome studies and the development of outcome measures. (4)Other curricular considerations such as rural services and the linkage of training programs with service systems.

c) Organization of competency statements

We have divided competencies into three areas: (1)Values/ethics/attitudes; (2)Knowledge and skills. We have been particularly interested in the first set of values/ethics/attitudes because we think that the area of SMI requires a perspective on these types of competencies that differ somewhat from those of traditional private practice for clients who have less severe deficits. We also attended to them because they have been somewhat ignored by educators even though they are critical to a successful public delivery system, and because they are strongly emphasized by consumers and family members.

The lists of competencies (found in Part II of the Adult Panel Report) reflect the views of the stakeholders, services literature, practice guidelines, standards of care and outcome material. Some of the competencies have been published, some were based on the published and unpublished work of others, and some were constructed by the members of the Adult Panel using their own sources, experiences, and wisdom.

d) Descriptions of Practice Guidelines, Provider Competencies, and Evaluation Methods

A source of endless misunderstandings and confusion is the multiple meanings of crucial processes such as clinical guidelines, standards of care, competencies, utilization reviews, quality monitoring screens, etc. In an attempt to avoid some of the confusion, the following outline might be helpful. It is arranged according to purposes served.

1) Clinical Practice Guidelines. These are usually statements about the state of the art as established by expert panels and/or established by research.

Most common examples are the clinical practice guidelines for treating specific disorders (e.g., the APA Work Groups [1993, 1995] on depression and bipolar disorders). These publications attempt to recommend the most helpful interventions for each disorder. Most books on the treatment of specific disorders (e.g., Gabbard, 1995; Linehan, 1993) describe what the authors believe are best practice. However, these books differ from clinical practice guidelines in that they may focus on an intervention the author prefers, may lack a research basis, and may provide more detail about the specifics of the intervention than might be found in practice guidelines.

Individual authors (Corrigan et al., 1995), organizations (IAPSRs, draft) and states (e.g., West Virginia, 1995) have also published descriptive statements which they believe are best practices. These may include value statements, perspectives on qualities of best systems, or recommend specific types of psychosocial services (e.g., Carling's supported housing, etc.).

Other words used include clinical guidelines or best practices, treatment recommendations (Lehman et al., 1996), and the assessment and treatment of various disorders (Center for Substance Abuse Treatment, 1994).

2) Competencies: Attitudes, values, knowledge, skills needed to deliver quality services. Usually competencies refer to those of the provider, but they can also refer to qualities of the system or program. They are usually based on the clinical practice guidelines above as well as current thinking and a variety of other factors. For our work, we divided competency statements into three areas: values (values, attitudes, and ethics), knowledge, and skills. Competency statements usually provide a list of core competencies and sometimes specify these core competencies with behavioral specifications (e.g., Vermont, 1993). At other times, this specification is left up to the training programs and faculty (e.g., South Carolina, 1995).

Some competency statements are accompanied by standards and evaluations. For example, nursing (American Nurses Association, 1994) provides a number of standards, each followed by measurement criteria.

3) Evaluations: Criteria for whether clinical guidelines and/or clinical competencies are demonstrated in particular service settings. In order to manage the quality and cost of mental health care, numerous methods of evaluating treatments, organizations, and providers have been developed. These methods examine observable criteria related to the "principles" (e.g. Human Affairs International, 1993) or "standards" (e.g., Oregon Health Plan, 1995). Sometimes "standards" are thought of as principles or major components (e.g., Accessibility, clinical appropriateness, etc.) and sometimes "standards" are thought of as major evaluative criteria (e.g., performance standards). Across the managed behavioral healthcare field, evaluations are being developed for managed care companies (NCQA, 1996; Accreditation standards for MBHC organizations), for programs and services, for providers (e.g., "credentialing criteria" and "provider profiles") and for various mental health procedures.

Other types/labels used for these evaluations include "quality assurance"; "performance indicators"; "performance measures" for "Report Cards" (AMBHA, and the MHSIP Task Force, 1996); "Satisfaction measures" (FACCT); Scales such as "Medical Necessity Scales," "Suicide scales," measures of severity of functioning, etc. Finally, there are a large number of formally developed outcome measures. How many of these measures/evaluations have been well or poorly developed is unknown since there is no public record of the process from managed care companies. SAIC (1995) has developed for the Department of Defense' CHAMPUS project the most methodologically sound process of all of these managed care evaluations. Based on clinical practice guidelines in existence, they developed "monitoring screens" and "utilization review criteria."

A very intriguing integration of the above three areas (best clinical practices, competencies, and evaluation) can be found in the National Latino Behavioral Health Workgroup (1996) which provided guidelines for managed behavioral healthcare systems in the area of cultural competence for working with Latino populations. In addition to its system perspective, it also provides provider competencies. By making explicit performance indicators and outcomes in the form of benchmarks, it provides a way to evaluate whether the cultural competency guidelines are being implemented. It also provides clinical guidelines for the system along with recommended performance indicators and benchmarks.

While it takes special skill and practice knowledge to move deductively from "best practices" to assessment criteria and specific evaluation methods, it is extremely difficult to move inductively from specific evaluation criteria to best practices and provider core competencies. Moreover, it is not necessarily advantageous to do so. Core competencies and practice guidelines are at a relatively high level of abstraction and can be implemented into a large array of specific situations. However, performance measures are usually very specific to the concrete context for which they are written. Thus, basic knowledge and skills (core-competencies) are fundamental for a large set of concrete circumstances and are ultimately shaped into particular delivery styles and contexts through onsite training in internships and inservice training, while evaluation criteria are usually quite specific to the context, programs, or company for which they are written.

II. REVIEW OF BIBLIOGRAPHIC MATERIALS

A) Mechanics of the Literature review

The areas of investigation for this project are described above in the introduction. Material for this review was collected from multiple sources.

- Published and private bibliographies (e.g., recommendations from the 28 Adult Panel members).

- Materials provided by the various stakeholders (e.g., material from the disciplines, consumers, families, managed care companies, and states).
- Relevant mental health practice guidelines were gathered from federal and state agencies, mental health professional organizations, (e.g., Practice Guidelines on Bipolar Disorders), and professional journals.
- Material on Standards of Care came from professional disciplines, JCAHO, mental health consulting and research organizations, states' departments of mental health, and managed behavioral healthcare organizations.
- Material on biopsychosocial services literature and outcome studies were obtained from books and review articles (e.g., Lehman & Dixon's 1996 critical review of reviews of effectiveness studies of interventions with schizophrenia). Additional literature searches used primarily Psyc Lit. (e.g., Kelley's unpublished review of 336 review articles on treatment effectiveness of biopsychosocial treatments for non schizophrenia related disorders commonly found among people with serious mental illness).
- Clinical indicators of quality care, performance measures, and report cards came from AMBHA, managed care companies, and consulting agencies such as WICHE.
- Competency statements were collected from the disciplines, consumer and family member organizations, states, mental health consulting organizations, material developed with CMHS' funding, articles and books. About half of the Adult Panel Members contributed competency statements for their areas.

Some of the above material was "in progress" or proprietary. It was used to help develop competency statements and this report but was not described in the literature section of Volume I of the Adult Panel.

Summarizing and evaluating the material. Approximately two hundred and fifty most relevant articles, books, and reports were summarized. The summary primarily describes what information is contained in each article.

B) Literature Review

a) Values/Attitudes/Ethics

In terms of ethics and values, all of the professions surveyed have codes of ethics. However, these ethics codes primarily address basic principles of care in traditional settings using traditional interventions (medication and/or various forms of psychotherapy). These codes do not adequately address the issues in public mental health delivery systems or are too basic to provide much guidance. An exception is IAPSRs' 1996 code of ethics which is more directed at relevant issues but is quite brief. In terms of managed behavioral healthcare and public systems, there are some useful but limited materials (e.g., Austed, 1996; Corcoran & Winslade, 1994; Curtis & Hodge, 1994; Sabin, 1994), and no single source where the many issues are addressed.

If the net is cast more widely, including principles, values, and attitudes, there is a larger set of materials available in published competency formulations (e.g., Johnson, 1990), in psychosocial rehabilitation literature (e.g., Anthony, 1993), in state planning documents (e.g., Carling & Curtis, 1993), in statements from NAMI (Malloy, 1995), and from consumers (e.g., Boswell & Rogers, 1996; Campbell, 1996; Sherman & Kaufmann, 1995). Most recently, CMHS has published "Principles for Systems of Managed Care" which presents six main principles (Quality of care, Consumer participation and rights, accessibility, affordability, linkages and integration, and Accountability), each with 3 - 9 subsidiary "should" statements for managed care systems (See Table 1).

b) Competency statements on Principles, Values, and Attitudes

1) Methodology. Seventeen competency statements were either obtained from the literature or were submitted by 9 panel members. In all of the 17 competency documents, 181 value/attitude statements were expressed, some with subheadings. Many of these statements partly or wholly overlapped with others. In order to develop a set of overarching categories for these 181 statements, they were submitted to five members of Dr. Coursey's research team on serious mental illness. Using a qualitative analysis, the five members independently sorted the statements into categories. At a subsequent meeting, each participant's categorical structure was presented and discussed. Common themes, categories, and structures across the independent sets were noted. Finally these were arranged into three major sections: (1) Principles and values of programs which train public-system service providers (See Table 2); (2) Values and attitudes of service providers (see Table 3), which was broken down into personal and interpersonal qualities; and (3) Values of the outpatient mental health system (see Table 4), which was broken down into values of the mental health system, principles of the rehabilitation approach, and values related to client treatment in a mental health system.

2)Results and discussion. The results of this can be seen on the three tables (5, 6, and 7). A number of points need to be made: (1)In this writer's judgment, the outcome is less than totally satisfactory. Certainly, other arrangements of the statements could be conceived. (2)Any arrangement of categories needs cross-validation and further refinements. An alternative and more sophisticated method of organizing the values/ethics/attitudes statements would be to use concept mapping (Trochim & Cook, 1993). (3)These value statements come from contributors who are working in and thinking about the ideal outpatient mental health system. Acute, inpatient hospitals and small delivery systems (systems providing only medication and psychotherapy) may require a somewhat different or smaller set. (4)Is there any validity to these value/attitudes assertions? I know of no controlled studies, but many of these statements have some sort of "negative validation" from the failure of our earlier system of institutionalization and its attitudes. Positive validation consists mostly of widespread individual and survey reports (e.g., Campbell & Schraiber, 1989) from consumers and family members who describe the positive and negative impact of values and attitudes. (5)How does a program inculcate values and attitudes in its students? This is a critical but difficult issue for public universities.

c) Knowledge/Skills as found in Practice Guidelines, Evaluative Methods, Outcomes, and Core Competency Statements

1)Practice Guidelines

Managed Care Practice Guidelines

Documents were obtained from 10 managed behavioral healthcare companies. We are grateful for their willingness to contribute to this project. However, the materials are confidential and consequently we will describe their contents only in the most general terms.

The standards of care/clinical treatment guidelines are part of the effort to rationalize behavioral health delivery, create and monitor a uniform high quality product, and to contain costs. Business principles are applied to all components of the service delivery system.

Treatment guidelines (preferred practices, practice parameters) are often quite prescriptive in terms of the type of treatments that are to be used with specific diagnoses. Guidelines are provided for most of the major diagnoses. These guidelines for each diagnosis are usually brief (1 to 5 single-spaced pages), and are without references. A good example of this type of guideline can be found in the recent state of Vermont Preferred Clinical Practices Guide (1995). In addition to preferred treatments for different diagnoses, there are also guidelines on determining medical necessity, when to use ECT, psychological assessment, descriptions of preferred types of psychotherapy such as problem-focused treatment or symptom-focused treatment. Treatment guidelines developed by the mental health professions will be discussed later.

Mental Health Professions and Clinical Practice Guidelines

The Department of Defense (Health Affairs) reviewed 65 mental health practice guidelines (SAIC, 1995). Three quarters of them were by the professions, with physician groups and psychiatry contributing two-thirds of them. The SAIC project also identified which professions were the intended audience, or if the guidelines were for mental health professionals in general. If all physicians including psychiatrists are considered a single profession, three quarters of the mental health clinical practice guidelines were written by and for the profession of the authors. This is a reasonable approach, professions such as psychiatry, psychology, psychosocial rehabilitation, etc., have their own focus of interventions in which they excel. On the other hand, this focus risks producing a very distorted view of overall best practice across disciplines. There is a real need and ready acceptance of these guidelines as an authoritative source for effective treatments. Yet the guidelines may not mention or only cursorily touch on effective interventions that are not usually employed by their constituents. The consequences are that providers, insurers, behavioral managed care, the legal profession, and others are usually not aware of the narrow scope and believe that what is presented is the full range of what we know about treatment. A concrete example is the excellent clinical guidelines for the treatment of schizophrenia being developed by the American Psychiatric Association. Reasonably, it is focused primarily on the medication aspects of treatment, and presents extensive material and suggestions on this topic. Material on psychosocial interventions such as social skills training, psychoeducation, family education, etc. are each described in several pages as useful adjuncts, as if only to alert the psychiatrist to these other services. This may be quite reasonable given that a panel of psychiatrists are writing it and the goal is to provide guidelines for psychiatrists, but it leaves the reader believing that these are peripheral and have little or no development, special skills or validity, when in fact none of those implications is true nor intended by the authors.

Almost all of the mental health practice guidelines developed by the professions have been formulated by psychiatrists: 24 by American psychiatrists versus 6 by all of the other professions (American Psychological Association, Nursing, Social Work, and Psychiatric Rehabilitation). These differences between the disciplines in the development of guidelines is not due to differences in the number or quality of efficacy studies. Indeed numerous controlled efficacy studies of serious mental illnesses demonstrate the positive benefits of a wide variety of psychosocial interventions across most disciplines, and the number and quality of these studies is rapidly growing.

A more empirical approach to developing practice guidelines is the Schizophrenia PORT project (Schizophrenia Patient Outcomes Research Team) by Lehman, Dixon and their team (Lehman, & Dixon, 1995). Their practice guidelines are based on a careful, balanced review of meta-analyses and reviews

of controlled studies in nine types of interventions for schizophrenia: conventional and recent antipsychotic medication, individual and group psychotherapy, psychosocial skills training, family interventions, vocational rehabilitation, assertive community treatment, and case management. While the review did not include all validated treatment interventions, it did cover the main interventions used and the ones for which there is a significant amount of research. Their results, along with additional reviews of research on other treatments of schizophrenia were then reviewed by a number of expert panels. They were then translated into 43 clinical guidelines in 7 areas: pharmacotherapies, electroconvulsive and other somatic therapies, psychological treatments, family treatments, rehabilitation, service systems, and acute inpatient care (Lehman, Buchanan, Dixon, Goldman, McGlynn & Scott, 1996). The patterns of care for schizophrenia are now being evaluated in two state systems. This project serves as a benchmark in establishing empirically defensible clinical practice guidelines, and marks the distance between high quality guidelines and a set of opinions from a group of respected practitioners.

2) Evaluative Methods

Managed Care Evaluative Methods

Unfortunately, there are no uniform set of terms for the various dimensions of this effort. We will therefore briefly describe the areas covered in each section. We have divided our discussion into standards/guidelines for clinical care and for quality management.

Clinical care standards and guidelines. The two main sets of guidelines used by case managers are levels of care criteria and diagnosis-based treatment guidelines. Diagnosis-based treatment guidelines were discussed above.

Standards for level (or intensity) of care usually include detailed criteria for placing a patient into a particular level of care such as inpatient hospitalization, outpatient care, and sometimes for residential services, home care, etc. The criteria to hospitalize, what services are provided, etc., are usually quite specific, even to describing what is to be done on the first and second days.

Quality Management standards and guidelines. Under this heading we will briefly review several ways managed care monitors quality and appropriate use of services, as well as other aspects of the delivery system.

Utilization reviews evaluate the necessity and appropriateness of the use of any resource such as hospitalization, prescription practices, etc. Narrowly, it primarily addresses the level of care and duration of treatment. It is usually carried out by third-party payers. Criteria take the form: If this happened or did not happen (e.g., mental status exam was not done), it is referred to next level of review. Another similar procedure is Quality Monitoring Screens. These are usually carried out by the providers. The screen is a set of specific service actions (e.g., if needed, was an appropriate referral made for substance

abuse). Each is rated on a simple scale. If the screen is failed, it goes to next level of review.

Other quality assessments may evaluate other aspects of the business: risk management (e.g., confidentiality, complaints management), benefit management, credentialing criteria, etc. In addition, there are outside accreditation organizations such as the National Committee for Quality Assurance (NCQA, 1996), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which have separate sets of criteria for evaluating additional aspects of the organization such as the quality of physical aspects of the building, record keeping, etc.

There is increasing interest and commitment to developing a wide range of performance indicators. For instance, the Institute of Behavioral Healthcare (1996) is developing performance indicators that measure access, appropriateness, quality, outcomes, and prevention; JCAHO has just sent out a request for indicators for behavioral health care; American Managed Behavioral Healthcare Association (AMBHA) is developing a "Report Card" which uses performance indicators for access to care, consumer satisfaction, and quality of care.

The recent work by Science Applications International Corporation (SAIC, 1995) is an outstanding achievement in carefully developing quality monitoring screens and utilization review criteria based on an explicit and public methodology, including specific criteria for the screens, use of the best of 65 mental health practice guidelines, with a carefully selected panel of experts. Unfortunately, this work takes a traditional inpatient hospitalization/outpatient treatment model that is not particularly relevant for a public mental health system. On the other hand, a number of states have developed impressive quality assurance criteria for their behavioral healthcare systems (Nebraska, Massachusetts, and Vermont).

3) Outcomes: Empirical studies and content of outcome measures

Clearly an important contributor to defining skills for service providers is whether the interventions they use are effective. Do the interventions improve the symptoms and deficits associated with a particular disorder? This is usually established by efficacy and effectiveness studies. Efficacy refers to the impact that a treatment has under optimal circumstances, e.g., that used in manualized controlled research. Effectiveness refers to the impact that a treatment has under usual treatment conditions, i.e., where patient, provider, and service system factors are less than optimum, but where the provider can exercise greater control in individualizing the treatment. Most effectiveness studies can be found under the rubric of services research.

But underlying outcome studies is a prior basic question. What is the definition of a positive outcome? What constitutes good outcomes has always been hotly debated. Early researchers asked who should define and report outcomes. Is it the therapist, client, or some outside person such as an "objective" rater, family member, researcher, or the service program? Most recently, with the advent of the consumer movement

and the increased emphasis on outcome measures by managed behavioral healthcare, consumers have strongly advocated that they should have a significant say in defining the criteria of a successful outcome. This section will first present a very brief summary of outcome studies with the traditional outcomes defined as symptom or deficit improvement. Then we will turn to the recent efforts to be more inclusive in defining optimal outcomes for clients with serious mental illnesses.

Controlled Outcome Studies

General outcomes. There is a remarkable amount of quickly growing evidence that specific biological interventions (e.g., Hirsch & Weinberger, 1995; Schatzberg & Nemeroff, 1995) and selected psychosocial services are effective (Lipsey & Wilson, 1993; Lehman & Dixon, 1995; also see Coursey [1996], section VIII, Psychosocial Services in Part I), while others provide no particular benefit or can even be harmful (Mueser & Berenbaum, 1990). The literature is now so large that we have reviews of reviews (e.g., Lehman & Dixon, 1995), meta-analyses (Hegarty, Baldessarini, Tohen, et al., 1994), and meta-analysis of meta-analyses (Lipsey & Wilson, 1993). Reviews are generally organized by treatments (Shriqui & Nasrallah, 1995), by diagnoses (e.g., See Kelley's summary of non-schizophrenic diagnoses, Table 5), or by both (Lehman & Dixon, 1995, see Table 6) (References for both tables can be found in Coursey (1966, Part III).

Long-term outcomes. Data from long-term research (e.g., Harding, Zubin, & Strauss, 1987; Hegarty, Baldessarini, Tohen, et al., 1994) demonstrate that outcomes for people with schizophrenia are reasonably hopeful. Torrey's (1995) review of 10 year or longer follow-up studies suggests that 25% completely recover, another 25% are much improved and live relatively independent, another 25% are improved but require extensive outpatient support networks, 15% remain unimproved and need long-term care in a sheltered setting, and 10% have died, primarily of suicide. These long-term studies provide an empirical foundation for an attitude of reasonable hope for clients provided with current good levels of care.

Outcome measures themselves

The most common evaluations of treatment outcome are symptom reduction and rehospitalization. There are serious problems with both: symptoms are not well correlated with the persons' ability to function, and rehospitalization can be a sign of coping on the part of the client or the lack of alternative sources of treatment. Recently, there has been an increased interest in other possible outcomes. (1)"Deficits" such as attention problems and other neuropsychological dysfunctions have been increasingly studied, but the correlation of these deficits with everyday functioning is not yet clearly established. (2)Rehabilitation programs focus more on level of functioning in daily living skills. Unfortunately, functional assessment batteries for people with serious mental illness are not well developed nor widely used. (3)Consumer satisfaction is commonly used in program evaluations. Usually global satisfaction questions are used and they invariably result in positive ratings. (4)Finally, costs are sometimes compared

between the experimental treatment versus traditional treatments. Measures for all of the above have been developed by researchers, clinicians, and mental health agencies.

The problem is that mental health consumers have not been asked to express what they are looking for in terms of outcomes. The consumer and ex-patient movements have become increasingly articulate about the services and treatment they want. In response, the Mental Health Statistics Improvement Program (MHSIP) of CMHS has supported the development of a consumer-oriented mental health report card (MHSIP Task Force, 1996). Report cards have been used by managed care and other healthcare organizations to help consumers assess the cost and quality of care across providers. Usually they report on organizational arrangements and provider activities rather than outcomes. The MHSIP Report Card was developed with consumers and family members and reflects their concerns. It is based on research and explicit values; it focuses on but is not limited to, serious mental illness; it emphasizes outcomes; it is research-based; and it is conscious about evaluation costs and staff burden (MHSIP Task Force, 1996, p. 6). It evaluates how a provider or service system is performing by examining four domains: access, appropriateness, outcomes, and prevention. Each domain is related to a number of value statements which are called "concerns." For instance, the concerns related to access include: (1) quick and convenient entry into services; (2) full range of service options; (3) cultural and linguistic access; and (4) financial barriers. Indicators are "operational specifications of how well an organization is performing relative to each concern." For instance, one indicator for concern #1 above is "the average length of time from request for services to the first face-to-face meeting with a mental health professional." Measures are the methodology used to derive and calculate the indicators. In the above example, the measure instructs the evaluator to get the average of the total time between request and the first meeting for all new admissions.

4) Core Competency Statements

The literature from the disciplines. An overview of the material from the disciplines shows that psychiatry, psychiatric rehabilitation, psychology, nursing, and social work all have readily available and high quality sets of competencies for working with serious mental illness, much of it due to the support of the Center for Mental Health Services and other earlier grant support. However, few of these competency documents consider the implications of the recent developments in the contractual arrangements between states and managed behavioral healthcare firms. The disciplines' competency statements also focus on those services which their members traditionally provide.

As a whole, family therapy and MA psychology and counseling programs have yet to develop competency statements for preparing their graduates to work in the public/managed behavioral healthcare system with clients or family members with serious mental illnesses. This may be due to a brief curriculum already filled with basic knowledge/skill development or it may be due to a lack of grant support that was afforded to the other disciplines. In spite of this, there are a number of high quality MA programs focused on issues of serious mental illness. These include programs for

alcohol/drug abuse counseling, psychiatric rehabilitation, and mental health public service counselors such as Carling's program in Vermont. The better quality and focus of some of these programs result in more in-depth training than is found in many of the disciplines with much longer training periods.

Consolidation of Competency Statements. The Adult Panel members were asked to review the competency statements in their areas and to submit relevant documents or to write an outline that summarizes the core competencies as seen from those perspectives. We received 20 documents (101 pages). These documents can be found in Coursey's report (1996, Part II). Two of the competency documents stood out as the most comprehensive and the least parochial. We therefore chose them to serve as basic working documents around which other material could be integrated. The documents were from Vermont (Carling & Curtis, 1993) and from South Carolina (Goldman, 1995). Both documents were developed for state public mental health systems and so they are well tailored to the larger goals of this project. They also had the advantage of not overemphasizing the skills/perspectives of any particular discipline. They were both developed with considerable input from consumers and service providers of their states.

Five members of Dr. Coursey's Research Team on Serious Mental Illness reviewed the relevant knowledge and skills statements from all of the other competency documents to see whether their specific competency statements fell logically and comfortably into the major categories found in the Vermont and South Carolina documents. To our surprise, they easily fit into both documents, with some minor exceptions which will be discussed below.

The Vermont Training Standards for staff who work with adults with serious mental illnesses in public mental health services. It is clear from its title that this document clearly fits with the CMHS project objectives. The document development was led by Laurie Curtis and Paul Carling and is a sophisticated, well-organized set of competencies. The first set of competencies partly relate to values/attitudes and has been included and discussed in the result section on values/attitudes above. In this section of the report, we will focus only on the knowledge/skills sections.

There are eight major sections to the document:

- Demonstrates respect for persons with mental illness;
- Demonstrates respect for family members of persons with mental illness and caring others;
- Demonstrates knowledge of mental illness and treatment/support strategies;
- Demonstrates knowledge of a variety of intervention and support strategies;
- Demonstrates ability to design, deliver, and ensure highly individualized services and supports;
- Demonstrates ability to access and employ community resources;
- Demonstrates knowledge of legal system and individual civil rights; and
- Works in cooperative and collaborative manner as a team member (agency and interagency teams, family members, service recipients, concerned others).

Some of its strengths are (1)its excellent articulation of competency statements; (2)Its ease of including other material into its format; (3)It's clear articulation of contemporary directions in service provision.

Some of its weaknesses are (1)the major categories are sometimes not clear (e.g., Categories one and two appear to be about "respect," but their subcategories include involvement of consumers and family members, knowledge, and providing information. Likewise both the third and fourth categories appear to be about treatment and support, although their content are clearly differentiated); (2)There is no category that focuses on clinical assessment, whether it is a diagnostic interview, mental status exam, functional assessment, behavioral observations, neuropsychological assessment, etc., or any of the increasingly popular tests (e.g., depression and anxiety inventories) or structured interviews; (3)Its primary focus is on the psychosocial rehabilitation outpatient model of intervention rather than the traditional medical model. (To be precise, it does include one subsection on mental illness and one on medication, but none on inpatient services.) This is a limitation because there is a legitimate basis for the medical model which is helpful in understanding symptoms and deficits, in connecting disorders to their biological foundations and to powerful and widely-used treatments, and in relating to a significant number of service providers and training programs who/which operate from that perspective.

The South Carolina Competency Document. This document is part of a report of the Adult Community Rehabilitation and Support Work Group for the South Carolina Department of Mental Health. I presume that this is not the final report of the work group. There are seven areas of knowledge:

- Characteristics of mental disorders;
- Human development, relations and learning;
- Diagnosis;
- Treatment elements;
- Documentation;
- Legal/ethical concepts; and
- Community resources/systems.

There are also two areas of skills:

- General or Basic skills; and
- Treatment.

Some of its strengths are: (1)the document does appear to reflect the input of line staff and consumers; (2)its real-life front-line grasp of the needed knowledge and skills in the public system; and (3)its specificity and comprehensive nature. Its drawbacks include: (1)the titles of the content areas often do not adequately define the categories, e.g. "behavioral management," "interagency relations," "Interactions with non-psychotropic treatment strategy"; (2)sometimes the titles seem too specific for core competencies, e.g., "assistive technology products"; and (3)the categories do not always

reflect common consensus about core competencies, although this is not necessarily a negative, e.g., "Problem solving," "Human development through the life cycle (normal vs. abnormal)."

III. GAPS IN PRACTICE GUIDELINES, CORE COMPETENCIES, OUTCOMES, AND EVALUATIVE METHODS

A. Problems in Clinical Practice Guidelines

Critique of Managed Care treatment guidelines

- (1) With some exceptions, it was not clear what if any practice guidelines were drawn upon in developing evaluations by the individual companies. No hint is given whether it was by expert panel, outcome studies, survey of literature on practice, material borrowed from other practice guidelines, or some other method.
- (2) Where guidelines or standards are expressed, they do not give any evidence that they followed the guidelines for developing guidelines (American College of Physicians, 1994; Institute of Medicine, 1993; American Psychological Association, 1995).
- (3) Because they are confidential, dialogue among experts and evaluation is unlikely to take place. As long as the guidelines remain confidential, it is unlikely that they will be subjected to nonpartisan services research or outcome evaluations. Nor is it possible to evaluate the balance between quality and cost savings of the recommendations.
- (4) From the viewpoint of training future service providers to work for managed behavioral healthcare companies, their treatment guidelines cannot be used to develop curriculum because of their proprietary nature.
- (5) None of the guidelines provide evidence for reliability such as interjudge agreement, or for content validity.

Evaluation of Clinical Practice Guidelines from the Professions.

- 1) The practice guidelines as they currently exist in the literature offer important information about quality service. However, the guidelines need to be carefully scrutinized because they are primarily guidelines for those treatment modalities used by a specific discipline. It is not always clear which guidelines have strong empirical support and which guidelines are the clinical opinions of experts. Therefore, guidelines also need to be evaluated in terms of their empirical data base and the professional and service orientation of its panel members.
- 2) The extent to which clinical practice guidelines can be useful in training service providers depends on the quality and applicability of the guidelines available. Clearly, the American Psychiatric Association guidelines on the treatment of schizophrenia contain some important information for students in psychosocial rehabilitation, but it has little use in defining the empirically-confirmed and

expert-recommended knowledge and skills needed to provide rehabilitation services to people with schizophrenia.

- 3) Given the above caveats, the use of clinical practice guidelines and standards of care (such as level of care needed) would represent a considerable step forward in student training, which is all too frequently guided by the professor's own training and favorite theories of intervention.
- 4) It is important that practice guidelines become cross-disciplinary so that the data collected from efficacy and effectiveness studies and the suggestions of expert panel members represent the full range of effective interventions and the full knowledge/skill base needed to provide those interventions.
- 5) Federal support is probably needed to create practice guidelines panels which are balanced in terms of the knowledge of the full range of effective interventions, and of the skills needed to treat the full range of symptoms, behavioral and social deficits, and handicaps that accompany mental disorders. The highest level of standards for practice guideline development needs to be employed (e.g., Clinton, McCormick, & Basteman, 1994).

B. Evaluative Strategies used in managed care

Comments on standards of care from managed care

The standards of care begin to provide a specificity to mental health interventions that could lead to greater clarity about the knowledge and skills needed by mental health providers, to more uniformity across programs, and to specific knowledge/skills competencies and quality indicators that could be used in training programs.

Unfortunately, there are significant barriers to this transfer.

- (1) Most of the material from managed behavioral healthcare companies is proprietary. This is to the detriment of both the quality of the standards and their utility for training.
- (2) They are not published and are unavailable to faculty without permission.
- (3) They may lack input from a wide range of experts and practitioners.
- (4) The individual criteria are without documentation or rationale.
- (5) It is not known if service consumers and their families have provided any input into them.
- (6) The guidelines about types of services that clinicians can provide give no indication of empirical validity, reliability, comprehensiveness, cost-effectiveness, etc. While many of the standards appear to be based on best practices among experts in a particular area, others lack research support or even any consensus among experts.
- (7) There is also a lack of consensus on criteria used by managed care, especially in the area of quality management. For instance, Science Applications International Corporation (1995) presented a table on outpatient utilization criteria for outpatient treatment from seven managed care companies (p. 2-25). There were 35 criteria in all from the seven companies. Using the table, I found that the average

number of companies using any one criteria was 2. Of the 35 criteria, only 5 criteria were used by more than a majority (i.e., 4 or more) of the companies.

(8) In the area of psychosocial interventions, most guidelines only allow psychotherapy. Yet the range of interventions that have an empirical base and that are useful for increasing functional capacity of people with serious mental illness is far greater. Johnson, Coursey, and Morris (1996) present a brief list of effective interventions along with the strength of the data and the names of researchers in the area.

Strong Research support

- + psychotropic medication (Davis, May, Hogarty)
- + assertive community Treatment (Stein & Test)
- + social learning (Paul & Lentz)
- + achievement groups (Fairweather)
- + family psychoeducation (Leff, Goldstein, Falloon, Hogarty)
- + interpersonal therapy--depression (Weissman, Klerman)
- + cognitive-behavior therapy--depression (Beck, Rehm,

Lewinsohn)

Medium Research Support

- + supportive psychotherapy (Hogarty, Falloon, Mendel)
- + group therapy (Kanas)
- + family education
- + patient psychoeducation (Eckman)
- + cognitive-behavioral therapy (Bellack, Brenner)
- + social skills training (Bellack)
- + vocational rehabilitation, supported employment (Bond)
- + psychosocial clubhouses

Also see Corrigan, McCracken, & Mehr (1995) for practice guidelines for extended psychiatric care, and see Lehman, Buchanan, Dixon, Goldman, McGlynn, & Scott (1996) for an excellent set of empirically-based treatment recommendations for schizophrenia alone.

C. Outcomes research

Studies of outcome

(1) We have a significant data base on services for people with SMI that could provide a set of empirically-established clinical guidelines for standards of care and training mental health providers (e.g., Lehman, Buchanan, Dixon, et al., 1996). This outcome research on serious mental illness also provides some safeguard against wishful thinking that inexpensive short-term treatments are necessarily equally successful when compared to longer-term and more costly interventions. Additional long-term cost-effectiveness studies are critical for the types of decisions that managed care companies must make on currently unsatisfactory foundations.

- (2) Managed care companies might want to increase their R&D funding in order to support research which evaluates best practices, quality standards, and the average length of care needed to resolve or stabilize a variety of mental conditions.
- (3) There is a great need for sophisticated research on many of the new programs being developed in psychosocial rehabilitation and other sectors of the public mental health system.
- (4) This rapid accumulation of research suggests that mental health service providers need to be research literate, and that training additional clinical researchers and program evaluators (see NIMH, 1991) would have high payoff for clients and managed care companies.

Comments on outcome measures

The most common evaluations of treatment outcome are symptom reduction and rehospitalization. There are serious problems with both: symptoms are not well correlated with the persons' ability to function, and rehospitalization can be a sign of coping on the part of the client or the lack of alternative sources of treatment. Recently, there has been an increased interest in other possible outcomes.

- (1) "Deficits" such as attention problems and other neuropsychological dysfunctions have been increasingly studied, but the correlation of these deficits with everyday functioning is not yet clearly established.
- (2) Rehabilitation programs focus more on level of functioning in daily living skills. Unfortunately, functional assessment batteries for people with serious mental illness are not well developed nor widely used.
- (3) Consumer satisfaction is commonly used in program evaluations. Usually global satisfaction questions are used and they invariably result in positive ratings.
- (4) Costs are sometimes compared between the experimental treatment versus traditional treatments. All of the above have been developed by researchers, clinicians, and mental health agencies.
- (5) One major problem is that mental health consumers have not been asked to express what they are looking for in terms of outcomes. The consumer and ex-patient movements have become increasingly articulate about the services and treatment they want. In response, the Mental Health Statistics Improvement Program (MHSIP) of CMHS has supported the development of a consumer-oriented mental health report card (MHSIP Task Force, 1996). The MHSIP Mental Health Report Card is an excellent example of a quality assessment of a mental health service system. Its strength are its explicit methodology, its literature base, and its inclusion of consumers throughout its development. It would also be an excellent teaching example of what an effective consumer-friendly service system might look like and how to evaluate a mental health system from that perspective.

D. Problems in Core Competencies

Values, ethics, and attitudes

- (1) There is no clear rationale for one way of organizing value competencies over another.
- (2) Any arrangement of categories needs cross-validation and further refinements. An alternative and more sophisticated method of organizing the values/ethics/attitudes statements would be to use concept mapping (Trochim & Cook, 1993).
- (3) These value statements come from contributors who are working in and thinking about the ideal outpatient mental health system. Acute, inpatient hospitals and small delivery systems (systems providing only medication and psychotherapy) may require a somewhat different set of values.
- (4) Is there any validity to these value/attitudes assertions? I know of no controlled studies, but many of these statements have some sort of "negative validation" from the failure of our earlier system of institutionalization and its attitudes. Positive validation consists mostly of widespread individual and survey reports (e.g., Campbell & Schraiber, 1989) from consumers and family members who describe the positive and negative impact of values and attitudes.
- (5) How does a program inculcate values and attitudes in its students? This is a critical issue but one which universities avoid to the extent possible.

Managed Care and competencies of mental health service providers

- 1) Currently, managed care certifies or credentials established practitioners who have certain degrees, experiences, and ability to deliver the types of services that managed care desires, or they contract with groups who then select appropriate personnel. Other than in some HMO types of organizations, managed care sponsors very little training and education of its clinical service providers.
- 2) Having created clinical practice guidelines, standards of care, and criteria for implementation, the question arises whether managed behavioral healthcare companies seriously want service providers to be trained to meet them. Because of the current excess of service providers, it may not be a current priority. If yes, they must either become significantly engaged in extensive training activity themselves or they need to engage in a dialogue with faculty in training programs about what skills and knowledge they want their employees to have.
- 3) If they want to improve their clinical practice guidelines, they must make them public and engage in a dialogue with a wide range of clinical services researchers, expert clinicians, and other healthcare organizations.
- 4) Of course such a dialogue will evoke controversy, but in the long run it could immeasurably improve the guidelines and ultimately the knowledge and skills of their potential employees.
- 5) Making public their clinical practice guidelines would let universities and training programs know what to require in terms of knowledge and skills needed and would also provide performance criteria that could be used to evaluate learning outcomes. Few training programs have made explicit a detailed list of knowledge and skill needed, much less an explicit set of criteria to measure success of their training.

Core competencies found in the Vermont (Carling & Curtis, 1993) and South Carolina (1995) Statements

Both are excellent starting places to build a unified set of core competencies for service providers. The specific strengths and weaknesses of each is given on pages 15-16 above. More generally, the limitations of both sets of competencies include:

- (1) They both need to be broadened by more fully including the medical model and practices.
- (2) Both need to be carefully scrutinized by all of the stakeholders to ensure that their own core competencies fall under one of the main categories or whether additional categories are needed.
- (3) These two competency statements as well as others collected for this project focus on outpatient treatment. While outpatient treatment is where most patients are treated; nevertheless, hospitalization and crisis services are critical treatments that require different skills and knowledge, and perhaps even different types of relationships to clients who are in the middle of a psychotic break.
- (4) Neither competency set suggests that providers need some understanding of research and the basics of program evaluation, even if only to allow them to read the professional literature.
- (5) Neither of the statements include wider issues such as the political and economic dimensions at both the state and national level which so potently influence the public mental health system.
- (6) Perhaps most importantly, neither of the statements adequately propose any education directed toward understanding and operating within a managed behavioral healthcare system. The beginning of such a direction can be seen in the South Carolina competencies (i.e., Documentation: Computer knowledge, Quality assessment and other documentation concepts, and Rules and regulations). In addition to the above suggestions, knowledge and skill statements should also include knowledge in the areas of prevention, risk management, brief intermittent psychotherapy, accountability standards such as provider profiles, outcome measurement, consumer satisfaction, performance indicators, as well as a basic understanding of the philosophy, organizational principles, and major components of managed behavioral healthcare.

IV. NEXT STEPS

These are my recommendations about the next steps. For me, the key starting place is attention to and creating a more balanced, integrated set of clinical practice guidelines for people with severe and persistent mental illness who are currently being served in the public systems. Secondly, these clinical guidelines then can be operationalized by standards of care, quality assurance, performance indicators, etc. This may mean revising and enlarging the excellent beginning of the SAIC document. Thirdly, the SMI clinical practice guidelines and the evaluative standards of care can be used in developing the core competencies needed by the providers and the delivery

system. These three documents can be initially worked on simultaneously because large segments are already developed, and because a new set of panels with experts in these three areas need to be developed and brought up to speed. But the panel on clinical practice guidelines on serious mental illness needs to be considerably ahead of the other two.

A. Clinical Practice Guidelines

First I will highlight what needs fixing with clinical guidelines for people with serious mental illness, then sketch the features that a comprehensive balanced set of guidelines needs to include.

a) Critical issues/biases/problems with Practice Guidelines:

- 1) Most practice guidelines have a bias because they are written for and by a specific discipline or a private business of managing care.
- 2) Most practice guidelines are written for a specific model of mental illness, either the medical illness model or the psychosocial competency model.
- 3) Most practice guidelines are focused on one specific diagnostic entity and ignore dual diagnoses of all sorts.
- 4) Most practice guidelines assume family/patient resources such as income, insurance, housing, etc.
- 5) Most practice guidelines assume that functional deficits are related to the disorder (e.g., person is too depressed to work) and that the disorder is episodic and/or reversible.
- 6) Many of the managed care practice guidelines assume that the least costly or intensive methods will be sufficient to return the client to basic functioning.
- 7) Many practice guidelines assume two basic resources: a hospital which provides emergency and short-term mental health interventions and an outpatient clinician who primarily uses the traditional interventions of medication and psychotherapy.
- 8) Most practice guidelines leave out the therapeutic/iatrogenic attributes of some systems and providers.

These gaps and assumptions need careful scrutiny in devising improved, clinically useful, and effective guidelines.

b) SMI Practice Guidelines for Treatments, Systems, and Service Providers:

Enlarged, balanced, SMI-focused Practice Guidelines need to be developed.

- 1) CMHS (perhaps in conjunction with other federal agencies) needs to develop practice guidelines that are useful for people with severe and persistent mental illnesses.
- 2) The practice guidelines need to integrate both the medical and psychosocial models.
- 3) They need to apply to people without personal/familial resources, housing, or income, and for the medicaid eligible population.

- 4) They need to be relevant for clients with severe and chronic functional deficits across all living skills, and for those with chronic cognitive impairments, even during periods of mental illness symptom abatement.
- 5) They need to include all effective and needed services which are cost effective in the long term.
- 6) They need to focus on the most common severe and disabling disorders, currently most commonly found in schizophrenia, bipolar, major depression, borderline personality disorder and obsessive compulsive disorders where these clients meet the usual criteria for the public mental health systems.
- 7) To the extent possible, they need to integrate the results from the adult and aging panels and cultural competency panels. A decision needs to be made whether to do the child panel separately.
- 8) The work group would start with already developed guidelines, then correct for the biases listed in section IV A-a above, and introduce a service systems approach as well as guidelines about effective provider and system attributes.

B. Writing standards and quality assurance using the SMI Practice Guidelines for Treatments, Systems, Service Providers.

Once the SMI Practice Guidelines are written, the next step is to operationalize them for state delivery systems. What would be the criteria (standards) and quality assurance statements that could be expected in the average state system that implements the SMI Practice Guidelines for Treatment, System, and Service Providers?

This Work Group would start by critiquing present standards as reported in the various panels (e.g., see II c above). It should pay special attention to DoD standards, the MHSIP Report Card, the Hispanic panel, standards for managed care from NAMI, guidelines for states contracting with managed care, as well as any other documents that have tried to write evaluative standards and performance indicators for state systems. These would serve as templates for the final document which could then become the CMHS standard for public system/managed care arrangements. It would also dovetail nicely with HMO patients' right bills.

C. Provider Competencies for persons who work in the public/managed care system.

Although much of the basic work could be done by this Work Group prior to the final products on Clinical Guidelines and on Evaluative Standards/performance indicators, ultimately the Provider Competencies product must build heavily on the other two reports. They also need to attend to the issues discussed in section III D above.

The Working Conference

If the conference is to plan the development of the three products above, close attention needs to be paid to the attendees. I would assume that current panel chairs

would be invited, but it seems to me that focusing on the three areas above means reorganization into three major panels and new criteria for the selection of chairs and participants--namely people with the expertise in the three areas (practice guideline development and SMI; experts in standards and quality assurance in the state/managed care system; and experts in writing Provider Competencies for public systems treating SMI). The overall Coordinating Committee would receive and comment on the plan developed by the Conference.

CMHS should also create adequate financing in terms of chairpersons, support services, and periodic 2 day meetings of each panel to work on their document, as well as smaller meetings of the chairs to provide information and coordination.

V. REFERENCES

American College of Physicians (1994). Criteria for evaluation of practice guidelines. In a presentation by L. Johnson White, Faulkner and Gray Medical Outcomes Conference IV, Washington DC. May 1994.

American Nurses Association (1995). Standards of psychiatric-mental health clinical nursing practice.

American Psychiatric Association Work Group on Bipolar Disorder. (1995). Practice guideline for treatment of patients with bipolar disorder. Washington DC: American Psychiatric Association. (R 2).

American Psychiatric Association Work Group on Major Depressive Disorder. (1993). Practice guideline for major depressive disorder in adults. American Journal of Psychiatry, American Journal of Psychiatry, 150, (April Suppl.). 1-26.

American Psychological Association (1995): American Psychological Association Task Force on Psychological Intervention Guidelines, Template for developing guidelines: Interventions for mental disorders and psychosocial aspects of physical disorders. American Psychological Association.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal, 16, 11-24.

Austed, C. S. (1996). Is long-term psychotherapy unethical? Toward a social ethic in an era of managed care. San Francisco: Jossey-Bass.

Behavioral Health Network of Vermont & National Community Mental Healthcare Council (1995). Preferred Clinical Practices Guide (version 2). Published by NCMHC, Rockville, MD.

- Boswell, D. & Rogers, J. (1996). Values, attitudes, ethical principles in Core competencies that mental health service providers should have to serve adults with serious mental illness in the age of managed care. National Mental Health Consumers' Self-help Clearinghouse. Philadelphia, PA.
- Campbell, J. (1996). Core competencies of service providers: Views of consumer stakeholders. Missouri Institute of Mental Health, University of Missouri at Columbia; St. Louis, MO.
- Campbell, Jean & Schraiber, Ron. (1989). The Well-Being Project: Mental Health Clients Speak for Themselves. California Department of Mental Health.
- Carling, P. & Curtis, (1993). Training Standards for Staff Who Work with Adults with Serious Mental Illnesses in Public Mental Health Services (Vermont Dept. of Mental health and mental retardation). Trinity College: Burlington, VT.
- Center for Substance Abuse Treatment. (1994). Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse. Treatment Improvement Protocol (TIP) Series # 9. Rockville MD: SAMHSA.
- Clinton, J. J, McCormick, K., & Basteman, J. (1994). Enhancing clinical practice: The role of practice guidelines. American Psychologist, 49, 30-33.
- Conn, V. (1995). Family Policy. (Commissioner's Policy Statement No. 71). Dept. of Mental Health, State of Connecticut. Hartford, Co.
- Corcoran, K., & Winslade, W. J. (1994). Eavesdropping on the 50-minute hour: Managed mental health care and confidentiality. Behavioral Sciences and the Law, 12, 351-365.
- Corrigan, P. W., McCracken, S., & Mehr, J. (1995). Practice Guidelines for Extended Psychiatric Care: From Chaos to Collaboration. Springfield, Ill.
- Coursey, R. D. (1996). CMHS Managed Care Initiative: Adult Panel. Core Competencies for Mental Health Service Providers. PART I (An Annotated Bibliography), PART II (Competency Statements), and PART III (Evaluation and Summary of Adult Material).
- Coursey, R. D. (1990). Values in the education of students about Serious Mental Illness. Statement of the Maryland Training Consortium on SMI. Psychology Dept, UMCP, College Park, MD.

- Cnaan, R. A., Blankertz, L., & Saunders, M. (1992). Perceptions of consumers, practitioners, and experts regarding psychosocial rehabilitation principles. Psychosocial Rehabilitation Journal, 16, pp. 95-119.
- Curtis, L. C., & Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. Psychosocial Rehabilitation Journal, 18, 13-33.
- Foundation for Accountability (FACCT). (1996). Health Risk and Satisfaction Measures. 220 NW Second Ave., Suite 725, Portland Oregon 97209.
- Freeman, M. A. & Trabin, T. (1994). Managed behavioral healthcare: History, models, key issues, and future course. Washington DC: Center for Mental Health Services, SAMHSA.
- Gabbard, G. O. (Ed. in chief). (1995). Treatments of psychiatric disorders. (2nd ed.). Washington DC: American Psychiatric Press.
- Goldman, C. (1995). Adult Community Rehabilitation and Support Work Group Report. South Carolina Department of Mental Health.
- Harding, C. M., Zubin, J., & Strauss, J. S. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? Hospital & Community Psychiatry, 38, 477-486.
- Hegarty, J. D., Baldessarini, R. J., Tohen, M., Waternaux, C. & Oepen, G. (1994). One hundred years of schizophrenia: A meta-analysis of the outcome literature. American Journal of Psychiatry, 151, 1409-1416.
- Hirsch, S. R., & Weinberger, D. R. (Eds.) (1995). Schizophrenia. Cambridge, Mass.: Blackwell Science.
- Human Affairs International (1993). Intensive and primary care management: Mental Health and Substance Abuse.
- IAPRS (1996). Practice Guidelines for Psychiatric Rehabilitation (Draft).
- Institute for Behavioral Healthcare. (1996). Performance Indicators in Behavioral Healthcare. Portola Valley CA: Behavioral Healthcare.
- Institute of Medicine (1993). Criteria for evaluation of practice guidelines. In The Medical outcomes and guidelines source book, pp. 575-576. Washington DC: Faulkner and Gray's Healthcare Information Center.

- International Association of Psychosocial Rehabilitation Services. (1996). Psychiatric Rehabilitation Code of Ethics. Columbia, MD.
- Johnson, D. L. (Ed.). (1990). Service needs of the seriously mentally ill: Training implications for psychology. Washington DC: American Psychological Association.
- Johnson, D. L. (1996). Notes for the CMHS Managed Care Initiative: Adult Panel on Core Competencies for Service Providers. Psychology Dept., University of Houston: Houston Texas.
- Johnson, D., Coursey, R., & Morris, J. (1996). Petition for the Recognition of a Proficiency in Serious Mental Illness in Psychology. Washington DC: American Psychological Association.
- Lane, N. (1996). Ethical principles and values. Training needs of managed care companies for providers treating seriously mentally ill adults. CNR Health.
- Lehman, A. F., Buchanan, R. W., Dixon, L. B., Goldman, H. H., McGlynn, E. A., & Scott, J. (1996). Schizophrenia Patient Outcomes Research Team (PORT): Treatment recommendations. Atlanta: Continuing education conference, March 1996.
- Lehman, A. T., & Dixon, L. B. (1995). Schizophrenia: Treatment outcomes research. A special section in Schizophrenia Bulletin, 21 (4), 561 - 675.
- Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorders. NY: Guilford Press.
- Lipsey, M. W. & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis. American Psychologist, 48, 1181-1209.
- Massachusetts (1995). Department of Mental Health Service Standards.
- Malloy, M. (1995). Managed Care: A primer for families and consumers. Arlington, VA.: National Alliance for the Mentally Ill.
- Marsh, D. & Conn, V. (1996). Adult Review Panel, Mental Health Managed Care Initiative: Families. Psychology Dept.: University of Pittsburgh at Greensboro, PA.
- Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-oriented Mental Health Report Card (April, 1996). The final report of the MHSIP

Consumer-Oriented Mental Health Report Card. CMHS, SAMHSA. 5600 Fishers Lane, Rockville MD 20857.

Mueser, K. T., & Berenbaum, H. (1990). Psychodynamic treatment of schizophrenia. Is there a future? Psychological Medicine, *20*, 253-262.

National Committee for Quality Assurance (NCQA). (1996). Draft accreditation standards for Managed Behavioral Healthcare Organizations. Washington DC.

National Institute of Mental Health. (1991). Caring for people with severe mental disorders: A National plan of research to improve services. DHHS Pub. No. (ADM)91-1762. Washington DC: Superintendent of Documents, U.S. Government Printing Office.

National Latino Behavioral Health Workgroup (1996). Cultural competence guidelines in managed care mental health services for Latino populations. Bolder CO: WICHE.

National Technical Assistance Center for Children's Mental Health. (1995). Quality Assurance Criteria & Procedures: Oregon Health Plan. Washington DC: Georgetown University Child Development Center.

Nebraska (1995). Nebraska Medicaid Mental Health Managed Care Program. Section I Treatment system level of care criteria.

Oregon Health Plan (1995). Quality assurance criteria and procedures. National Technical Assistance Center for Children's Mental Health. Georgetown University Child Development Center.

Paulson, R. (1996). Values. Portland State University. Portland, Oregon.

Sabin, J. M.. (1994). A credo for ethical managed care in mental health practice. Hospital and Community Psychiatry, *45*, 859- 860.

Schatzberg, A. F., & Nemeroff, C. B. (eds.). (1995). The American Psychiatric Press Textbook of psychopharmacology.

Science Applications International Corporation (SAIC). (1995). Mental health quality monitoring screens and utilization review criteria. Department of Defense, Health Affairs Contract # MDA906-93-D-0003.

Sherman, P. & A compilation of the literature on what consumers want from mental health services. Cambridge, MA: Human esearch Institute.

- Shriqui, C. L., & Nasrallah, H. A. (eds.). (1995). Contemporary issues in the treatment of schizophrenia. Washington DC: American Psychiatric Press.
- Silver, S. & Stockdill, J. (June, 1993). Values for the System. State of Maryland DHMH, Draft Plan for Comprehensive Mental Health Services: FY 1995 - FY 1999. Dept. Health and Mental Hygiene: Baltimore, MD.
- South Carolina Department of Mental Health. (1995). Adult Community Rehabilitation and Support Work Group Report.
- Spaniol, L. (1996). The values of a psychiatric rehabilitation approach. Center for Psychiatric Rehabilitation. MA.: Boston University.
- Task Force on a Consumer-oriented Mental Health Report Card. (1996). The final report of the Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-oriented Mental Health Report Card. CMHS, SAMHSA. 5600 Fishers Lane, Rockville MD 20857.
- Texas Department of Mental Health and Mental Retardation State Hospitals System. (1994). The Quality System Oversight Plan.
- Torrey, E. F. (1995). Surviving schizophrenia. (3rd ed.). New York: Harper.
- Trochim, W. M. K., & Cook, J. (1993). Workforce Competencies for Psychosocial Rehabilitation Workers: A Concept Mapping Project. Columbia, MD: International Association of Psychosocial Rehabilitation Services.
- Vermont Department of Mental Health and Mental Retardation (July 1993). Training Standards for staff Who Work with Adults with Serious Mental Illnesses in Public Mental Health Services.
- West Virginia Office of Behavioral Health Services. (1995). Guidelines of practice for persons with serious mental illness.
- Zahniser, J. (1996). Provider competencies relate to outcome studies and outcomes/performance measurement. WICHE, Boulder, CO.

VI. MEMBERS OF ADULT PANEL

Name and Address

Phone, Fax, Email

TOM BACKER, Ph.D.
Human Interaction Research Institute
1849 Sawtelle Blvd.
Suite 102
Los Angeles, CA 90025-7007

W 310 479-3028
F 310 479-4650
sec. 619 574-6413

JEAN CAMPBELL, Ph.D.
Missouri Institute of Mental Health
University of Missouri--Columbia
5247 Fyler Ave.
St. Louis, Missouri 63139-1361
National Center for Consumer Studies & Training

(314) 644-7829, 8822
Fax (314) 644-8834

PAUL CARLING, Ph.D.
University of Vermont
70 Howard Street
Burlington, VT 05401-4814

W 802 658-0000
H 862-6270

VICTORIA CONN, R.N. Vicky
220 French Rd.
Newtown Square, PA 19073

W 610 356-1541
Fax 610 356-1167

DANIEL B. FISHER, M.D.
Medical Director
East Middlesex Human Services
25 Bigelow St.
Cambridge, MA 02139

W 1 800-769-3728
617 246-2010

JEANNE C. FOX, Ph.D., RN
S.E. Rural MH Research Center
University of Virginia
Madison House
Charlottesville, VA 22901

W 804 979-8560

CYNTHIA FEIDEN WARSCH
Value Behavioral Health
3110 Fairview Park Drive, South
Falls Church, VA 22042

W 703 205-7000

HOWARD GOLDMAN, M.D.

H 301 983-1671

ROW Science
UMAB
Mailing Address: 10600 Trotters Trail
Potomac MD 20854

W 301 294-5667
W410 706-2490, 6669

CHARLES GOLDMAN, M.D.
341 St. Thomas Church Rd.
Chapin, SC 29036

H 803 345-2209
W 803 434-4250 or 9250

COURTENAY HARDING, Ph.D.
Campus Box C249
Dept. of Psychiatry
Univ. of Colorado Health Sciences Center
4200 East Ninth Avenue
Denver, CO 80262

W 303 270-5622
W 303 270-5793
H 303 743-0322

SCOTT HINKLE, Ph.D.
852-8924
Curry Bldg. UNCG
Greensboro NC 27412-5001
hinkle@dewey.uncg.edu

W 910 334-3427; H 910
Fax 910 334-4120/3433
email:

RUTH HUGHES, Ph.D.
Director of I.A.P.S.R.S.
10025 Governor Warfield Pkwy.
Suite 301
Columbia, MD 21044-3357

W 410-730-7190

DALE JOHNSON, Ph.D.
Department of Psychology
University of Houston
Houston, Texas 77204-5341

W 713 743-8621
Fax 713 743-8633

JEFFREY JUE, Ph.D.
Director of Social Services
PO Box 42
Modesto, CA 95353

W 209 558-2505

CATHERINE KANE, Ph.D., RN
Western State Hospital; P.O. Box 2500
Staunton VA 24402-2500

W 540 332-8311 M-W
Fax 540 332-8065
804 924-0100 UVa. Th F

MICHAEL KELLEY, Ph.D.
Director, Vesta.

W 301 505-1700 #14
Fax 301 505-0030

4615 Wheeler Hills Rd.
Oxon Hill, MD 20745
HOME: 912 Hickory Circle
LaPlata MD 20646

301 609-9709

NANCY LANE, Ph.D.
CNR Health

1 800 654-5160

Mailing Address: 6166 N. Bay Ridge Ave. Milwaukee, WI 53217

ANTHONY LEHMAN, M.D.
Center for Mental Health Services Research
University of Maryland School of Medicine
645 West Redwood St.
Baltimore, MD 21201

1 410 706-2490

DIANE MARSH, Ph.D.
Psychology Dept.
University of Pittsburgh
Greensburg, PA 15601-5895

412 836-9684
Fax 412 836-7133

NOEL MAZADE, Ph.D.
NASMHPD
Research Institute
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314-1591

703 739-9333

BOB PAULSON, Ph.D.
Portland State University
3135 N.E. 17th Ave.
Portland, OR 97212
Mailing address: PSU/RRI
PO Box 751
Portland, OR 97207

503 725-5195

JOSEPH ROGERS
National Mental Health Consumer Self-Help Clearinghouse
Suite 1000
1211 Chestnut St.
Philadelphia, PA 19107

W 215 751-1810 x 273
H 215 763-3119
F 215 735-8307

LEROY SPANIOL, Ph.D.
The Psychiatric Rehabilitation Journal
930 Commonwealth Ave.

617 353-3549
Fax 617 353-9209

Boston, MA 02217

KATHY STERNBACH
GreenSpring Health Services
5565 Sterrett Place
Columbia, MD 21044

W 410 964-8010
Fax 410 740-8573

SANDRA SUNDEEN, RN
Human Resource Development Division
Mental Hygiene Administration
201 W. Preston St., 4th floor
Baltimore, MD 21201

W 410 767-6612
Fax 410 333-5402

JAMES ZAHNISER, Ph.D.
WICHE
P.O. Drawer P
Boulder CO 80301

W 303 541-0253

Table 1.

Table 2: Principles and Values of Programs which Train Public-System Service Providers¹

Goals of the Educational Process

1. Education should provide a full range of options, understandings, and viewpoints about the problems and solutions in the field.
2. The process must include both training (of specific skills) and education (exploratory learning and reflection).
3. Education of service providers needs to provide a balance between scientific/clinical knowledge and the human experience of the disorder.
4. Students should be trained to think critically, to respect data and evaluation, and to stay current in the scientific and applied aspects of their work.
5. Future service providers should receive training as systems change agents.
6. Service providers should have a wide range of knowledge and skills relative to helping individuals with disabilities.
7. Service providers should respect and use the diverse skills provided by other disciplines and seek to develop transdisciplinary relationships.
8. For each field of mental health providers, there should be a minimal required knowledge base and skills competency in working with persons with serious mental illnesses.

Values Concerning Consumers, Their Families, and Service Providers

Respect for, and empowerment of, clients and their families should be an underlying value. Examples of its realization would include:

1. Individuals receiving services, and their families, are potential teachers about coping with the challenges of serious mental disorders. Service providers can and should learn from those receiving services and from their families.
2. Students and providers should be aware of the power dimension in provider-consumer relationships, and should be taught how to avoid abusing it.
3. Consumers and family members need to be involved in all decisions concerning themselves. To the extent possible, all forms of coercion and physical force should be avoided.
4. Service providers need to be respectful of the consumer's and the family's experiences, perceptions, and values that are brought to the relationship.
5. Service providers need to respect the choices of persons with serious mental illnesses. As much as possible, success must be formulated in each individual's personal terms.
6. Students must see persons with serious mental illness as fellow human beings, be able to enter their frame of reference, and understand their cultural/ethnic background. This is also true in working with families.
7. Service providers should value the role of families in the care and support of their mentally ill relatives.
8. Service providers should understand the value of the consumer and family movements and other forms of self-help groups.
9. Service providers should seek client feedback on their procedures.

Values Concerning Service Organizations, Programs, and Larger Systems which Affect Service

1. Community integration is a mandate for the service system and the community, while preserving the right of consumers to make choices about his/her living arrangements. This assumes a proactive stance on the part of service providers to educate the community and to build the necessary bridges for persons with serious mental illnesses.
2. Education should help students to understand the impact of larger socioeconomic, legal, and administrative systems on service provision and clients.
3. Service providers should be aware of how economic arrangements provide incentives and disincentives for particular types of behaviors, programs, and systems.
4. Service providers need to work to diminish the fragmentation of the service delivery system.
5. Service providers need to be trained to develop programs and interventions that fit the diverse nature of the population rather than expecting people to fit existing programs.
6. The value of respect and empowerment should also apply to direct service staff. For example, input from direct service staff needs to be solicited in designing and running programs.

¹ Coursey, R. D. (1990). Values in the education of students about Serious Mental Illness. Statement of the Maryland Training Consortium on SMI.

Table 3: Values, and Attitudes of Adult Mental Health Service Providers

A) PERSONAL QUALITIES OF SERVICE PROVIDERS

a) Knows and Applies Professional Standards¹

1) Knows & applies ethics and standards

Knowledge of legal system: civil laws, court procedures, commitment laws & procedures, advocacy organizations.

Knowledge of individual rights such as confidentiality, civil rights, patient rights.

Knowledge of ethical guidelines and boundaries for community support work. Reports ethical, civil rights transgressions.

Connects individuals to legal and advocacy resources as needed/requested.

2) Professional work ethic²

Dependable (keeps appointments, "hang in there" with difficult clients).

Advocate for consumers.

Builds positive working relationships within and across agencies (communicates well, consults, negotiates differences).

Team Player. (Works well with others, accepts others' roles, open to feedback and suggestions, supports others).

Keeps good records.

Works with significant others (family, relatives and others, with consumer's approval).

Gets results.

Accountable in all its forms (financial, clinical, programmatic, uses evaluation).

Commitment to developing more humane and responsive system of care.

Obtains continuing education (theory, research, and practice), and integrates new learning into daily work practice.

Commitment to using research and technology.

b) Personality characteristics

Accepts limitations of self & others
h system.s

Assertive

Awareness of own strengths & weakness

Creative

Flexible

Honest

Non-judgmental

Open-minded

Trustworthy

Etc.

¹Material primarily from Carling and Curtis, Training Standards for Staff Who Work with Adults with Serious Mental Illnesses in Public Mental Health Services.

²Material taken primarily from Zahniser, J. (1996). Provider competencies relate to outcome studies and outcomes/performance measurement.

B) INTERPERSONAL QUALITIES OF SERVICE PROVIDERS

General attitudes/values/skills toward clients

a) Empathic.

Sensitivity to the experiential world of serious mental illness.
Accepting feelings without pathologizing.
Understanding the burden of living with the illness and its consequences.
Communication skills that validate, support, and reveal opportunities for growth.

b) Respectful.

Preserves clients' dignity, self-esteem, and avoids blame and stigma.
Recognizes that clients and family members are the experts on the specifics of the problem and their own needs.
Knows the relevant literature on stigma and discrimination and its impact on people with serious mental illnesses.
Avoids stigmatizing language and corrects own inappropriate attitudes.

c) Perceives the uniqueness of each client.

Treats consumer as an unique individual, not a diagnosis.
Avoids labels and stereotypes.
Is aware of racial, ethnic, gender and religious dimensions of client behavior and beliefs.
Has realistic expectations.

d) Holistic understanding.

Is aware of the role of biology, basic human needs, social, economic, political, vocational, spiritual, and practical factors in the expression and recovery in serious mental illness.
Integrates a wide range of perspectives in understanding and intervening with clients.
Is flexible, pragmatic, and open-minded in developing treatment interventions.

e) Promotes consumer input, choice and cooperation.

Emphasizes choice and cooperation with client rather than force and intimidation.
Involves client in a working partnership.

f) Hope and rational optimism.

Fosters hope, rational optimism in the recovery process.
A longitudinal belief in the potential for recovery with realistic expectations in setting treating goals.
Understands the episodic nature of severe mental illness and that relapse does not prevent recovery.
Knows that recovery is not a linear process, but involves growth and setbacks, periods of rapid change and little change.

g)Competency and strengths perspective.

Assists consumers to identify and use their strengths to deal with their deficits and problems.
Builds consumers' strengths, skills, and knowledge of their illness so they can manage their symptoms and the rest of their life.
Through self-help groups and other methods, support consumers to make choices and become more independent and self-responsible.

h)Consumer well-being and satisfaction.

The consumers' sense of well-being and satisfaction with their lives and their behavioral healthcare should be a goal at all levels of service.

i)Collaborative approach to family, significant others, providers, & payers.

The provider uses a collaborative, cooperative approach to problems by including consumers, significant others, the family, and other relevant personnel in treatment planning and execution. The payer or managed care entity is also a part of the contemporary treatment system and must be an integral part of the collaborative process.

Table 4: Values of the Outpatient Mental Health System

A) VALUES OF THE SYSTEM ITSELF ¹

1)Basic personal rights. Persons with mental illness have the same rights and obligations as other citizens of the state... right to choice, the fullest possible control over their own lives and opportunities to be involved in their communities.

2)Empowerment. Consumers and families will be involved in decision-making processes at the treatment level and collectively in the planning and operation of the mental health system. An array of services and programs must be available to allow consumer choice. Programs must be relevant to and recognize varying cultural, ethnic and racial needs,

3)Family and community support. Provide families with the assistance they need in order to maintain or enhance the support they give to their family members.

5)Least restrictive setting. Services should be provided in the least restrictive, most normative, and most appropriate setting to meet a variety of consumer needs.

6)Working collaboratively at all levels of state service and across agencies.

7)Effective management and accountability.

8)Local governance. Local management of resources will improve continuity of care, timely provision of needed services, and better congruence of services and resources to needs.

9)Staff resources. Staff must be provided with adequate support systems and incentives. Opportunities must be provided for skill enhancement training or retraining.

10)Community education & early identification and prevention activities for risk groups of all ages, public education, and efforts which support families and communities.

¹ Slightly edited from S. Silver & J. Stockdill (June, 1993). Values for the System. State of Maryland DHMH, Draft Plan for Comprehensive Mental Health Services: FY 1995 - FY 1999.

B) PRINCIPLES OF THE REHABILITATION APPROACH²

- 1) Focus on strengths and competencies, not on pathology
- 2) Providing differential care for different needs
- 3) Focus on here and now rather than past problems
- 4) Committed staff
- 5) Respecting and enhancing clients' self determination
- 6) Utilizing environmental supports and persons in the rehab process
- 7) Enhancing normalization
- 8) Social change with and on behalf of clients
- 9) Early intervention and prevention
- 10) Work-centered rehabilitation process
- 11) Equipping clients with skills
- 12) A social rather than medical model
- 13) All people have an underutilized potential for growth and development³
- 14) Setting no limits on participation

² Edited from R.A. Cnaan, & L. Blankertz (1991). Comparing consumers, practitioners, and experts orientation to psychosocial rehabilitation principles. Paper presented at the IAPSRs 16th Annual Conference, Baltimore, MD, June 26, 1991. Fifteen principles culled from 200 articles on PSR, and confirmed by samples of experts, consumers, and practitioners. Rated in order from most essential.

C) VALUES RELATED TO CLIENT TREATMENT IN A MENTAL HEALTH SYSTEM

a) Service Planning

1) Services are coordinated to enhance the total well-being of the consumer, rather than isolated programs that address individuals' deficits, or that specialize in only one segment of ones' well-being.

2) Consumer is treated as an equal in developing individual service plans
Training and support may be needed to help consumers become real participants.

3) Families should be involved in planning for their family member where they are the primary caregivers. Families should also be provided with resources such as education, support, respite care, advice, etc.

b) Service Provision

1) Continuing care is available over the person's lifetime.

2) The service system must provide an integrated system of care.

3) Services are available throughout the community served by the system and are easily accessed, flexible scheduling of appointments, reasonable hours with after-hours availability.

4) Ongoing evaluation of customer satisfaction and measurement of outcomes.

5) Wide range of available services. Hospitalization, medication, and psychotherapy are an inadequate set of services for people with serious mental illness.

6) Has adequate and accessible crisis care for people with SMI, and longer term hospitalization integrated into the system of care.

7) Family involvement

c) Service providers

1) Staff should have adequate pre-service and continuing education as well as supervision in providing specific services to people with serious mental illness.

2) Service providers know and apply relevant legal, ethical, and professional standards in their work (Americans with Disabilities Act, civil rights, confidentiality in treatment, Fair Housing Act, mental health laws of the state, patient rights, informed consent, sexual harassment, staff rights, relevant standards of care, professional treatment guidelines, and state, agency, and managed care policies and procedures, etc.)
