

Behavioral Health Case Management Training

Strengths Based and
Recovery Principle
Practices

Behavioral Health Case Management Training

Introductions:

- Name
- Name of Agency ?
- Where is located?
- What population do you serve?
- What services? (MH &/or SA)
- Years of behavioral health experience?
- Goals for this training?

Module One

Serious Mental Illness



MODULE 1

Since you have decided to become a Behavioral Health Case Manager, it's important to emphasize some of the things that come along with working in this field.

This module will provide some fundamental information you will need when working with adults who have a serious mental illness.



MODULE 1

Individuals with psychiatric disabilities are as complex and diverse a group as the population in general.

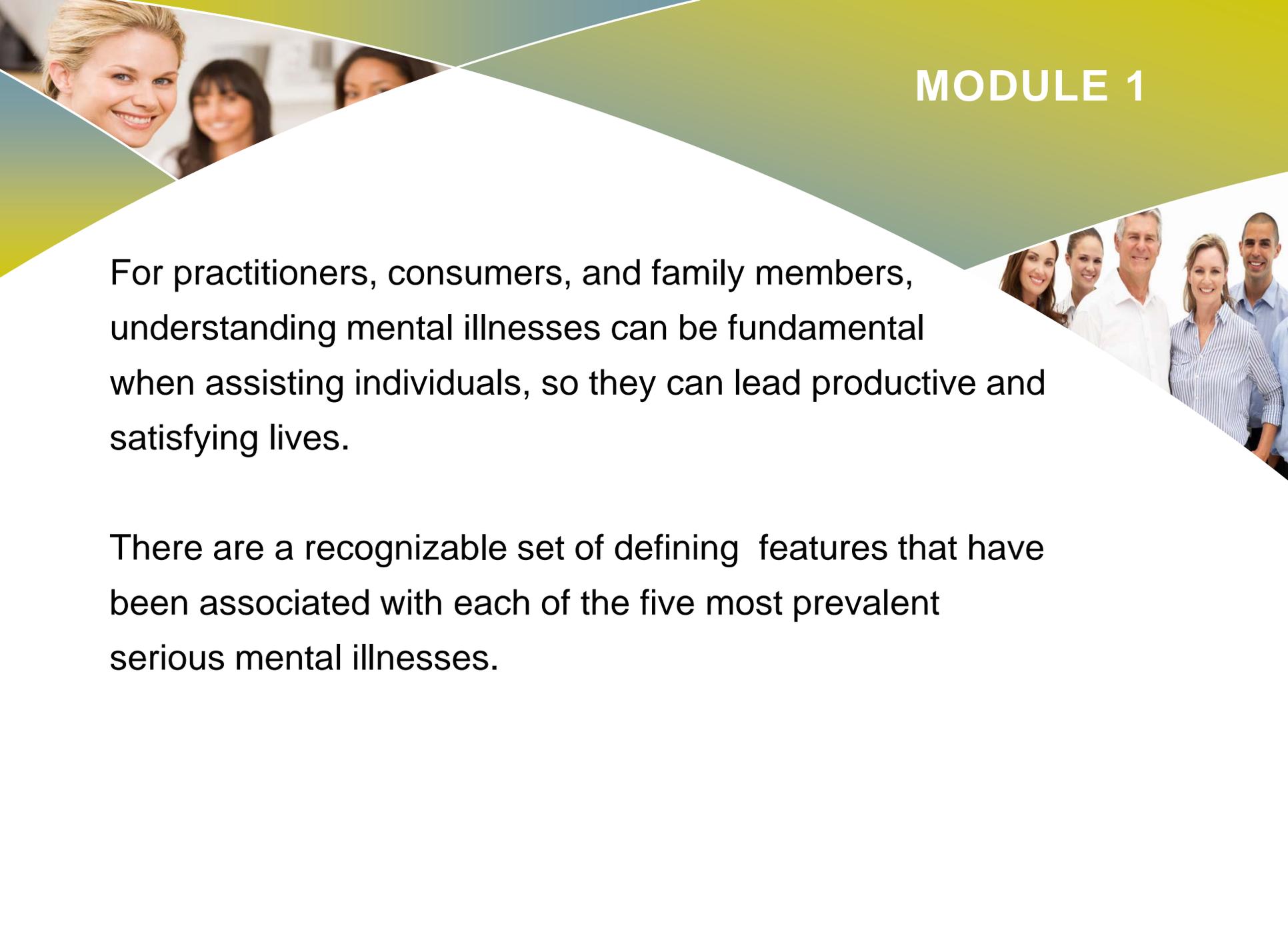
Some individuals with a psychiatric disability may have difficulty attaining important life goals and functioning effectively in one or more life domains such as: activities of daily living and performance of social, cultural and occupational roles without assistance.



MODULE 1

- More than 5 million people in America in the United States have been diagnosed with a severe and persistent mental illness.
- They are our family members, neighbors, co-workers and friends.
- Not only can your role as a behavioral health case manager help with their survival, it can also reduce or eliminate functional deficits, interpersonal/environmental barriers and provide a richness and meaning to their lives.

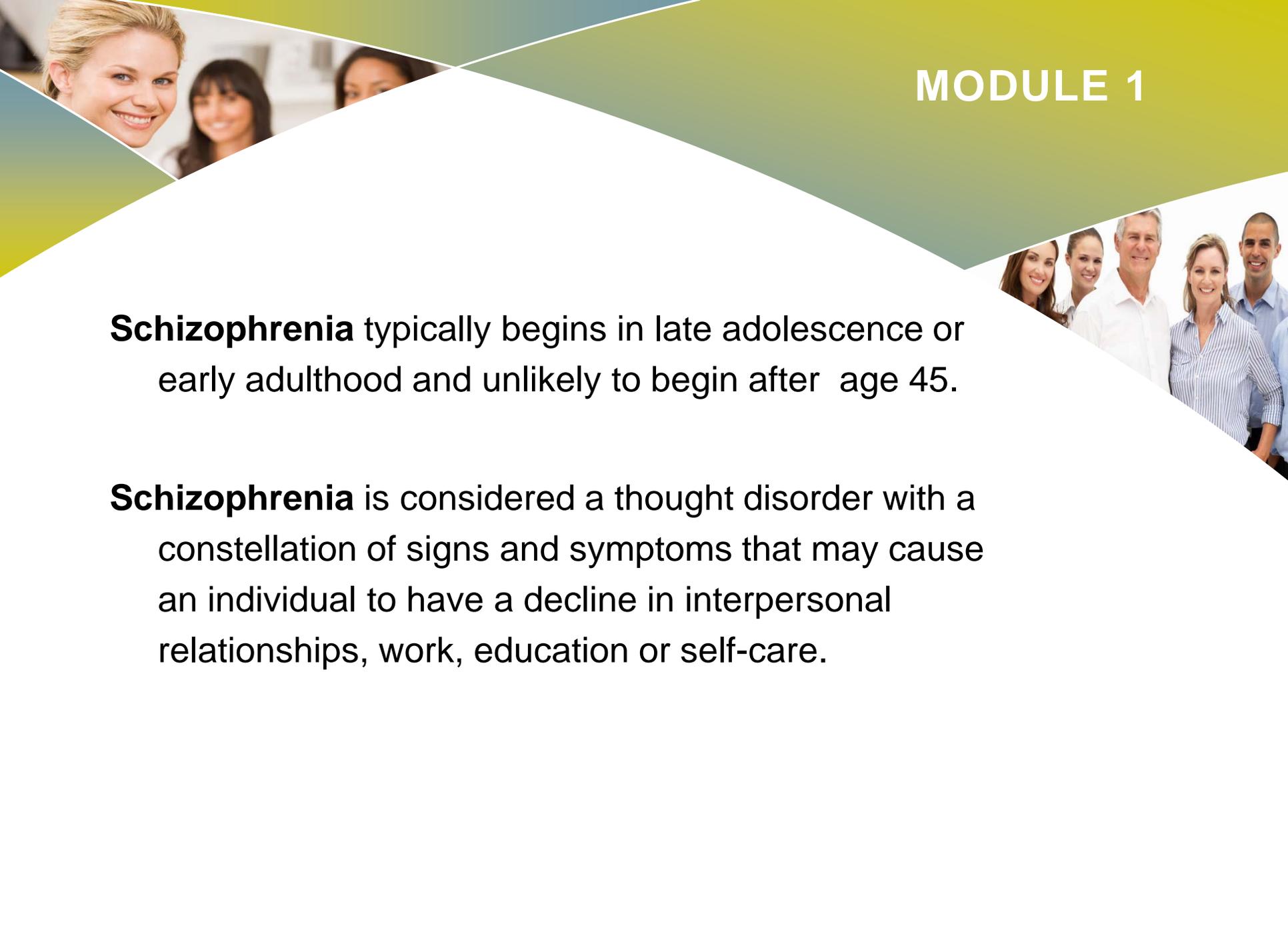




MODULE 1

For practitioners, consumers, and family members, understanding mental illnesses can be fundamental when assisting individuals, so they can lead productive and satisfying lives.

There are a recognizable set of defining features that have been associated with each of the five most prevalent serious mental illnesses.



MODULE 1

Schizophrenia typically begins in late adolescence or early adulthood and unlikely to begin after age 45.

Schizophrenia is considered a thought disorder with a constellation of signs and symptoms that may cause an individual to have a decline in interpersonal relationships, work, education or self-care.

Associated features of **Schizophrenia**:

- **Cognitive impairments** – Impaired attention and memory, confusion, difficulty concentrating and distractibility, inability to transfer information from one situation to another; impairment of logic, problem solving and ability to do abstract thinking; lack of insight
- **Inappropriate affect** – Smiling, laughing, or other facial expressions displayed in the absence of an appropriate stimulus

Associated features of **Schizophrenia**:

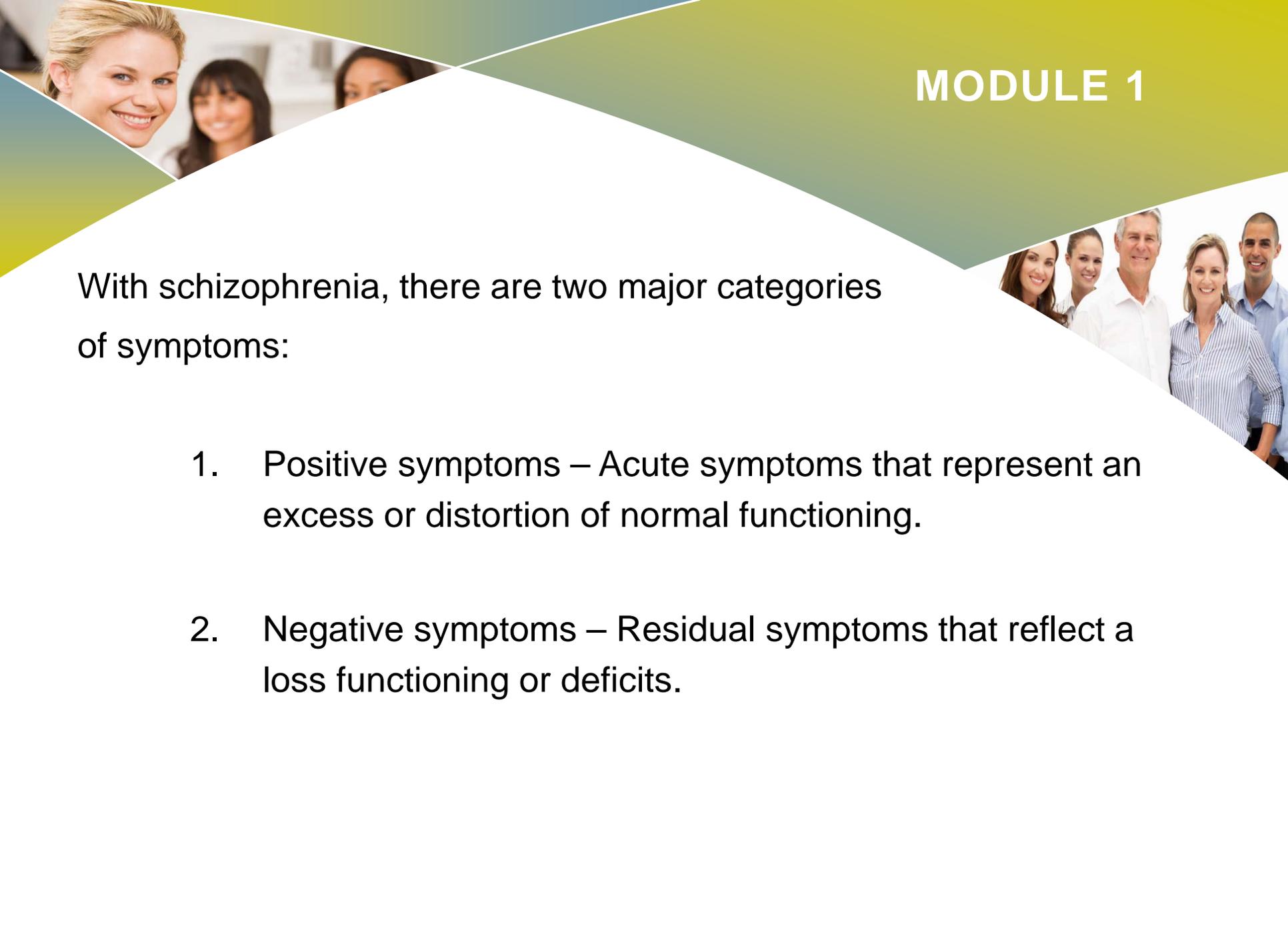
- **Dysphonic mood** – depression, anxiety, anger
- **Psychomotor activity abnormalities** – pacing, rocking, apathetic immobility
- **Grimacing, posturing, old mannerisms, ritualistic or stereotyped behaviors**
- **Disturbances in sleep**



Individuals with **Schizophrenia** often have impairments in perception, inferential thoughts (ability to reason), language, communication and behavioral monitoring that affect their:

- Fluency (the ease of processing information)
- Productivity of thought and speech
- Capacity to enjoy oneself
- Attention span
- Volition (ability to commit to a particular course of action)
- Drive or motivation

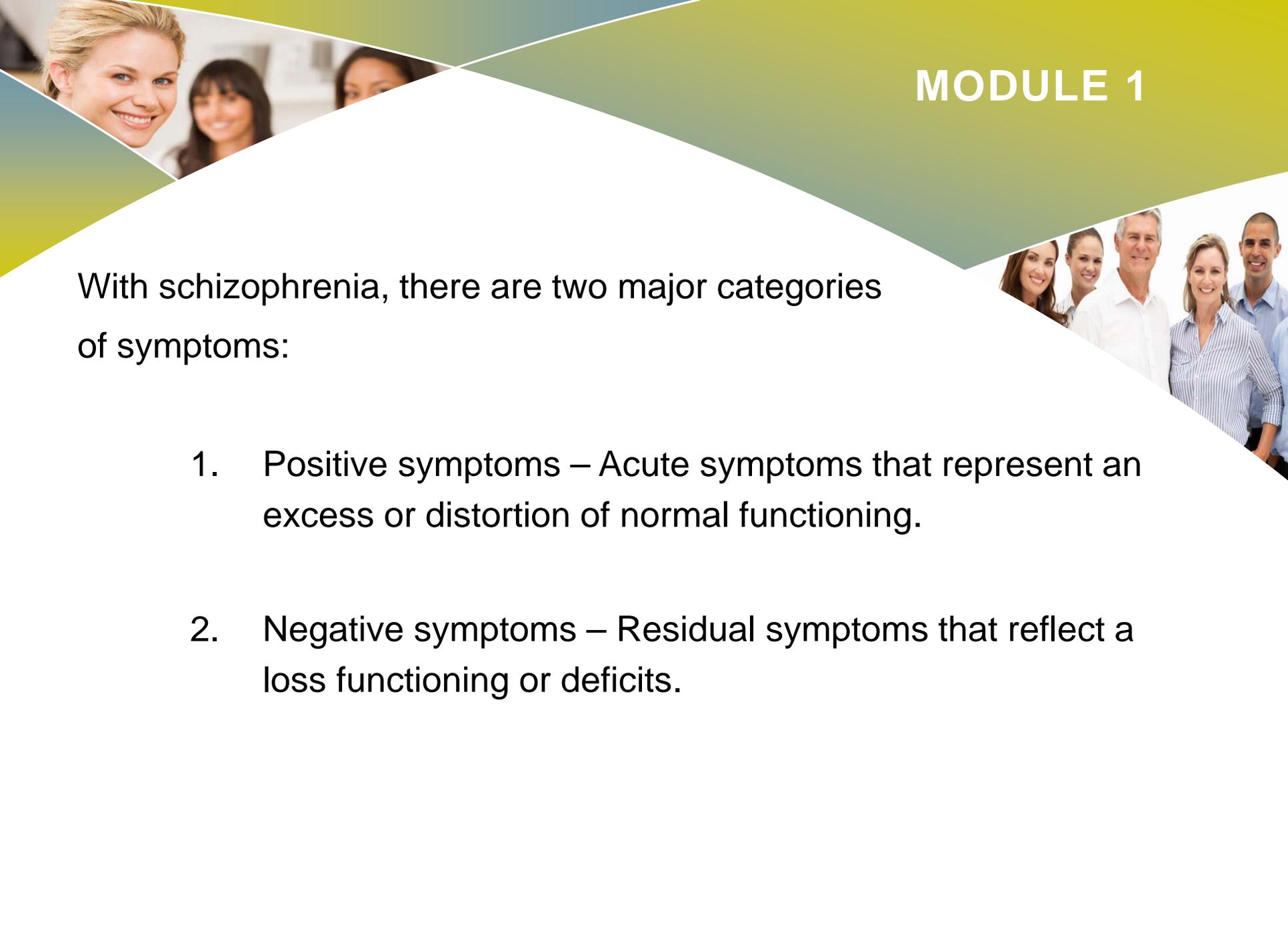


The slide features a decorative background with overlapping geometric shapes in shades of green and yellow. In the top-left corner, there is a partial photo of three smiling women. In the top-right corner, there is a photo of a diverse group of five people (three women and two men) smiling. The text 'MODULE 1' is positioned in the upper right area, overlaid on the green and yellow shapes.

MODULE 1

With schizophrenia, there are two major categories of symptoms:

1. Positive symptoms – Acute symptoms that represent an excess or distortion of normal functioning.
2. Negative symptoms – Residual symptoms that reflect a loss functioning or deficits.



MODULE 1

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1. Positive symptoms – Acute symptoms that represent an excess or distortion of normal functioning.
2. Negative symptoms – Residual symptoms that reflect a loss functioning or deficits.

Examples of **positive symptoms**:

3. **Disorganized Speech** – Grossly impaired language, communication and thinking; this is often considered to be the most prominent feature of Schizophrenia; it encompasses the “loosening of associations” among ideas that would otherwise be logical; and
4. **Grossly disorganized or Catatonic behavior** – Problems in goal directed behavior that may exacerbate performance in one or more of life’s domains; marked motor abnormality including a state of immobility; purposeless unstimulated excessive motor activity.

MODULE 1

To see a personal story about Schizophrenia,
please click on the following link:

<http://www.youtube.com/watch?v=cHt6e7jqY5U>



MODULE 1

Mood disorders are characterized by changes in affect or emotion that are characterized by extreme or prolonged states of sadness, apathy, or elation.

Energy level, participation in daily activities, appetite, self- esteem, thinking, speech, sex drive and interpersonal relations can be impaired.



MODULE 1

It is estimated that **50% of all suicides** are attempted/completed by individuals that have a mood disorder.

Although NOT ALL mood disorders are considered a serious mental illness, two exceptions are **Bipolar Disorder and Major Depression.**



MODULE 1

The onset of **Bipolar disorder** typically occurs prior to the age of 35 and usually begins in late adolescence or early adulthood.

Bipolar disorder is characterized by episodes of *mania* (increased state of excitement, expansiveness and/or irritability) and then shifts to cycles of *depression* (deepened state of sadness, melancholy, hopelessness).



Associated features of **Mania**:

1. **Inflated self-esteem or grandiosity** – An inflated sense one's worth, power, knowledge and importance
2. **Diminished need for sleep**
3. **Severe insomnia** – Difficulty falling asleep; waking in the middle of the night and unable to return to sleep
4. **Pressured speech** – Speech that is increased, accelerated, difficult to interrupt and is usually loud and emphatic



Associated features of **Mania**:

5. **Flight of ideas or racing thoughts** – Nearly continuous flow of accelerated speech with abrupt changes in topics; speech may be disorganized and incoherent
6. **Distractibility** – Attention easily drawn to irrelevant stimuli
7. **Increase in goal-directed activity** – Excessive planning and participation in multiple activities
8. **Increase in psychomotor agitation** – Excessive motor activity that is usually unproductive and non-productive

Associated features of **Mania**:

9. **Excessive involvement in pleasurable activities without considering potential for painful consequences** – Unrestrained buying sprees, sexual indiscretions or other activities that does not represent their typical behavior
10. **Poor judgment, inappropriate irritability, impulsiveness and inappropriate social behaviors that may be intrusive and demanding**





MODULE 1

To learn more information about Bi-polar disorder, please click on the following link:

<http://www.youtube.com/watch?v=MBUOoQk0hhU>

Associated features of **Depression**:

1. **Depressed mood most of the day and nearly everyday** – Persistent sad, anxious or empty mood; appears tearful
2. **Feelings of hopelessness, pessimism, guilt, worthlessness, helplessness nearly everyday** – Such feelings are excessive, inappropriate, and may have delusional features
3. **Thoughts of death, attempted suicide or suicidal ideation with or without a specific plan**

Associated features of **Depression**:

4. **Diminished interest or pleasure in almost all activities** – (e.g. work, school, hobbies and activities that were once enjoyed)
5. **Fatigue or loss of energy nearly everyday**
6. **Psychomotor agitation or retardation almost daily** – Extreme restlessness, irritability or slowed response to environmental stimuli
7. **Insomnia or hypersomnia** – Difficulty sleeping or oversleeping nearly everyday

Associated features of **Depression**:

8. **Difficulty thinking, remembering, concentrating, making decisions nearly everyday**

9. **Significant appetite loss, weight loss or weight gain** – A change of more than 5% of body weight in one month

10. **Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders & chronic pain**

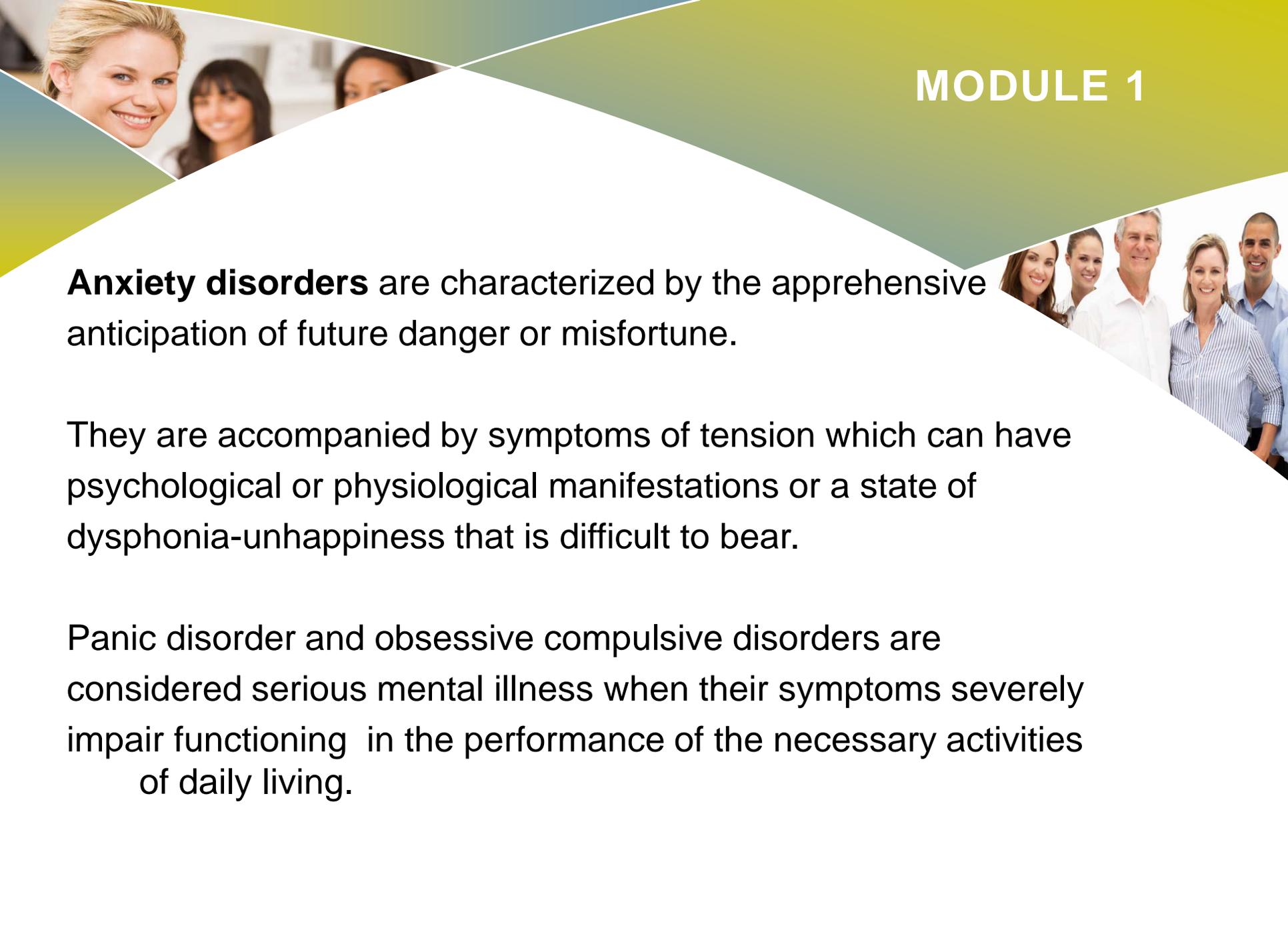


MODULE 1

To learn more about Depression, please click on the following link:

http://www.youtube.com/watch?v=NWY_NPJ39iQ





MODULE 1

Anxiety disorders are characterized by the apprehensive anticipation of future danger or misfortune.

They are accompanied by symptoms of tension which can have psychological or physiological manifestations or a state of dysphonia-unhappiness that is difficult to bear.

Panic disorder and obsessive compulsive disorders are considered serious mental illness when their symptoms severely impair functioning in the performance of the necessary activities of daily living.

Symptoms of Panic Disorders:

- **Panic Attack** – Discrete period of intense fear where an individual experiences multiple somatic or cognitive symptoms that develop abruptly
 - **Derealization** – Altered sensations/perceptions where people seem unfamiliar or mechanical
 - **Depersonalization** – Dreamlike sensations or perpetual distortions where the individual feels detached from their body or mental processes.
- Chest pains
 - Trembling or shaking
 - Difficulty breathing
 - Choking
 - Nausea
 - Dizziness
 - Chills or hot flashes
 - Sweating
 - Fear of losing control
 - Fear of dying
 - Palpitations, racing or pounding heart
 - Numbness or tingling sensation





Obsessive Compulsive Disorder

Features of this disorder include **obsessions** (recurrent thoughts and impulses that are time consuming each day) and **compulsions** (involuntary, repetitive and dysfunctional behaviors that are initiated in order to prevent or reduce anxiety).



OBSESSIVE Symptoms:

- Recurrent and persistent **thoughts**, impulses or images that are often viewed as intrusive, inappropriate and cause anxiety and the individual may attempt to ignore or suppress these thoughts with other thoughts or actions
- Excessive worries about real-life problems

COMPULSIVE Symptoms:

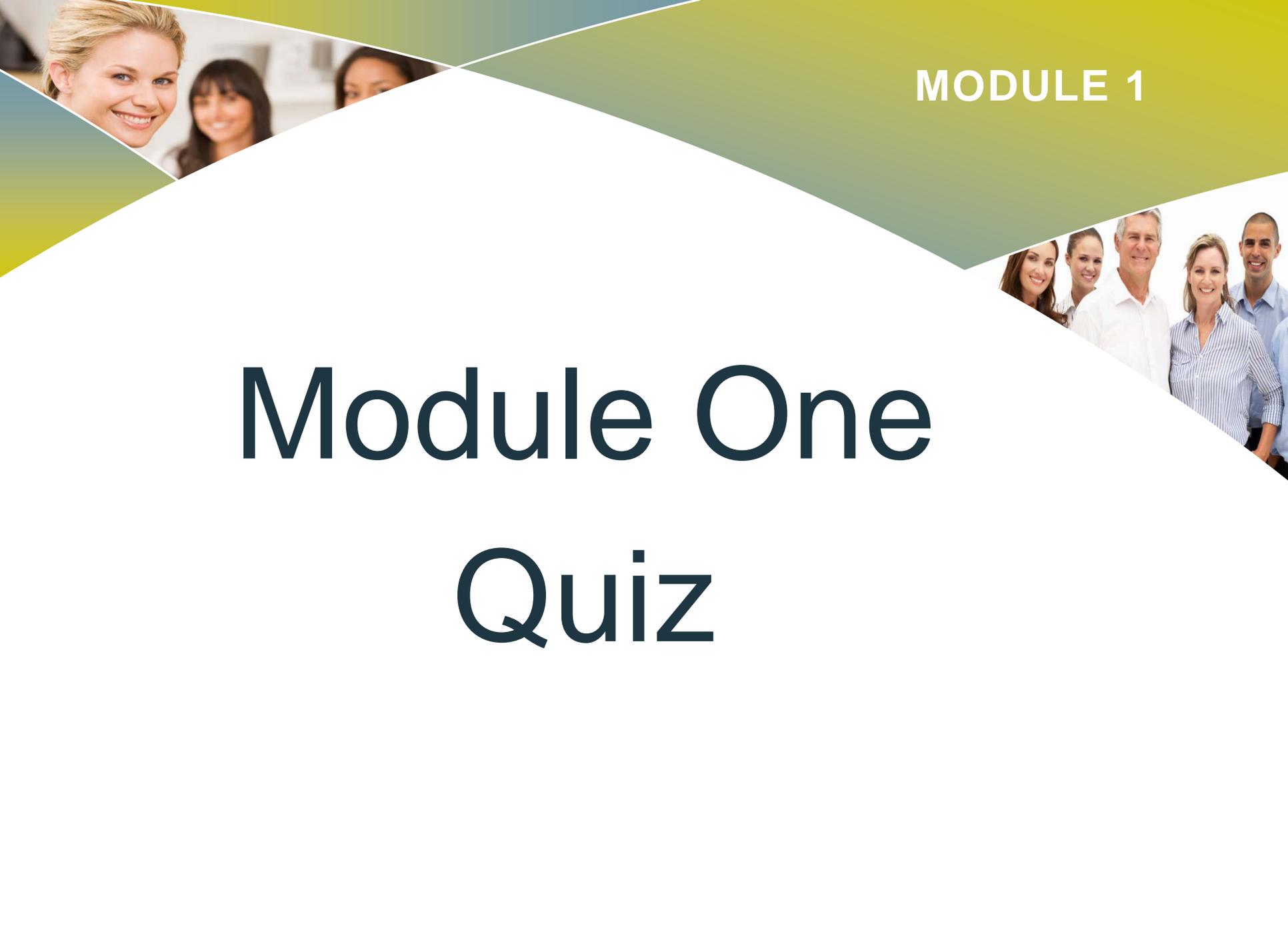
- Repetitive and ritualistic behaviors that are driven by obsessive thought; Performed in order to reduce or prevent distress, a dreaded event or situation

MODULE 1

To learn more about Anxiety Disorders, please click on the following link:

http://www.youtube.com/watch?v=_Cr7IomSy8s





MODULE 1

Module One Quiz

MODULE 1

1. Individuals with psychiatric disabilities are as complex and diverse a group as the population in general and all of them will have difficulty performing in every life domain.
 - a. True
 - b. False



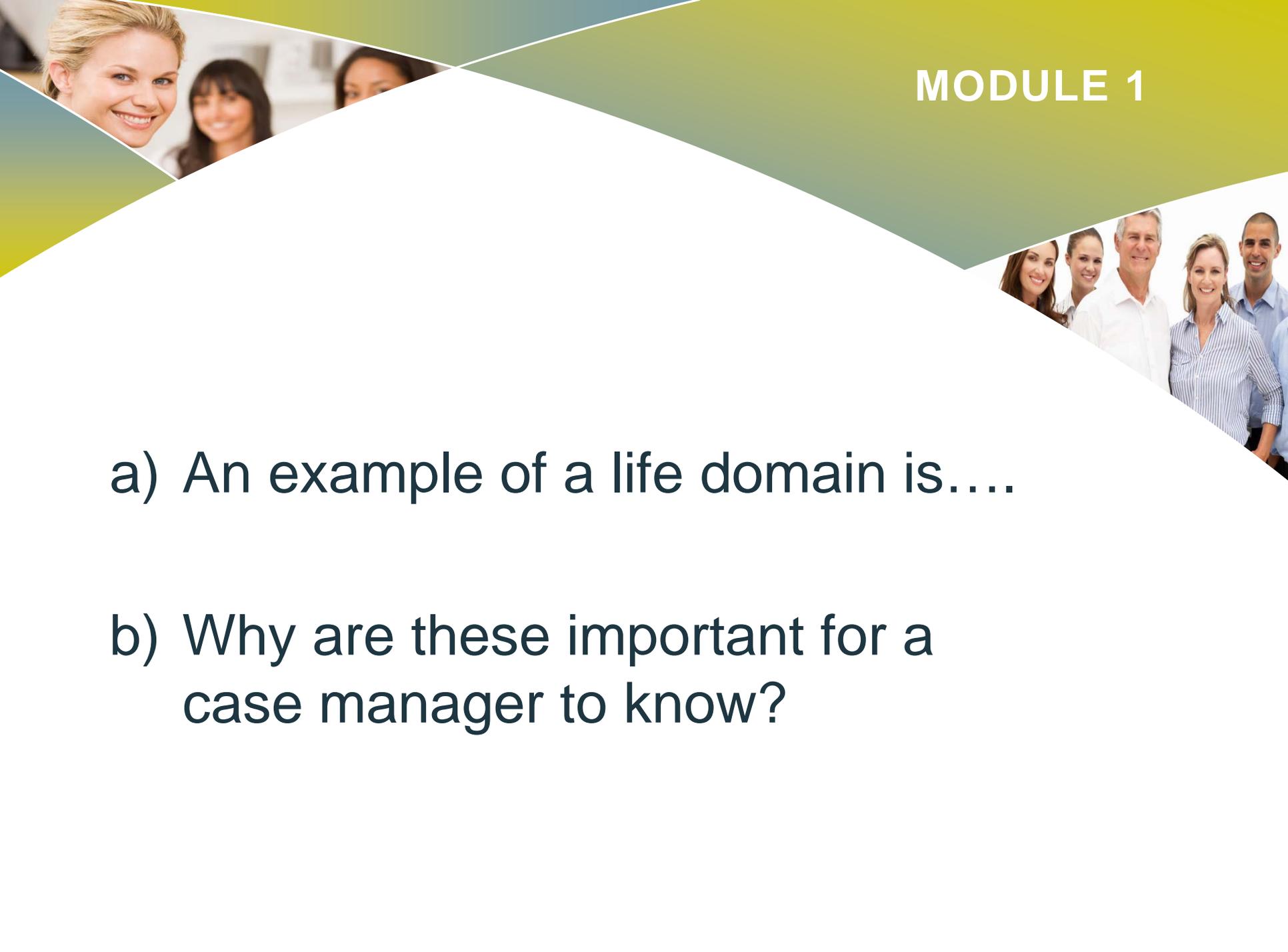
MODULE 1

1. Individuals with psychiatric disabilities are as complex and diverse a group as the population in general and all of them will have difficulty performing in every life domain.

Answer:

b. False

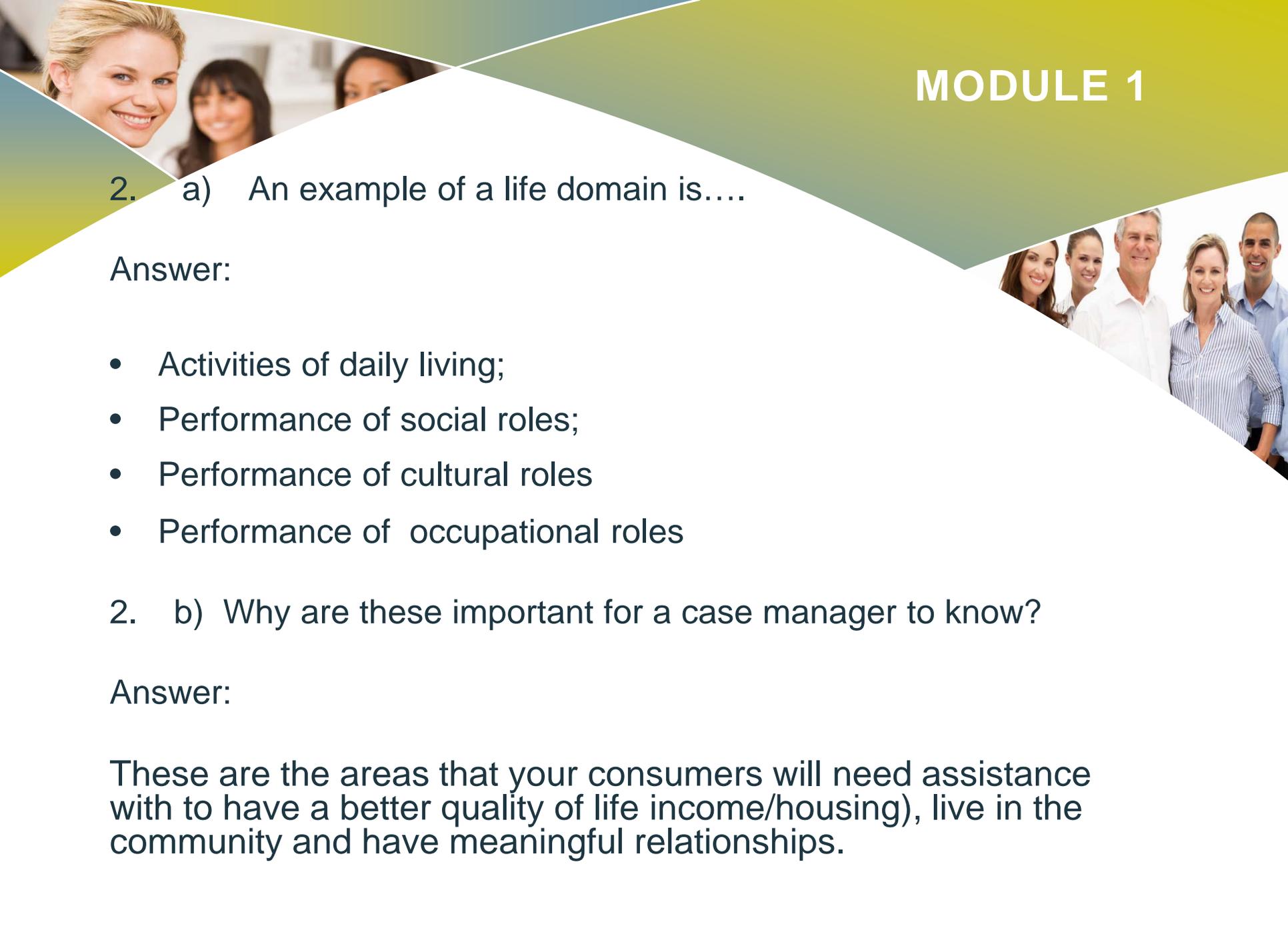




MODULE 1

- a) An example of a life domain is....

- b) Why are these important for a case manager to know?



MODULE 1

2. a) An example of a life domain is....

Answer:

- Activities of daily living;
- Performance of social roles;
- Performance of cultural roles
- Performance of occupational roles

2. b) Why are these important for a case manager to know?

Answer:

These are the areas that your consumers will need assistance with to have a better quality of life (income/housing), live in the community and have meaningful relationships.

3. An example of a serious mental illness could include....



3. An example of a serious mental illness could include....

Answer:

- Schizophrenia
- Bipolar Disorder
- Major Depression
- Some Anxiety Disorders

4. When does the onset of many serious mental illnesses begin?



4. When does the onset of many serious mental illnesses begin?

Answer:

late adolescence or early adulthood.

MODULE 1

- 
- 
5. Schizophrenia is considered a _____ disorder with a constellation of signs and symptoms that may cause an individual to have a decline in interpersonal relationships, work, education or self-care.
- a. Anxiety
 - b. Mood
 - c. Depressive
 - d. Thought

MODULE 1

5. Schizophrenia is considered a _____ disorder with a constellation of signs and symptoms that may cause an individual to have a decline in interpersonal relationships, work, education or self-care.

Answer:

a. Thought



6. A positive symptom of **Schizophrenia** is
- a. Delusions
 - b. Auditory hallucinations
 - c. Disorganized speech
 - d. All of the above
 - e. None of the above



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7. A negative symptom of **Schizophrenia** is
- a. Inability to initiate & persist in goal directed activities
 - b. Flat affect
 - c. Lack of pleasure & interest
 - d. Social isolation
 - e. All of the above
 - f. b, c, & d

7. A negative symptom of **Schizophrenia** is
- a. Inability to initiate & persist in goal directed activities
 - b. Flat affect
 - c. Lack of pleasure & interest
 - d. Social isolation
 - e. **All of the above**
 - f. b, c, & d

8. Obsessive Compulsive Disorder is classified as a(n)
 - a. Thought disorder
 - b. Mood disorder
 - c. Anxiety disorder
 - d. All of the above

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- a. Thought disorder
 - b. Mood disorder
 - c. Anxiety disorder**
 - d. All of the above

- 
9. The associated features of Bipolar Disorder include
- a. Diminished need for sleep
 - b. Inflated self esteem
 - c. Increased state of excitement
 - d. All of the above

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 - d. All of the above**

10. Anxiety disorders are accompanied by symptoms of tension which can have _____ or _____ manifestations.



11. Anxiety disorders are accompanied by symptoms of tension which can have

- psychological or
- physiological manifestations.



Module Two

Understanding the Effects of Stigma



MODULE 2

This module will review ways in which stigma impacts individuals with serious mental illness.

This review will include reasons why our society sometimes stigmatize individuals with mental illness and describe the social structures that **impede their opportunities for employment, housing & health;** and

strategies that may help individuals with serious mental illness overcome stigma and its harmful effects.





MODULE 2

The endorsement of stigma impacts the individual with mental illness, their families, service providers, and the general public.

In addition, stigma may decrease participation in behavioral health services and greatly hinders an individuals rehabilitation goals.





MODULE 2

Public Stigma is when the general population endorses the prejudice toward mental illness; discriminates against them; prevents them from attaining such community integration goals as obtaining a good-paying job or living in comfortable housing.

Self-stigma is when the individual with mental illness internalizes the prejudice and suffers diminished self-esteem and self-efficacy which undermines the person's sense of personal empowerment.



Public Stigma

- Stereotype- negative belief about a group (e.g., dangerousness, incompetence, character weakness)
- Prejudice- agreement with belief &/or negative emotional reaction (e.g., anger, fear)
- Discrimination- behavior response to prejudice (e.g., avoidance of work & housing opportunities, withholding of help)

Self- Stigma

- Stereotype- negative belief about the self (e.g., character incompetence)
- Prejudice- agreement with belief &/or negative emotional reaction (e.g., low self-esteem, low self-efficacy)
- Discrimination- behavior response to prejudice (e.g., fails to pursue work & housing opportunities)

The Negative Impacts of **Public Stigma**

- 1. The loss of rightful life opportunities**- obtaining competitive employment and living independently in safe and affordable housing.
 - The reaction of the criminal justice system:
 - Criminalizing mental illness is one way in which the criminal justice system reacts to individuals with serious mental illness and the number of individuals entangled in the criminal justice system continues to rise.
 - An individual exhibiting signs and symptoms of their mental illness are more likely to be arrested by the police and generally spend more time incarcerated than individuals that do not have a mental illness.
- 

The Negative Impacts of **Self- Stigma**

1. **Diminished self-esteem; self- efficacy and confidence**

- Individuals with psychiatric disabilities may internalize the ideas and believe that they are less valued.
 - Individuals with psychiatric disabilities may believe that they can't successfully perform a certain behavior in a specific situation.
 - These feelings have been correlated with individuals failing to pursue work or independent living situations which they might otherwise succeed.
- 

The Negative Impacts of Self-Stigma

2. Accessing services

- Individuals with psychiatric disabilities may choose not to seek treatment or fail to fully adhere to their prescribed treatment because they do not want to be identified with the stigmatized group.
 - Perceptions of and identification with existing stereotypes about mental illness can hinder the individual that has a mental illness from getting much needed help which may make their life unnecessarily more difficult.
- 

The Opposite of Stigma

Community integration – The affirmative vision specifying that the public is responsible for helping individuals achieve their life goals.

Personal empowerment – Asserts the ultimate control over all domains of one's life. Despite societal stigma, individuals have positive attitudes about themselves and wish to promote community action.



Challenging Self-Stigma

Change cognitive schemas – The way that individuals perceive and understand the negative emotions and feelings and help the individual reframe them as beliefs rather than facts and helping them identify less distressing alternative interpretations.

Disclosure – Although there are costs (disapproval, using the information to hurt them or restrict access to opportunities) associated with disclosure there are also many benefits (support, understanding, empowerment, reducing stigma) and each individual has to decide what is best for them.



Challenging Public Stigma

Protest – Appealing to the moral or economic authority to ask people to stop prejudice;

Education – Contrasting the myths of mental illness with facts (public service announcements, books, flyers). People with a better understanding of mental illness are less likely to endorse stigma and discrimination; and

Contact – Facilitating face-to-face interactions between people with mental illness and the public. The optimal interventions include equal status between groups, common goals, no competition/joint effort and authoritative sanction for the contact (endorsement by a community organization).





MODULE 2

Beyond the Shadows of Stigma

To learn about an innovative way that consumers are educating the public and dealing with the effects of stigma:

<http://cpr.bu.edu/resources/webcast/beyond-the-shadows-of-stigma>





MODULE 2

Module Two

Quiz



1. **Self- stigma** is when the individual with mental illness internalizes the prejudice and suffers diminished self- esteem and self- efficacy which undermines the person's sense of personal empowerment.
 - a. True
 - b. False
- 

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 - a. **True**
 - b. **False**
- 

- 
2. A strategy to reduce public stigma is
- a. Education
 - b. Changing cognitive schemas
 - c. Disclosure
 - d. All of the above
 - e. None of the above

- 
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- a. **Education**
 - b. Changing cognitive schemas
 - c. Disclosure
 - d. All of the above
 - e. None of the above

- 
3. The negative impacts of stigma may include
 - a. Difficulty accessing safe and affordable housing
 - b. Diminished belief in one's ability
 - c. Involvement in the criminal justice system
 - d. All of the above
 - e. None of the above

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 - a. Difficulty accessing safe and affordable housing
 - b. Diminished belief in one's ability
 - c. Involvement in the criminal justice system
 - d. **All of the above**
 - e. None of the above

4. The three characteristics of public and self- stigma , are stereotype, prejudice, and acceptance.
 - a. True
 - b. False
- 

- 
4. The three characteristics of public and self- stigma , are stereotype, prejudice, and acceptance.
- a. True
 - b. False**



Module Three

Recovery is a Reality!

MODULE 3



Whether you are talking about mental illness, substance abuse, or co-occurring (mental illness and substance abuse) disorders, it is very important to know that individuals do recover and lead very full and productive lives.

This module will help you understand the concept of recovery as it applies to mental health, substance abuse, and co-occurring disorders, and offer some considerations for providing recovery focused services.



Mental Health Recovery

Over a period of years, the mental health field has been making a shift in the way they approach treatment for individuals with mental illness. This shift has been moving away from the traditional medical model of care to a recovery model.



MODULE 3



Medical Model

Traditional Practices: Harsh restraint methods Sheltered Workshops, Long term hospitalization, Massive doses of medications, Staff directed treatment

Traditional Task: Stabilization, Custodial care

Traditional Beliefs: Will never be able function in society, Impaired judgment and can't trust thinking, Needs to be stabilized and cared for, Has something wrong with them that someone else needs to fix, Do not understand their own needs, Will not recover

Traditional Responsibility of the Provider: Will provide appropriate custodial care based on staff wisdom and input

Traditional Responsibility of the Consumer: Be obedient and learn to comply

MODULE 3



Recovery Model

New Practices: Consumer & family education, Consumer run initiatives, Community- based services, Medication to suit the individual, Consumer lead treatment planning, Self- help groups, Supported Employment, Education, & Housing

New Tasks: Educate recipient of services, Involve recipients of services at all levels of planning, policy, development, and service over-site

New Beliefs: People in recover do function well in society, make a positive contribution to society, learn ways to manage symptoms, use experience with mental illness as a source of knowledge & expertise, learn from & teach each other, recover from mental illness

New Responsibility of the Provider: Create an environment that is conducive to recovery goals and beliefs, Nurture a belief in recovery for consumers who have been previously taught they cannot recover, Seek out and act on consumer wisdom and input

Traditional Responsibility of the Consumer: Self-advocacy... dialogue with the system about what is and is not helpful, Take ownership of one's own recovery, Use self-help groups for support, Develop illness management skills



People Do Recover!

Recovery rates for mental illness surpass the treatment success rates for many other physical illnesses, including heart disease.

- Schizophrenia, 60%
- Bipolar Disorder, 80%
- Major Depression, 65%- 80%
- Addiction Treatment, 70%

(Report of the National Advisory Mental Health Council, March 1998)



MODULE 3

- Numerous longitudinal research studies have demonstrated recovery rates as high as 68% among people with serious mental illness.
- Concerning these studies, Courtenay Harding, Ph.D., who studied people for as long as 32 years following their first admission to a state hospital comments....

“These studies have consistently found that half to two-thirds of patients significantly improved or recovered, including some cohorts [chronic cases]”

Institute for the study of Human Resilience
Boston University Sargent College of Health and Rehabilitation Sciences



MODULE 3

For purposes of her study she defined recovery as

- No current medications,
- Working,
- Relating well to family and friends,
- Integrated into the community, and
- Behaving in a way that one would not be able to detect that the person had ever been hospitalized for any kind of psychiatric problem



Definitions of Recovery

There are many definitions of Recovery as it pertains to people with mental illness, but an important thing to note is that Recovery does not mean symptom free.

There are many consumers who live very full and productive lives; who continue to live with symptoms of their disorder.

MODULE 3

Recovery is both a Journey and a Destination....

And an overall paradigm for achieving wellness and optimal mental health (SAMHSA)

To learn about one groups journey of recovery, click on the following link:

www.youtube.com/watch?v=LekjVJkucyl&feature=player_embedded



Principles Necessary to Achieve Mental Health Recovery



The Substance Abuse and Mental Health Administration (SAMHSA) outlines 10 Fundamentals of Recovery in a Consensus Statement released in 2006.

Click on the following link to read all about it:

[www.power2u.org/downloads/SAMHSA_recover
Statement.pdf](http://www.power2u.org/downloads/SAMHSA_recover_statement.pdf)

MODULE 3

The Ultimate Goal of Recovery is....

- The establishment or re-establishment of normal roles in the community,
- The development of a personal support network, and
- An increased quality of life.

But more than that.....

Please click on the following link:

<http://www.youtube.com/watch?v=jhK-7DkWaKE>

MODULE 3

A Life with.....

HOPE

Dreams

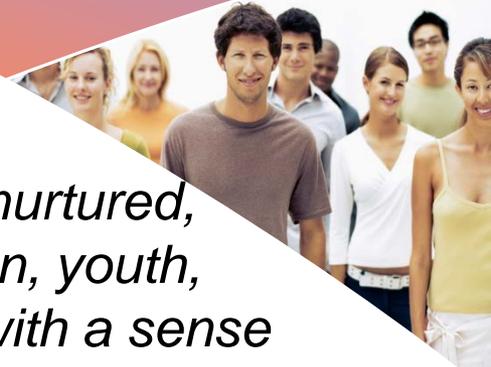
GOALS

To learn more, click on the following link:

http://www.recoverywithinreach.org/education/sm_files/1995DeeganRecovery%20As%20a%20Journey%20of%20the%20heart.pdf

Resilience and Recovery for Children

- The terms resilience- (*an inner capacity that when nurtured, facilitated, & supported by others empowers children, youth, and families to successfully meet life's challenges with a sense of self-determination, mastery, hope, and well being.* (Resiliency Ohio) and recovery are currently being used when referring to children's mental health care regarding which one although there is some debate in the field regarding which term(s) would best fit.



Resilience and Recovery for Children

There appear to be mixed feeling about using the term recovery related to children's mental health.

There are many service providers who do not like the term recovery. They feel it is not a good fit for children.

However, there are some underlying concepts of recovery that are appealing to stakeholders; especially young people and their families. These concepts center primarily around the focus on hope and optimism.

Resilience and Recovery for Children

Hope and optimism are also prominent in the concept of resilience. “Resilience brings attention to the strengths of the child as protective factors and as assets for the process of positive development. Resilience also draws attention to the family as the most important asset a child can have.”

“When young people have hope, connectedness, and opportunities, they are more likely to be able to “bounce back” from adversity.”

(Resilience and Recovery: Changing Perspective and Policy in Ohio. Focal Point- Summer 2005)



MODULE 3

Resilience and Recovery for Children

To learn more about resiliency, please click on the following link:

http://www.resiliencyohio.org/resiliency_ohio_video.php

MODULE 3

People First Language

“To begin this discussion, we should acknowledge that the childhood adage , “sticks and stones can break my bones, but names can never hurt me” is patently untrue.

Words, and the meanings with which they are imbued, can achieve accuracy and relevance or they can transmit dangerous stereotypes and half-truths. They can empower or disempower, humanize or objectify, engender compassion or elicit malignant fear and hatred.

Words can inspire us or deflate us, comfort us or wound us. They can bring us together or render us enemies. Put simply, our lives are profoundly shaped by the words we apply to ourselves and those that come to us from others.” (William L. White)



MODULE 3

- **People first language** is a form of politically correct language aiming to avoid perceived and subconscious dehumanization when discussing people with disabilities.
- The basic idea is to replace, e.g., “disabled people” with “people with disabilities”,
- “Mentally ill people” with “people with mental illness”, thus emphasizing that they are people first and the disability second.



MODULE 3

- Further, the concept favors the use of “having” rather than “being”, e.g. “she has a learning disability” instead of “she is learning disabled”
- The rationale behind people-first language is that it recognizes that someone is a person, a human being, or citizen first, and that the disability is a part, but not all of them.





The Importance of Language

- The words we use reveal our beliefs about recovery, both to our co-workers and to the people we serve.
- It is absolutely vital to make a commitment to use “People First Language” as you embrace Recovery Principles
- In addition to changing the language we use, it is important to note that it is also vital that we assist the people we serve with reframing (changing one’s perspective or changing a meaning of something- usually from negative to positive) the negative terms they may use to refer to themselves and their peers.

MODULE 3



INSTEAD OF SAYING.....

SAY.....

Handicapped/ disabled

People with disabilities

He's schizophrenic

He has Schizophrenia

Brain Damage

Brain injury

Alcoholic/ addict

Person/people experiencing an alcohol/ drug problem

Suffering with

Recovering from!

MODULE 3

MODULE THREE QUIZ



MODULE 3

1. To be in recovery, you have to be symptom free.
 - a. True
 - b. False



MODULE 3

1. To be in recovery, you have to be symptom free.

- a. True
- b. False**

2. The 10 fundamental components of recovery include:

- a. Holistic
- b. Self- directed
- c. Non-linear
- d. All of the above
- e. Both a & b



- 
- 
2. The 10 fundamental components of recovery include:
 - a. Holistic
 - b. Self- directed
 - c. Non-linear
 - d. All of the above**
 - e. Both a & b

- 
- 
3. According to *Resilience and Recovery, Focal Point, Summer 2005*, which of the following make it more likely that a young person will be able to “bounce back” from adversity:
- a. Hope
 - b. Optimism
 - c. Connectedness
 - d. Both a & c
 - e. All of the above

- 
- 
3. According to *Resilience and Recovery, Focal Point, Summer 2005*, which of the following make it more likely that a young person will be able to “bounce back” from adversity:
- a. Hope
 - b. Optimism
 - c. Connectedness
 - d. **Both a & c**
 - e. All of the above

MODULE 3



4. Which of the following is **not** an example of People First Language
- a. He is brain damaged
 - b. He has schizophrenia
 - c. People with disabilities
 - d. People experiencing an alcohol and drug problem

- 
- 
4. Which of the following is ***not*** an example of People First Language
- a. **He is brain damaged**
 - b. He has schizophrenia
 - c. People with disabilities
 - d. People experiencing an alcohol and drug problem



Module Four

Case Management:
Theory of Strengths

WHAT IS CASE MANAGEMENT?

National Association of Case Management

- © Case management and service coordination are professional practices in which the service recipient is a partner, to the greatest extent possible, in assessing needs, defining desired outcomes, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is a process that assists the person to achieve the greatest possible degree of self-management of disability and/or life challenges. The individual/family and the practitioner plan, coordinate, monitor, adjust, and advocate for services and supports directed toward the achievement of individualized, personal goals for community living.

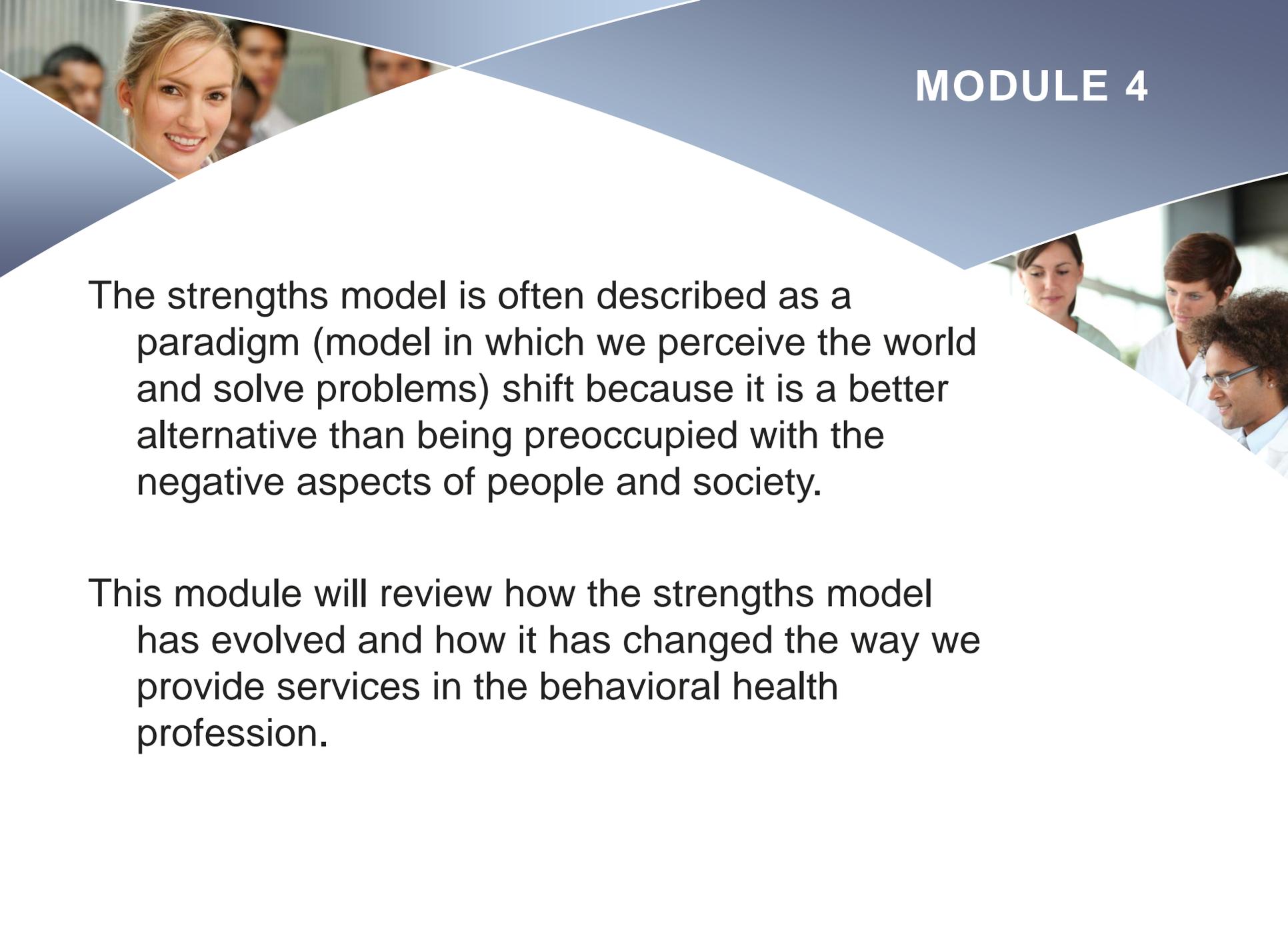
WHAT IS CASE MANAGEMENT?

National Association of Case Management

- Engaging in a hopeful relationship with the person/family served
- Assessment of strengths and needs
- Developing in partnership with the person/family a service plan to achieve desired outcomes

WHAT IS CASE MANAGEMENT?

- Locating, linking and following up with needed services and supports
- Monitoring, Coordinating and adjusting services and supports to achieve desired outcomes
- Crisis prevention and intervention
- Advocacy for the person/family



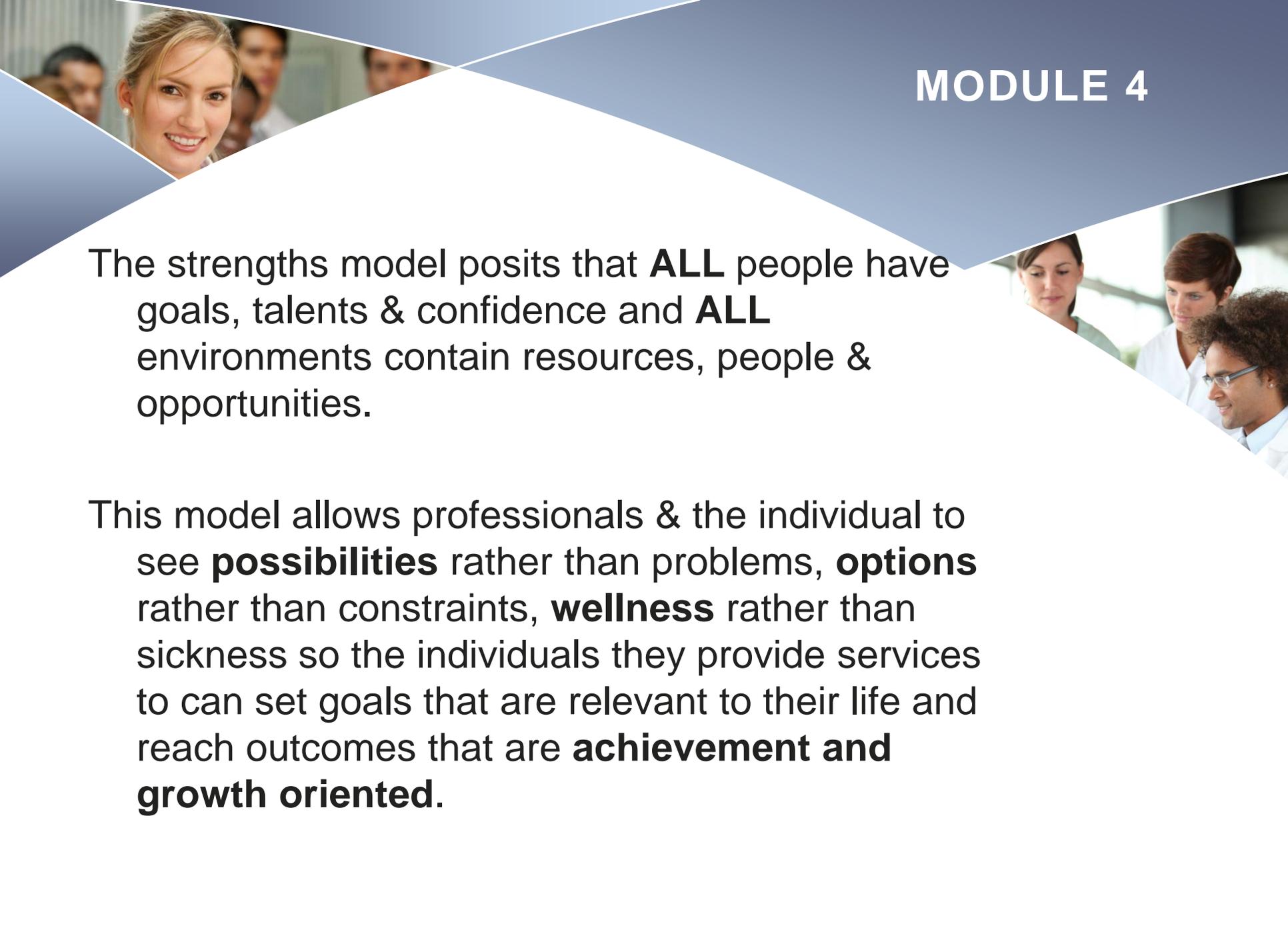
MODULE 4

The strengths model is often described as a paradigm (model in which we perceive the world and solve problems) shift because it is a better alternative than being preoccupied with the negative aspects of people and society.

This module will review how the strengths model has evolved and how it has changed the way we provide services in the behavioral health profession.

Although it was not intentional, deficit orientations toward the individuals & environments, labeling and blaming the victim are part of the social processes that may have caused individuals with psychiatric disabilities to:

- internalize negative images thrust on them and/or
- lose their identity as people and only view themselves as their diagnosis.

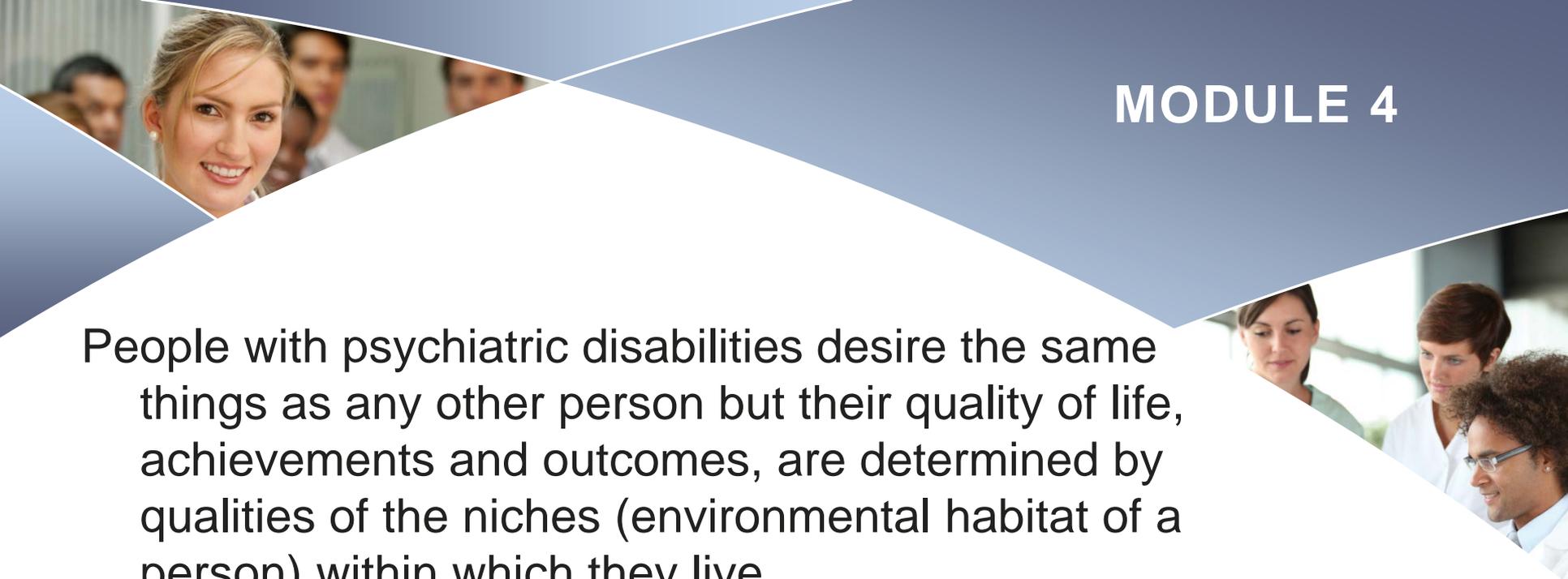


MODULE 4

The strengths model posits that **ALL** people have goals, talents & confidence and **ALL** environments contain resources, people & opportunities.

This model allows professionals & the individual to see **possibilities** rather than problems, **options** rather than constraints, **wellness** rather than sickness so the individuals they provide services to can set goals that are relevant to their life and reach outcomes that are **achievement and growth oriented**.

MODULE 4



People with psychiatric disabilities desire the same things as any other person but their quality of life, achievements and outcomes, are determined by qualities of the niches (environmental habitat of a person) within which they live.

The concept of a niche can be a unifying element in the strengths model because it attends to both individual and environmental factors.

There are two types of niches at the extreme: **entrapping** and **enabling**.

Most niches lay somewhere between the two extremes and contain elements of both.

ENTRAPPING NICHE

- Highly stigmatized
- Restricted/limited social world more comfortable with “their own kind”
- Define themselves by their illness & have few incentives to set & work towards goals
- Unrealistic perception & interpretation of abilities-limited opportunities to learn skills- few expectations for personal growth
- Sparse economic resources may lead them to seek reinstitutionalization.

ENABLING NICHE

- 
- Not stigmatized or treated as outcasts
 - More access to others outside “their own kind”
 - Able to view themselves outside their illness & have many incentives to set & work towards goals
 - Realistic perception & interpretation of abilities- many opportunities to learn skills-high expectations for personal growth
 - Adequate economic resources- strong motive to avoid institutionalization

Individual Strength: Aspirations

- For many individuals with psychiatric disabilities, they have had a life marked with distress, pain, disappointment, failure and overwhelming messages of what they can't do.
- They have lost their dreams or have diminished them to modest levels.
- The strengths model is more concerned with achievement than with solving problems; with thriving more than just surviving, with dreaming and hoping rather than just coping, and with triumph instead of just trauma.

Individual Strength: Competencies

- Competencies include skills, abilities, aptitudes, proficiencies, knowledge faculties and talents.
- Continuing growth occurs through recognition and development of strengths.
- For many individuals with psychiatric disabilities, their talents and abilities go unrecognized by themselves, family, acquaintances and professionals.
- One strength of all individuals is their ability to determine what is best for them.

Individual Strength: Confidence

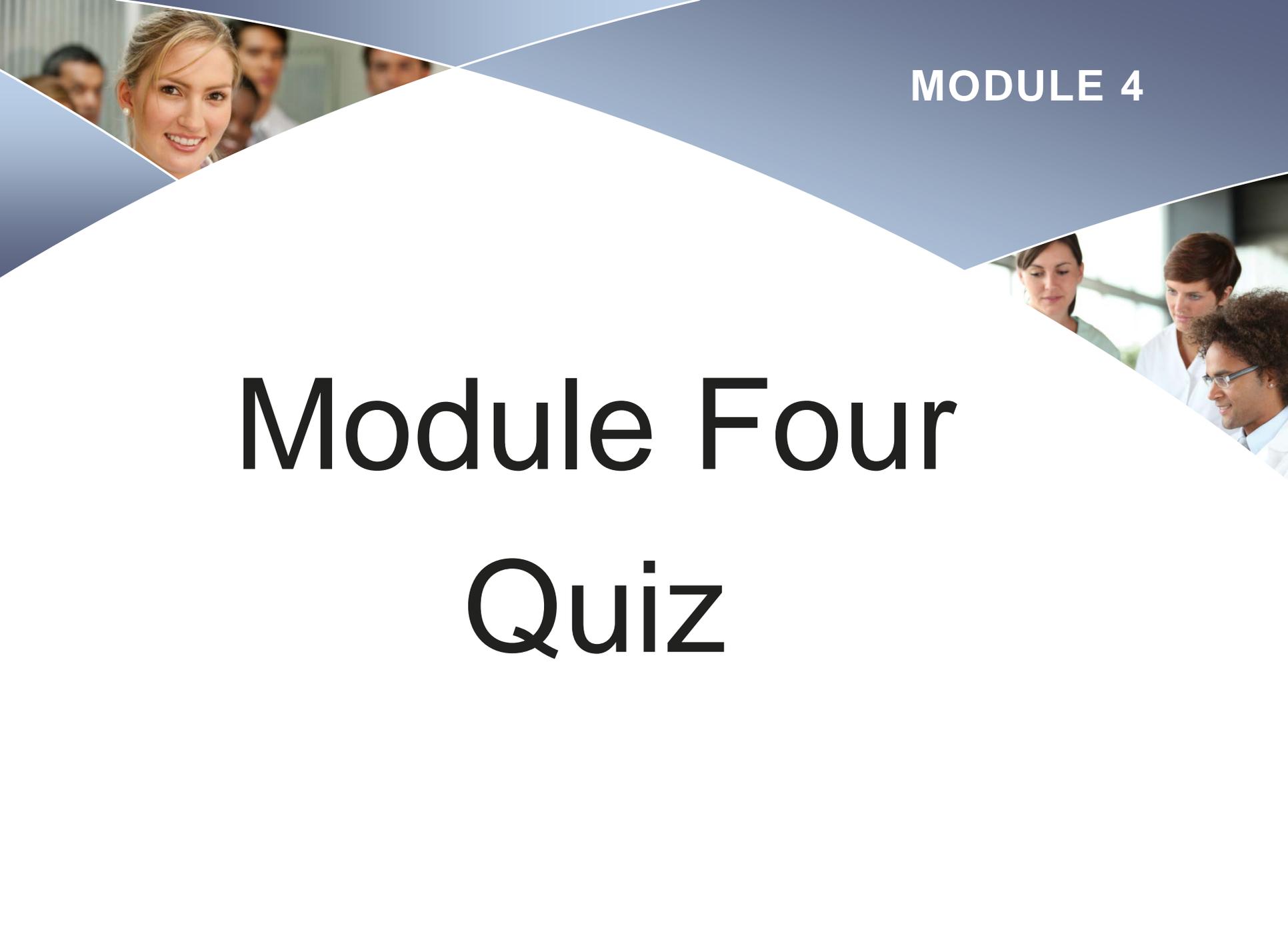
- The concept of confidence is related to power, influence, belief in one's self and self efficacy.
 - There are two levels of confidence:
 1. the perceived ability of one's self to achieve a task; and
 2. a generalized sense of oneself that each person brings to different situations. Some individuals are more confident than others when approaching a task whereas others perceive themselves as being inept. This level has some similarity to “learned helplessness.”
- 

Environmental Strengths

Resources- Having access to environmental and personal resources outside of the behavioral health service system helps individuals achieve their goals.

Social relations- A meaningful relationship with at least one person can provide many benefits such as companionship, emotional support, caring, partnership, recreation, socialization and the opportunity to give and share.

Opportunities- Access to opportunities in the community that are naturally occurring and relevant to their goals.

A collage of business professionals in a meeting. The top left shows a woman smiling, and the top right shows a group of people looking at a screen. The background is a mix of white and blue geometric shapes.

MODULE 4

Module Four Quiz

1. Community integration and “normalization” would promote a(n) _____ niche.

- a. Entrapping
- b. Paradigm
- c. Enabling
- d. All of the above

1. Community integration and “normalization” would promote a(n) _____ niche.

- a. Entrapping
- b. Paradigm
- c. **Enabling**
- d. All of the above

- 
2. Assisting an individual with getting a ride to and/or from work by a co-worker would be an example of a formal resource.
- a. True
 - b. False

2. Assisting an individual with getting a ride to and/or from work by a co-worker would be an example of a formal resource.
- a. True
 - b. False**

- 
3. Confidence, resources and competencies are all examples of individual strengths.
- a. True
 - b. False

- 
3. Confidence, resources and competencies are all examples of individual strengths.
- a. True
- b. **False**

4. Deficit oriented systems may cause individuals to internalize negative images and only identify themselves only by their illness.
 - a. True
 - b. False

4. Deficit oriented systems may cause individuals to internalize negative images and only identify themselves only by their illness.
 - a. **True**
 - b. **False**

5. A result of individuals that have had service providers do everything for them or the belief that they can't do anything correctly is often referred to as _____.
- a. Confidence
 - b. Competency
 - c. Strength
 - d. Learned Helplessness

5. A result of individuals that have had service providers do everything for them or the belief that they can't do anything correctly is often referred to as _____.
- a. Confidence
 - b. Competency
 - c. Strength
 - d. **Learned Helplessness**



Module Five

The Purpose &
Principles of the
Strengths Model



When providing behavioral health case management services, it is important to know the purpose and the principles of the strengths model.



This module will review how this model can assist individuals in reclaiming and transforming their lives by identifying and securing a range of resources both personal and environmental needed to live, play and work in the community of their choice.



The strengths model may provide an enhanced sense of power for both the client and the case manager by

1. Replacing mutual conflict with a partnership;
2. Encouraging vigilance in identifying strengths and enhancing the services provided;
3. Defining the community as an oasis of possibilities not limitations can be seen; and
4. Improving outcomes so the individual and the case manager see results which increases satisfaction they bring.



The following six principles are derived from the theory of the strengths model:

Principle 1:

People with Psychiatric Disabilities can Recover, Reclaim and Transform their Lives

- The capacity for growth is already present within the people we served and they can better their lives.
- The case managers role is to help create conditions for growth and recovery.
- Their symptoms are only part of their being.





Principle 2:

The Focus is on Individual Strengths not Deficits

- Focusing on deficits can shape the way we view an individual and may result in socializing them into disability rather than helping them reclaim their lives.
- The focus should be on what the individual has achieved so far, what resources have been used or are currently available.





Principle 3:

The Community is Viewed as an Oasis of Resources

- Even when the community seems like a desert of burned bridges, blocked doors and discrimination, there are members of the community who want to be a part of building a supportive community.
- An individual's behavior and well being is largely determined by the resources available and the expectations toward the person.





Principle 4:

The Client is the Director of the Helping Process

- The belief that individuals have the right and are capable to determine the form, direction and substance of the help they receive is the cornerstone of the strengths model and contributes to the effectiveness of case management.
- Individuals want to have more involvement about their treatment. The strengths model involves them in every step of the process.





Principle 4:

The Client is the Director of the Helping Process

- Individuals may have difficulty feeling empowered because decisions have been made without their input and/or approval.
- Allows the case manager to use the individual's natural energy for recovery, rather than wasting energy trying to convince (or coerce) them to do something that is not meaningful to them which often leads to tension in the relationship, passive acceptance or the use of such terms as “noncompliance” or “resistant to treatment”.





Principle 5:

The Worker-Client is Primary and Essential

- Without a trusting relationship, an individual's strengths, talents, skills, desires and aspirations will lie dormant and the case manager will not be able to obtain a rich and detailed view of their life.
- A cooperative relationship often starts with playing basketball, washing dishes or shopping. This allows the individual to test the sincere commitment of the case manager.
- As confidence replaces skepticism, goals become more ambitious, communication more honest and assistance more valid and accessible.





Principle 6:

The Primary Setting for Our Work is the Community

- A person's behavior and ability is often different in a "structured" setting like day treatment than it is in more "normalized" settings like their home where the development of their strengths may feel more comfortable and natural.
- The individual's perception of available resources may not be accurate. Many times, they are unaware of the potential resources in their community.





Module Five Quiz



1. The consumer being the director of the helping process can lead to

_____.

- a. Chaos
- b. Non compliance
- c. Tension
- d. Empowerment



1. The consumer being the director of the helping process can lead to _____.

- a. Chaos
- b. Non compliance
- c. Tension
- d. **Empowerment**



2. A weekend bowling league would be an example of a formal resource.
 - a. True
 - b. False



2. A weekend bowling league would be an example of a formal resource.
- a. True
- b. **False**



3. The goal on the individuals treatment should be individualized and relevant to their aspirations.
 - a. True
 - b. False



3. The goal on the individuals treatment should be individualized and relevant to their aspirations.

- a. **True**
- b. **False**

- 
- 
4. Passive acceptance occurs when
 - a. The consumer directs the helping process
 - b. There is a trusting relationship between the case manager and the client
 - c. The client reclaims and transforms their lives
 - d. All of the above
 - e. None of the above

- 
- 
4. Passive acceptance occurs when
- a. The consumer directs the helping process
 - b. There is a trusting relationship between the case manager and the client
 - c. The client reclaims and transforms their lives
 - d. All of the above
 - e. **None of the above**



5. The strengths model can enhance the sense of power felt by the case manager and the client by
 - a. Reducing conflict and creating a partnership
 - b. Seeing possibilities in the community
 - c. Increasing outcomes and a sense of satisfaction
 - d. All of the above
 - e. None of the above



5. The strengths model can enhance the sense of power felt by the case manager and the client by
 - a. Reducing conflict and creating a partnership
 - b. Seeing possibilities in the community
 - c. Increasing outcomes and a sense of satisfaction
 - d. **All of the above**
 - e. None of the above



Module Six

Ethics – Part 1

Professional Ethics in the Helping Profession



MODULE 6

Most of us have heard the term “ethics” but what are they and how do they apply to the work as a Behavioral Health Case Manager?

This module will help you gain a general understanding of what ethics are, who establishes what is ethical, and important considerations for ethical practice in the behavioral health field.



What are Ethics?

According to *Dictionary.com* ethics are...

- a system of moral principles: the ethics of a culture
- the rules of conduct recognized in the respect to a particular class of human actions or a particular group, culture, etc,: medical ethics; Christian ethics.
- moral principles, as an individual
- that branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.

MODULE 6



What are Ethics?

Click on the following link:

<http://www.youtube.com/watch?v=ZlaHxC7BT0A>



Ethics fill the middle ground between law and religion:

- The law deals with criminal activity and punishment (sets a floor or minimum)
- Religion deals with virtue and sin (sets goal or ideal)

Organizational or professional ethics falls in between. It goes well above the law, and links to personal beliefs of a profession with its consumers.

Basic Ethical Principles

- Autonomy – refers to freedom of choice and allowing individuals to make decisions that affect their lives; service providers act in a way that respects and promotes a client’s right to make their own choices.
- Non-maleficence – refraining from engaging in any behavior that would cause harm; above all, “do no harm”

Basic Ethical Principles

- Beneficence – to assist others; service providers doing good, and being beneficial to clients
- Dual Relationships – where a provider may have had contact with a client in a social context as well as in a professional role

Basic Ethical Principles

- Justice – fairness in dealing with all persons served; service providers ensure equal treatment and resources for all
- Fidelity – faithfulness and the duty to keep promises; service providers make an arrangement with clients and establish trust by living up to an agreement
- Veracity – (truthfulness) without trust, the service provider will not be able to establish a working relationship with the client

Who establishes what is “ethical”?

- Law
- Licensure Boards
- Businesses and Agencies



Law

All behavioral health services are governed by laws.

Examples:

- The Americans with Disabilities Act of 1990 (ADA)

<http://askjan.org/links/adasummary.htm>

- The Health Insurance Portability & Accountability Act of 1996 (Public Health Law 104-191- HIPPA)

<http://www.hipaa.co/hipaa-rules>

Licensure Boards

Licensing Boards regulate the licensing & conduct of various service providers.

Examples:

State Board of Licensed Social Workers

- Social Workers

State Board of Licensed Alcohol & Drug Counselors-T

- Alcohol & Drug Counselors

Business and Agencies

Businesses and agencies establish ethics/guiding principles/values that their employees and/or people they do business with must follow.

In Oklahoma, some agencies are also responsible for formulating rules and regulations with regard to specific service providers.

Business & Agencies

Examples:

State Health Department

- Licensed Professional Counselor (LPC)

Department of Mental Health and Substance Abuse Services

- Certified Behavioral Health Case Manager

Core Considerations

There are many things to keep in mind when providing services that follow basic ethical principles. However, there are three core areas that must be emphasized with the provision of behavioral health case management and behavioral health rehabilitation services:

- Competence
- Confidentiality
- Professional Boundaries

Competence

What is competence?

According to *Dictionary.com*, competence is:

- The quality of being competent, adequacy; possession of required skill, knowledge, qualification, or capacity
- The state or quality of being adequately or well qualified; ability
- A specific range of skill, knowledge or ability
- The quality of being competent or capable of performing an allotted function



MODULE 6



Competence

One of the important things you can do to help ensure that you are utilizing basic ethical principles in your practice, especially non-maleficence, is to practice within the range of your skill, knowledge, and ability.

How do we establish competence?

- Education – Take classes, acquire degrees
- Training – Receive specialized training (classroom, on-the-job), seek out and receive on-going training throughout career

How do we establish competence?

- Experience – Receive knowledge from time spent providing a specific type field of service, working in a specific type of work
- Supervision/Consultation – Receive direction and insight from clinical supervisor, seek advise and information from supervisor and experienced co-workers

Rule of Thumb

Consult, Consult, Consult!

When in doubt,
Talk it out.



Other Considerations

Competence also involves:

- Referral – Knowing when a client needs to be referred to another professional (when their needs have exceeded your abilities, or when the treatment you are providing is not effective)

Other Considerations

Competence also involves:

- Self-care- knowing yourself [being able to spot **burnout** (*fatigue, frustration, or lack of interest that results from prolonged stress*), **counter transference** (*service provider's repressed feelings through identification with the emotions/experiences/problems of the client*), and **compassion fatigue** (*emotional distress or lack of interest that results from the constant demand of caring for others*)]

MODULE 6

Fatigue, stress, hurt, etc. can impair a providers ability to honestly or objectively address the client's issue.

Lack of attention to self-care can create potential for:

- Compromised service
- Poor decision making
- Inappropriate boundaries
- Over- identification (counter transference)

Competence Regulations

To assist with increased understanding of competence expectations, please review the following examples of existing competence regulations for other behavioral health professionals:

Certified Behavioral Health Case Manager (CBHCM)

450:50-7-1. Responsibility and scope of practice

- (b) Certified behavioral health case managers shall practice within the boundaries of their competence based on their education, training supervised experience, state and national accreditation and licenses.
- 

Confidentiality

What is confidentiality?

According to *Dictionary.com*, confidentiality is:

- The ethical principle or legal right that a physician or other health professional will hold to keep secret all information relating to a patient; unless the patient gives consent permitting disclosure.

What is Privacy?

According to *Dictionary.com*, privacy:

- The freedom from unauthorized intrusion: state of being let alone and able to keep certain personal matters to oneself.



MODULE 6



Confidentiality and privacy are essential in any helping relationship. They are central to the development of the trust needed to facilitate recovery.

People will be less likely to share information and take the risks necessary for growth if they think that their service provider is telling others about things they thought were private.

Confidentiality requirements within the behavioral health field include three (3) key areas of focus.

- Duty to Protect Privacy
 - Duty to Warn
 - Duty to Report
- 

Duty to Protect Privacy

It is the responsibility of a behavioral health practitioner to protect the privacy of consumer health information. This means **NOT** sharing information with others, written or verbal, without the consumer's permission. This includes whether the consumer has ever sought, is receiving, or has ever received behavioral health services.

There are certain circumstances in which the law requires that confidentiality be broken. This is when the behavioral health practitioner is fulfilling the Duty to Warn or their Duty to Report.

Duty to Warn

Duty to warn applies to cases where the consumer is dangerous to others and has identified targeted individual(s).

In these situations, the behavioral health practitioner **MUST** breach confidentiality to warn the identified victim/third party about imminent danger.

Additionally, the practitioner can warn the local police authorities and inform them about what may eventually happen.



MODULE 6



Duty to warn originated from two rulings (1974 & 1976) of the California Supreme Court in the case of *Tarasoff v. Regents of the University of California*.

The legal case was brought by the Tarasoff family after their daughter, Tatiana Tarasoff, was murdered by Prosenjit Poddar who was under psychological care in the university counseling center.

Jablonski by Pahls v. United States extended this responsibility to include the review of previous records, which may contain history of previous violent behavior, a predictor of potential for future violence.

The application of duty to warn laws places practitioners in the uneasy situation of breaching another law, that of confidentiality. However, if the clinician has reasonable suspicion of what may happen, he/she is protected from prosecution.



Duty to Report

Behavioral health practitioners have a duty to report:

- Child Abuse and Neglect

<http://www.ok.gov/health2/documents/06%20REPORTING%20BROCHURE%20WITH%20COLOR.pdf>

- Vulnerable Adult Abuse

<http://www.okdhs.org/programsandservices/ap/s/default.htm>



Important to Note

It is outside the scope of practice a Behavioral Health Case Manager to assess an individual regarding harm to self or others and to provide crisis intervention services. If you suspect that a consumer is at risk of harm to self or others, you will want to consult your supervisor and a licensed clinician.

Other Considerations

In the provision of rehabilitation services, there are a couple of unique confidentiality and privacy considerations:

- **Group services** – When services are provided in a group setting, it is important to orient all group members to the concepts of confidentiality and privacy and emphasize that information shared in the group should be kept confidential.
- **Community Based Services** – When providing services in the community, you will want to be sure that dialog is not within hearing distance of others, and that group activities do not identify the health concerns of the group.

Confidentiality Regulations

To assist with increased understanding of confidentiality expectations, please review the following examples of existing confidentiality regulations for other behavioral health providers. you will want to be sure that dialog is not within hearing distance of others.



MODULE 6



Module Six

Quiz

MODULE 6

1. Refraining from engaging in any behavior that would cause harm is which of the following basic ethical principles?
 - a. Beneficence
 - b. Non- Maleficence
 - c. Veracity
 - d. Autonomy



MODULE 6

1. Refraining from engaging in any behavior that would cause harm is which of the following basic ethical principles?
 - a. Beneficence
 - b. Non- Maleficence**
 - c. Veracity
 - d. Autonomy



MODULE 6

- 
- 
2. Competence includes knowing when a client needs to be referred to another professional.
 - a. True
 - b. False

MODULE 6

- 
- 
2. Competence includes knowing when a client needs to be referred to another professional.
- a. **True**
 - b. False

MODULE 6

- 
- 
3. Are there any circumstances where a client's confidentiality may be broken?
 - a. Yes
 - b. No

MODULE 6

- 
- 
3. Are there any circumstances where a client's confidentiality may be broken?
- a. **Yes**
 - b. No

- 
- 
4. A service provider's duty related to cases where the consumer is dangerous to others and has identified targeted individual(s) is referred to as:
 - a. Duty to Report
 - b. Duty to Protect Privacy
 - c. Duty to Warn
 - d. None of the Above

- 
- 
4. A service provider's duty related to cases where the consumer is dangerous to others and has identified targeted individual(s) is referred to as:
- a. Duty to Report
 - b. Duty to Protect Privacy
 - c. Duty to Warn**
 - d. None of the Above

5. HIPPA was established to protect individuals from losing health coverage when changing employees:
- a. True
 - b. False

5. HIPPA was established to protect individuals from losing health coverage when changing employees:
- a. **True**
 - b. False

6. The American Disability Act (ADA) is divided into five (5) titles. Which of the following are included?
- a. Employment
 - b. Telecommunications
 - c. Public Accommodations
 - d. All of the above
 - e. None of the above



6. The American Disability Act (ADA) is divided into five (5) titles. Which of the following are included?
- a. Employment
 - b. Telecommunications
 - c. Public Accommodations
 - d. **All of the above**
 - e. None of the above



Module Seven

Ethics – Part 2

Professional Ethics in
the Helping Profession

Professional Boundaries

What are Boundaries?

According to *Dictionary.com* a boundary is:

- Something that indicates bounds limits; a limiting or bounding line
 - Something that indicates a border or limit
- 

MODULE 7



Professional boundaries are guidelines for the relationship between the service provider and the client. They are the line between the self of the service provider and that of the client. Boundaries meet several functions in therapeutic relationship :



- Safety for the service provider and the client;
- Helps keep the relationship professional; and
- Gives both the client and service provider a valid sense of control in the relationship, resulting in the client getting the maximum benefit from services



MODULE 7

In any professional relationship a power imbalance is characteristic. The service provider's power comes from the client's trust that the provider has the ability to help with the problems, and through the client's disclosure of personal information that would not normally be shared.

Because of this power, the service provider has a duty to act in the best interests of the client, and is responsible for managing issues of boundaries, even if the client seems to encourage boundary violations.





MODULE 7

Most service providers wouldn't knowingly cross boundaries, but difficulties in relationships do occur. Some common areas that can result in difficulties as follows:

- Self- disclosure
 - Giving or receiving gifts
 - Dual or overlapping relationships
 - Becoming friends
 - Romantic relationships
- 



Self-Disclosure

Although in some cases a degree of self disclosure may be appropriate, service providers need to be careful that the purpose of the disclosure is for the client's therapeutic goal. Too much self disclosure shifts the focus from the client to the provider and can confuse the client in terms of the roles and expectations of the relationship.

Giving or Receiving Gifts

Service providers should not offer or accept gifts of more than token value from their clients. Doing so may pressure the other party to reciprocate the gift and affect the quality of care.

For example, a client who receives a gift from a provider could feel pressured to reciprocate to avoid receiving inferior care.

Or a provider who accepts a significant gift from a client risks altering the therapeutic relationship, and could feel pressured to reciprocate by offering special care.



Dual or Overlapping Relationships

Dual relationships should be avoided. These occur when in addition to the role of a service provider, the provider has a position of significant authority or emotional relationship with their client.

Some examples of dual relationships include course instructor, work place supervisor, or family member.

It is important to remember that the purpose of avoiding dual relationship exploiting the inherent power imbalance in the therapeutic relationship.





MODULE 7

Overlapping relationships are relationships where a service provider has contact with the client, but no significant authority or emotional relationship.

This type of relationship may occur for service providers who are members who are members of small communities, or for providers who work with a particular client population with which they are affiliated (ex: religious or ethnic groups, gay or lesbian community).

Overlapping relationships, while potentially problematic, may not always be possible to avoid. Situations where there may be overlapping relationships need to be assessed on a case by case basis.



Becoming Friends

It is strongly recommended that service providers do not become friends with their clients, and important to note that regulations for many practitioners prohibit it.

This is because the power imbalance from therapeutic relationship may still influence the client even after treatment.



Romantic Relationships

It is unacceptable for a service provider to date a current client. In addition, professional standards tend to prohibit a provider from engaging in a sexual relationship with a former client who has received service within the past two years.



Romantic Relationships

It is unacceptable for a service provider to date a current client. In addition, professional standards tend to prohibit a provider from engaging in a sexual relationship with a former client who has received service within the past two years.



Other Considerations

- When you have questions regarding boundaries, or if you are uncomfortable about talking with your clients about boundaries, consult your supervisor or experienced co-workers.
 - Some questions to consider when examining potential boundary issues are:
 - Is this in the best interests of my client?
 - Whose needs are being served (mine or the clients)?
 - Will this have impact on the services I am providing?
 - Should I consult my supervisor or experienced co-worker?
- 

Boundaries and Regulations

To assist with increased understanding of professional boundaries, please review the following examples of existing regulations for other behavioral health professionals:



Certified Behavioral Health Case Manager (CBHCM)

450:50-7-2. Consumer Welfare

- 
- (b) Certified behavioral health case managers must be aware of their influential positions with respect to consumers and not exploit the trust and dependency of consumers.

Certified behavioral health case managers shall refrain from dual relationships with consumers because of the potential to impair professional judgment and to increase the risk of harm to consumers.



Examples of such relationships include, but are not limited to, familial, social, financial, business, professional or close personal relationships with consumers.

(1) Certified Behavioral Health Case Managers shall not have any type of sexual contact with consumers and shall not provide case management services to persons with whom they have had a sexual relationship with.

(2) Certified behavioral health case managers shall not engage in sexual contact with former consumers for at least two (2) years after terminating the professional relationship

Ethical Scenarios

What do you
think?



Competence



A new case manager Behavioral Health Case Manager (BHCM) , with no behavioral health experience, is conducting an individual educational (rehabilitation) session. During the session, the client reports that they have plans to kill themselves tonight. The BHCM proceeds to try to assess the client and provide crisis intervention.

Did the BHCM do the right thing?

Competence

Answer

No.

The BHCM did not have the expertise to address the situation. As soon as the client verbalized plans to harm themselves, the BHCM should have consulted a licensed therapist.



Confidentiality



A BHCM is having challenges with a client they are working with. They are extremely stressed out. They go out to dinner with a friend and talk about the client's issues and their frustrations.

Is this ok?

Confidentiality



Answer

No.

Client information must be kept confidential. When having challenges with a client's treatment, you should consult your supervisor.

Professional Boundaries

A BHCM is working with a client and during the course objectives the client tells them about the church they attend. They invite the BHCM to attend church.

The BHCM has been looking for a new church to attend, and thinks the church sounds really great, but politely declines the client's invitation.

Did the BHCM do the right thing?

Professional Boundaries

Answer

Yes.

By declining the invitation, the BHCM helped to preserve the professional relationship and avoided an overlapping relationship.



MODULE 7



Ethics in Action

Click on the following link:

<http://www.youtube.com/watch?v=i2bRO3IGUUK>





MODULE 7



MODULE SEVEN QUIZ



1. Relationships where a service provider has contact with the client, but no significant authority or emotional relationship:
 - a. Dual Relationship
 - b. Overlapping Relationship
 - c. Therapeutic Relationship
 - d. None of the Above



1. Relationships where a service provider has contact with the client, but no significant authority or emotional relationship:
 - a. Dual Relationship
 - b. Overlapping Relationship**
 - c. Therapeutic Relationship
 - d. None of the Above



2. The ethical decision making topic in the “Ethics in Action” video is:
 - a. The client tells the therapist that they plan to harm someone
 - b. The client tells the therapist that they plan harm themselves
 - c. The client tells the therapist that she is pregnant
 - d. None of the Above



2. The ethical decision making topic in the “Ethics in Action” video is:
 - a. The client tells the therapist that they plan to harm someone
 - b. The client tells the therapist that they plan harm themselves
 - c. The client tells the therapist that she is pregnant**
 - d. None of the Above



Module Eight

Wellness & Self-care



MODULE 8

It is important to emphasize some of the things that come along with working in the behavioral health field and the importance of personal *self-care* and *wellness*.

This module will help you to understand some of the challenges that come along with this field of work, potential warning signs of stress, and ways to help manage that stress.





MODULE 8

Research from the past few decades indicates that turnover rates in mental health agencies are high, approximately 25%-50% per year.



Turnover can contribute to reduced productivity, financial stress in the organization, fractured relationships with clinical clients, and fragile clinical teams.

The Role of Staff Turnover in the Implementation of Evidence-Based Practices in the Mental Health Care. Emily M. Woltmann, MSW, Rob Whitley, Ph.D., Mary Brunette, M.D., William C. Torrey, M.D., Laura Coots, M.S., David Lynde, MSW, and Robert E. Drake, M.D., Ph.D.

Burnout

Exhaustion of physical, mental, or emotional strength or motivation, usually as a result of prolonged involvement in a stressful, frustrating, or emotionally demanding situation.

Gradually builds up to a breaking point (takes longer than compassion fatigue or vicarious trauma) and the stress and frustration comes from all types of work-related stressors (paperwork, bureaucratic issues, home & work situations, colleagues, workload, complications, red-tape, frustrations, etc...)

Burnout can occur in ANY profession



Research on Burnout



Research clearly indicates that psychotherapists working in public agencies such as community mental health centers are among a group of employees categorized in a high-stress work environment (Dunbar, McKelvey, & Armstrong, 1980).

In addition, studies show that those employed in public settings are more dissatisfied and prone to occupational stress and burnout than those in private practice (Ackerley et al., 1988; Chermis & Egnatious, 1978; Raquepaw & Miller, 1989).

Research on Burnout



The potential for burnout in counseling practice has been well documented. For example, Farber & Heifetz (1982) investigated prevalence of burnout in mental health professionals. These researchers found burnout in 71% of the psychologists, 43% of the psychiatrists, and 73% of the social workers.

Another studies by Farber (1985) discovered that 36% of their sample of mental health professionals reported moderate levels of burnout, and only 6.3% indicated a high degree of burnout.

DIFFERENCES



Compassion Fatigue

- Preoccupation with absorbing trauma and emotional stresses of others
- Symptoms similar to burnout, but onset is faster with better opportunity to recover
- May lead to burnout

Burnout

- Subtle, overtime, and leads one to believe he/she is not meant for this type of work
- Feelings of being ineffective, callous, negative, emotional absence, sarcastic, and “stuck”

Wellness: Prevention is Key

How to provider burnout or compassion fatigue by focusing
on *wellness & self-care*.....





MODULE 8

Adding wellness and self-care to the top of your to-do-list may sound like a strange concept, however it is essential to your well being as oxygen.

You can't give to others from an empty place. Taking time for self-care allows you to be replenished and energized instead of irritable, angry and overwhelmed.

If you nurture, love and appreciate yourself, you will be able to do the same for others.

Importance of Self-Care by Cindy Ricardo



What is Wellness?

Dictionary.com defines wellness as:

- The quality or state of being healthy in body and mind, esp. as the result of deliberate effort
- An approach to healthcare that emphasizes preventing illness and prolonging life, as opposed to emphasizing treatment diseases

Wellness= Optimal Health and Vitality





7 DIMENSIONS OF WELLNESS

- Physical wellness
- Emotional wellness
- Intellectual wellness
- Spiritual wellness
- Social/Cultural wellness
- Environmental wellness
- Occupational wellness



Physical Wellness

The ability to maintain a healthy quality of life that allows us to get through our daily activities without undue fatigue or physical stress. The ability to recognize that our behaviors have a significant impact on our wellness and adopting healthful habits (routine check ups, a balanced diet, exercise, etc.) while avoiding destructive habits (tobacco, drugs, alcohol, etc.) will lead to optimal Physical Wellness.



Emotional Wellness

The ability to understand ourselves and cope with the challenges life can bring. The ability to acknowledge and share feelings of anger, fear, sadness or stress; hope, love, joy and happiness in a productive manner contributes to our Emotional Wellness.

Intellectual Wellness

The ability to open our minds to new ideas and experiences that can be applied to personal decisions, group interaction and community betterment. The desire to learn new concepts, improve skills and seek challenges in pursuit of lifelong learning contributes to our Intellectual Wellness.

Spiritual Wellness

The ability to establish peace and harmony in our lives. The ability to develop congruency between values and actions and to realize a common purpose that binds creation together contributes to our Spiritual Wellness.

Social Wellness

The ability to relate to and connect with other people in our world. Our ability to establish and maintain positive relationships with family, friends and co-workers contributes to our Social Wellness.

Environmental Wellness

The ability to recognize our own responsibility for the quality of the air, the water and the land that surrounds us. The ability to make a positive impact on the quality of our environment, be it our homes, our communities or our planet contributes to our Environmental Wellness.



Occupational Wellness

The ability to get personal fulfillment from our jobs or our chosen career fields while still maintaining balance in our lives. Our desire to contribute in our careers to make a positive impact on the organizations we work in and to society as a whole leads to Occupational Wellness.



ABC's of Support & Self Care Strategies

Awareness-

- Of our needs
- Limits of our physical and emotional resources

Balance-

- Between activities, work, play and rest

Connection-

- To oneself, others, and something larger

-Saakvitne & Pearlman (1996)



Steps to Self-Care and Wellness

Examine your values. Do what's important to you. Don't sweat the small stuff. Get the leisure time you need to avoid burnout. Use goals for daily living.

Build yourself up. Have positive 'self-talks.' Discipline yourself not to overreact emotionally to stressful situations. Anticipate life change events and plan for them in advance if possible. Affirm your value.

Eastern Washington University
Counseling & Psychological Services



Steps to Self-Care and Wellness

Learn to relax. Meditate. Listen to soothing music. Breathe deeply and block out the world twice a day for 15 minutes or so. Pace yourself and give yourself time to recharge.

Exercise regularly. Three to four times a week for 30-60 minutes a session.

Eat sensibly. Maintain your normal weight with a low-fat, high carbohydrate diet (or follow the most recent recommendations of health professionals)

Steps to Self-Care and Wellness

Avoid chemical solutions. Stop smoking. Avoid caffeine. Limit your alcohol and avoid other drugs.

Take control of your life. Maintain a sense of humor. Delegate responsibility and combat perfectionism. Resist unreasonable demands on your time. Spend time with your family. Nurture your friendships and do things you enjoy. Always keep one foot in something comfortable. Live through your values.



Eastern Washington University
Counseling & Psychological Services

Other Considerations

- Mindful meditation has been shown to decrease depression and anxiety while boosting empathy.
- Keeping a journal. Research suggests that reflective writing helps prevent compassion fatigue.
- A daily act of self-centering. Set an alarm for noon and take four deep breaths; or when you wash your hands, sink into the experience, feeling the sensation of the water on your skin while noting, “I am worthy of my own time.”
- Staying connected to the outside world with at least one phone call every day. Better yet, get outside, even just to take a walk.
- And don't be afraid to ask for help.



Tim Jarvis; O, *The Oprah Magazine*

Just Remember

When you're caring for someone, practicing self-awareness and self-care can help you maintain your boundaries; this, in turn, allows you to be fully compassionate without being consumed by the other person's pain.





MODULE 8

MODULE EIGHT QUIZ



MODULE 8

1. Research from the past few decades indicates that turnover rates per year in mental health agencies are as high as:
 - a. 25%-50%
 - b. 60%- 85%
 - c. 70%- 90%
 - d. 10%-25%



MODULE 8

1. Research from the past few decades indicates that turnover rates per year in mental health agencies are as high as:
 - a. **25%-50%**
 - b. 60%- 85%
 - c. 70%- 90%
 - d. 10%-25%



MODULE 8

- 
- 
2. Studies show that those employed in private practice are more dissatisfied and prone to occupational stress and burnout than those in public settings.
 - a. True
 - b. False

MODULE 8

- 
- 
2. Studies show that those employed in private practice are more dissatisfied and prone to occupational stress and burnout than those in public settings.
- a. True
 - b. **False**

- 
- 
3. According to Saakvitne and Pearlman (1996) the ABC's of Support and Self Care Strategies:
 - a. Awareness, Balance, and Connection
 - b. Availability, Background, and Collaboration
 - c. Alertness, Belonging, and Caring
 - d. Affirmations, Behaviors, and Communication

- 
3. According to Saakvitne and Pearlman (1996) the ABC's of Support and Self Care Strategies:
 - a. **Awareness, Balance, and Connection**
 - b. Availability, Background, and Collaboration
 - c. Alertness, Belonging, and Caring
 - d. Affirmations, Behaviors, and Communication

Module Nine

The Functions of Case Management



MODULE 9

The strengths model is highly effective. In the previous modules, we reviewed the theory, the purpose and a set of principles.

This module will review the method of the strengths model which can be organized onto five functions. These functions will be discussed further during the face-to-face training.

1. Engagement and relationship
2. Strengths assessment
3. Personal planning
4. Resource acquisition
5. Collective and continuous collaboration and graduated disengagement

MODULE 9



Engagement – The initial meetings with the person where the purpose is to create a trusting and reciprocal relationship between practitioner and the client as a basis for working together and begin the developing a collaborative helping partnership.

What are some of the techniques that you use during the engagement process?



MODULE 9

Relationship- The most important aspect of being a case manager is the helping relationship between you and the person you serve.

We want relationships that contribute to their recovery journey rather than serve as an obstacle.



CRITICAL ELEMENTS IN THE HELPING RELATIONSHIP

- Purposeful- goal directed
- Reciprocal- learn/work together
- Genuine- sincere commitment
- Trusting- mutual trust & respect so individuals can share their fears, hopes & dreams & we refrain from being judgmental and instead seek understanding & meaning.
- Empowering- individual sees themselves as the director of this process and feels free to make decisions

Strengths Assessment –The process of gathering information regarding the 7 “life domains” which appear to be directly related to successful community tenure. Information focuses on the **current**, **previous** (resources explored in the past), and **desired situation**. The goal is to collect information on personal and environmental strengths as a basis for working together.

1. Activities of Daily Living (ADLs)
2. Financial/Insurance/Legal
3. Educational/Vocational
4. Social Supports/Family/Friends
5. Mental Health/Substance Abuse/Gambling
6. Health/Medical
7. Cultural/Spiritual/Wellness/Recreation/Leisure

STRENGTHS ASSESSMENT

- Regardless of method or orientation, the purpose of assessment is to collect information needed to establish the direction and means of intervention.
 - Strengths based requires us to identify (for ourselves, others and consumers) the abilities a consumer possess which may not be obvious, even to themselves.
 - Identify what is right with people and expand beyond what is wrong with them.
- 

STRENGTHS ASSESSMENT PROCESS

The development of this should be unique. There are six key issues to remember:



1. Thorough and Detailed
2. Ongoing Process
3. Conversational in Manner
4. Person's Own Words
5. Evolve at consumer's Pace
6. Occur in the Community

ASSESSMENT COMPARISON

Strengths Assessment

- Holistic
- Consumers standpoint
- Conversational
- Person is viewed as unique
- Focus on here & now
- Encouragement & validation is essential
- Individualizes person by being specific & detailed

Problem Assessment

- Diagnosis is problem
 - Questions focus on problems
 - Analytical
 - Focus on diagnosis assessment
 - Consumer lacks insight or in denial
 - Client are passive and providers direct decision making
- 

RELATIONSHIP: A NEW PARTNERSHIP



Spirit Breaking

- Chastising
- Being rude
- Imposing one's own standard
- Attributing everything to MI/SA
- Restricting Choice
- Making generalization
- Making decisions for person
- Telling person what they are not ready for

Hope-Inducing

- Demonstrating care & kindness
- Communicating belief
- Supporting person's decision
- Normalizing experience
- Pointing out achievement
- Offering support to reduce fear
- Acknowledging goals are person's goals

Personal Planning- the creation of a mutual agenda for work between the person and the case manager focused on achieving the goals that the person has set. It requires discussion, negotiation and agreement on long and short term goals or tasks; assignment of responsibility and target dates for accomplishment. The strengths based assessment is used as the primary source for information and guidance.





Resource Acquisition – The purpose is to acquire the environmental resources desired by individuals to achieve their goals and ensure their rights, to increase each individual's assets. A primary focus is to break down the walls separating them from the community, to replace segregation with true community integration. To be successful, practitioners require new perspectives concerning “community” and a wide variety of interpersonal and strategic plans.



Collective Continuous Collaboration and Graduated Disengagement – Typically thought of as “monitoring,” this concept addresses the multidimensional nature of ongoing modification and adaptation that takes place during the helping process, determining the extent to which people are able to engage in activities. This should be noted on the recovery plan and there is less concern for “compliance” and more concern with an individual’s ability to creatively use their strengths and community resources to cope from day to day in ways that promote self-efficacy, community integration, and recovery.

Collective Continuous Collaboration
and **Graduated Disengagement** –
Refers to the helping behavior that is
consciously designed to replace the
case manager or program staff in
something with or for an individual.



MODULE 9

Module Nine

Quiz



MODULE 9

1. Graduated disengagement is part of the collaborative process between the case manager and the client and involves discussing when the client will not need the assistance of the case manager and other staff.
 - a. **True**
 - b. **False**

MODULE 9

2. The engagement relationship should be a partnership that consists of...
 - a. Reciprocation
 - b. Trust
 - c. Collaboration
 - d. All of the above
 - e. **Empowerment**





MODULE 9



3. The personal/recovery plan is developed based on the consumer's goals and the primary source of information and guidance should come from the
 - a. The client's chart from the previous service provider
 - b. Therapist
 - c. **Strengths assessment**
 - d. b & c
 - e. All of the above

MODULE 9

- 
- 
4. The goal of resource acquisition is to acquire environmental resources to keep the consumer segregated in their community.
- a. True
- b. **False**

MODULE 9

- 
- 
5. The main concern with client and the goals on their personal plan is modifying their behavior & compliance.
- a. True
- b. **False**



Module Nine

The Principles &
Practice of Psychiatric
Rehabilitation



MODULE 10

Behavioral Health Rehabilitation Services are critical services in an individual's journey toward recovery.

We've all heard the phrase "knowledge is power," and that is what rehabilitation services are all about—increasing an individual's knowledge, skill, and personal power to achieve the life they want.

This module will provide an introduction and overview of rehabilitation services, considerations for providing them effectively, and how to document the services.





MODULE 10



“Psychiatric rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives.”

Psychiatric rehabilitation services are collaborative, person directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.” (emphasis added)

Boston University Center for Psychiatric Rehabilitation
Sargent College of Health and Rehabilitation Sciences



MODULE 10

Psychiatric (psychosocial) rehabilitation began to emerge as a field of practice during the latter part of the 20th century. This movement, in fact, spurred the development and growing consensus regarding the basic philosophy, knowledge, principles, and programs comprising the psychiatric rehabilitation field.

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Sargent College of Health and Rehabilitation Sciences





MODULE 10

During that same time period, proponents of psychiatric rehabilitation helped to promote the notion that people with psychiatric disabilities could recover from the catastrophe of severe mental illnesses, an outcome which had not been recognized by most professionals in the mental health system. Helping people to recover from severe mental illnesses is the ultimate goal of psychiatric rehabilitation services.



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MODULE 10

The major intervention strategies are to improve the individual's: **capacity** to perform certain tasks and functions (e.g., interacting with family and friends, interviewing for a job, listening to a lecture); **ability** to perform in certain roles (e.g., worker, student, resident, friend); **skills** and **supports** to help them live, work, play, learn, participate and regain valuable roles in their community.



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The Core Principles of Psychiatric Rehabilitation

- 
- Principle 1.** Psychiatric rehabilitation practitioners convey hope and respect, and believe that all individuals have the capacity for learning and growth.
- Principle 2.** Psychiatric rehabilitation practitioners recognize that culture is central to recovery, and strive to ensure that all services are culturally relevant to individuals receiving services.
- Principle 3.** Psychiatric rehabilitation practitioners engage in the processes of informed and shared decision making and facilitate partnerships with other persons identified by the individual receiving services.

- Principle 4.** Psychiatric rehabilitation practices build on the strengths and capabilities of individuals.
- Principle 5.** Psychiatric rehabilitation practices are person-centered; they are designed to address the unique needs of individuals, consistent with their values, hopes and aspirations.
- Principle 6.** Psychiatric rehabilitation practices support full integration of people in recovery into their communities where they can exercise their rights of citizenship, as well as to accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.

Principle 7. Psychiatric rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.

Principle 8. Psychiatric rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.





Principle 9. Psychiatric rehabilitation practices strive to help individuals improve the quality of all aspects of their lives; including social, occupational, educational, residential, intellectual, spiritual and financial.

Principle 10. Psychiatric rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans.



MODULE 10



Principle 11. Psychiatric rehabilitation services emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Programs include structured program evaluation and quality improvement mechanisms that actively involve persons receiving services.

Principle 12. Psychiatric rehabilitation services must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

Foundation Skills

- A practitioner must seize opportunities to assist an individual to recognize their strong points- positive attributes and inherent natural abilities.
 - The ability to communicate effectively is one of the core competencies of the psychiatric rehabilitation practitioner.
 - Good communication skills help guarantee the proper exchange of information between the practitioner and the consumer.
- 

Establish Trust Through Active Listening

Competent practitioners communicate by using proven active listening techniques:

- Clarification – Summarizes the major issues and brings the issue(s) into sharper focus
 - Reflecting – Rephrasing the expressed feeling to show the consumer that you understand what is being said
- 



MODULE 10

Reframing – provides an alternative interpretation of an issue, generally moving from a negative view to a positive one

Paraphrasing – the practitioner repeats what was said in their own words what was heard so the that the individual can hear it back



The Complexities of Communication

- Individuals with psychiatric disabilities may have difficulty communicating because of their symptoms and/or the affects of their medications (drowsiness, slow response time, and memory disturbances).
 - Non verbal messages such as body language, eye contact, rate of speech and the tone of voice may help increase communication but can also make interpretation more difficult.
 - Verbal communication and nonverbal communication may be incongruent (ex: saying “it’s nice to meet you!” and not smiling or making eye contact).
- 



ESTABLISH TRUST THROUGH ACTIVE LISTENING

KNOWLEDGE	SKILLS
A. How a disorder & its symptoms may affect communication	A. Identifying & communicating individual strengths
B. Interpersonal communication theories	B. Speaking clearly to individuals in various stages of recovery
C. How questions and questioning techniques impact response	C. Matching language to level of functioning, verbal skills, & cultural/ethnic background
D. Interpersonal communication techniques	D. Active listening, both verbal and nonverbal



MODULE 10

List of laws, regulations and agencies that a rehabilitation practitioner should have basic knowledge to help consumers make informed choices:



Confidentiality regulations	American with Disabilities Act (ADA)
Department of Labor regulations (DOL)	Vocational rehabilitation regulations
Housing & Urban Development regulations (HUD)	Medicaid/Medicare
Rehabilitation Act and amendments	Social Security disability regulations
	Social Security work incentives

Provide Interventions to Foster Recovery

Competent practitioners must have the necessary skills to provide interventions and know the most current and best practice treatments that foster recovery.

Interventions should include evidence-based practices, such as supported employment, assertive community, integrated dual disorders treatment, psychosocial education, illness management and recovery.



Emphasize Choices to Facilitate Goals

Practitioners that help individuals with psychiatric disabilities must be knowledgeable in skills that emphasize choices for individuals in order to facilitate their goal achievements and maximize their self-determination.





MODULE 10



The skills to emphasize choices help the individual add new skills (or enhance existing ones) and supports to be successful and satisfied in an environment of one's choice.

The practitioner can help an individual actualize their needs and desires by matching the them with appropriate services and expanding their social supports (family, friends, employers, coworkers).

Emphasize Choices to Facilitate Goals



KNOWLEDGE	SKILLS
A. Rehabilitation choices	A. Communicating rehabilitation choices to individuals
B. Treatment choices	B. Communicating treatment choices to individuals
C. Treatment vs. rehabilitation needs	C. Analyzing services that best match an individual's goal
D. Social supports	D. Identifying opportunities to develop social supports
E. Housing options	E. Identifying housing options that meet each individual's needs
F. Vocational services	F. Helping individuals to choose, get, and keep a job

Advocate to Stakeholders

Practitioners must have the knowledge and skills to advocate with stakeholders that individuals with psychiatric disabilities need to make informed choices in order to foster recovery.

Often practitioners must articulate concisely and advocate for individuals in recovery and must be able to work on their behalf, while respecting their wishes.



Advocate to Stakeholders



KNOWLEDGE	SKILLS
A. The range of relevant stakeholders	A. Speaking on behalf of individuals consistent with their wishes & interests
B. The interests of stakeholders	B. Communicating clearly with stakeholders
C. The range of choices open to individuals	
D. The definition of recovery	
E. The varying courses of recovery	

Promote Efficacy of Psychiatric Rehabilitation

Competent practitioners who are knowledgeable and current on the research and best practices must promote efficacy of psychiatric rehabilitation with colleagues and throughout the system to disseminate knowledge of the value of psychiatric interventions.



Take Personal Action to Facilitate Recovery

To support recovery for individuals that have a psychiatric disability, practitioners must have the skills and ability to:

- Make good decisions – To be able to choose the correct actions that will help the individual with their recovery, and
 - Respect the autonomy of the individual and implement actions that will facilitate and not cause harm to the individual in the recovery process.
- 

Service Approaches in Psychiatric Rehabilitation

Psychiatric rehabilitation services are as vast and complex as the aspirations of the individuals who receive the services.

The practices include strategies to address every life domain to help individuals with psychiatric disabilities achieve personal hopes and goals.



Rehabilitation Assessment

- Assessment is the cornerstone of intervention for persons with psychiatric disabilities.

 - The core values of the assessment include:
 - 1) Collaboration;
 - 2) Shared decision making; and
 - 3) Consumer-centered goals.
- 

The assessment serves four (4) broad overlapping functions:

- Identify treatment and rehabilitation needs ;
 - Assess strengths of the individuals and the challenges/barriers in their relationships and environment that may affect them achieving their goals;
 - Develop the rehabilitation plan; and
 - Monitor the progress of the rehabilitation goals and plan and altering those goals and plan as needed
- 

Illness Self-Management

- Illness self-management is about educating individuals about their illness, symptoms and medications and is a crucial step for consumers to be able to make informed treatment choices and this in turn may reduce the impact distressing/problematic symptoms, relapses and hospitalizations.
 - Illness self-management also helps individuals with psychiatric disabilities identify/pursue/achieve personal goals to achieve personal wellness and control over their lives.
- 

Social Functioning

Social functioning can be defined as the quality and depth of an individual's interpersonal relationships, and their ability to meet socially defined roles and expectations.

Social functioning is a multifaceted concept that can best be understood several life domains:

role functioning, social relationships, self-care and independent living skills, leisure and recreational activities and community integration.



ROLE FUNCTIONING

Role functioning concerns an individual's ability to meet socially and culturally defined roles such as worker, student, parent, homemaker, caregiver. When an individual fails to meet these roles, the responsibility shifts to others and this can affect the individual's social environment and relationship with others.

SOCIAL RELATIONSHIPS

There are 2 types of **social relationships**:

Affiliative: aimed at getting emotional needs met. They're sustained connections with others that are affectionate, meaningful, enjoyable, and mutually rewarding.

Functional: aimed at getting instrumental needs met (e.g. doctors, landlords, sales clerk, etc.).

SELF-CARE and INDEPENDENT LIVING SKILLS

Self-care skills typically include the ability to attend to hygiene/grooming, dress appropriately for the weather and social situations, and respond to medical needs (doctor, taking medication, diet).

Independent living skills encompass a broad range of abilities, such as cleaning/maintaining one's home, appropriate interactions with neighbors, cooking, doing laundry, money management, shopping and using public transportation.

LEISURE and RECREATIONAL ACTIVITIES

Leisure and recreational activities include fun and entertaining pursuits, such as hobbies, sports, watching TV, or going to the movies, hiking, communing with nature, and reading.

These activities should involve personal meaning, growth, fulfillment, or health maintenance or improvement, such as keeping a journal, artistic expression, exercise, or spiritual enrichment.

COMMUNITY INTEGRATION

Community integration can be conceptualized as the extent to which individuals with a disability live side by side with others and participate regularly in social activities in their community.

Evidenced- Based Medicine and Shared Decision Making

- Evidenced-based medicine and shared decision making acknowledges that the consumer is the expert regarding their own experiences, values and preferences for treatments, risks and outcomes.
 - Shared decision making is a true partnership in which the consumer's choices are honored and by creating an environment of trust, choice, and individuality can thrive.
- 

- To participate in shared decision making, consumers need better education and support so they may communicate effectively to express their preferences and concerns to develop strategies for using their medications effectively.
- 

Supported Employment

Supported employment has emerged as an evidenced-based practice approach to vocational services. This approach and principles of supported employment focus on empowering the consumers to make decisions and search for jobs that they are interested in quickly (without delays for prolonged assessment and training), and count on service providers to support them by integrating mental health and vocational services for as long as they need them.





Principles of Evidence-Based Supported Employment

ZERO EXCLUSION	Rather than professionals making the decisions about readiness, consumers make the decision.
INTEGRATION OF VOCATIONAL and MENTAL HEALTH SERVICES	Complete collaboration between vocational rehabilitation & mental health at all levels would be ideal.



MODULE 10



BENEFITS COUNSELING

In order to make good decisions about vocational goals, individuals need to have an accurate understanding of their benefits (Social Security, health insurance, housing assistance, food assistance) and how working may impact them.

CLIENT PREFERENCES

Vocational goals, supports, and timing should be highly individualized according to client preference (disclosure, type of work, work hours & setting and not the professional's judgment).



MODULE 10



RAPID JOB SEARCH	Assessment is minimized in favor of rapidly helping them pursue a job of their choice. For consumers with little or no work experience, the job search becomes a way to learn about various jobs.
FOLLOW- ALONG SUPPORTS	Services that are individually tailored and according to the consumer's preferences. These services can be on or off site and are available as long as the consumers requests them.
TEAM-BASED SERVICES	Supported employment is most effective when provided by a multidisciplinary team with expertise in several relevant areas such as work, benefits, mental health, substance abuse, housing, and mental illness.

Supported Education

Supported education assists consumers with postsecondary education in integrated educational settings for individuals with psychiatric disabilities.

Although there is not as much study and research on supported education, the principles are very similar to supported employment.



Module Ten

Quiz



1. Which of the following are core principles of psychiatric rehabilitation?
 - a. People have the capacity to learn and grow
 - b. People are to be treated with dignity and respect
 - c. The involvement and partnership of persons receiving services and family members is an essential ingredient in recovery
 - d. Both a & b**
 - e. All of the above



MODULE 10

2. Although non verbal messages may be difficult to interpret, they are still an important part of communication.

- a. True
 - b. False
- 

3. Competent practitioners should have a basic knowledge of evidence based practices and the policies and laws that impact a consumers benefits so they assist the consumer with making _____.
- a. the choices that the agency wants them to make
 - b. **informed choices**
 - c. a & c
 - d. All of the above

- 
4. Active listening is a way to establish trust. Which of the following are techniques of active listening?
- a. Reframing
 - b. Clarification
 - c. Paraphrasing
 - d. All of the above**
 - e. None of the above

5. Evidenced-based medicine and shared decision making acknowledges that the consumer is the expert regarding their own experiences, values and preferences for treatments, risks and outcomes.

a. **True**

b. False



- 
6. Available psychiatric rehabilitation service approaches should address every domain of the individuals life. Which of the following would be considered a psychiatric rehabilitation service approach?
- a. Housing
 - b. Illness Management
 - c. Employment
 - d. All of the above**
 - e. None of the above

Module Eleven

Rehabilitation

Services

In Oklahoma, behavioral health rehabilitation services are primarily funded through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and Oklahoma Health Care Authority (OHCA).

Both agencies have administrative rules and provider/service manuals that outline service and program requirements.

Although this module will outline some of the parameters of these services, you should refer to the rules and manuals that during the general course of your work. This information can be located on the ODMHSAS and OHCA websites

Rehabilitation Services

Rehabilitation services are face-to-face services provided to develop skills necessary to perform activities of daily living and successful integration into community life.

These services include educational and supportive services regarding independent living skills, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention).

Rehabilitation services are education based services which generally involve two (2) primary functions:

- **Curriculum based education-** facilitation of class-like educational experiences, based on a pre-developed written curriculum
- **Skill practice-** facilitation of opportunities to practice and giving feedback



MODULE 11

When providing rehabilitation services, you will not be facilitating group or individual services that **directly** focus on the discussion of thoughts and feelings like a therapy session does.

You will providing structured educational opportunities, and any **facilitated** discussion should be focused on assessing whether or not individuals are learning the material.

It is important to note, however, that many times after the educational material is presented, consumers share their thoughts and feelings about the material (without any prompting) as a natural response to the service you have provided.



Things to Note

- Generally, group is more effective for social skills development as it gives opportunities for interaction and practice.
- For translating independent living skills into real world practice, it is helpful to work with individuals in their own community environment.

Rehabilitation Programs

In addition to general individual and group rehabilitation services, rehabilitation services can also be provided through the structure of a defined program, such as the ODMHSAS Psychiatric Rehabilitation (PSR) program model.





MODULE 11

Psychiatric Rehabilitation **programs** are programs that promote recovery, community integration and improved quality of life for individuals that have been diagnosed with a mental illness, or co-occurring mental illness and substance use disorder.

Psychiatric rehabilitation **services** are collaborative, person directed, and individualized. They focus on helping individuals re-discover skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.



ODMHSAS funds two (2) types of Psychiatric Rehabilitation programs for adults age 18 and older:

- General Psychiatric Rehabilitation (PSR) Programs
- ICCD Clubhouse

PSR Programs

PSR programs provide a combination of services incorporating social, educational, occupational, behavioral and cognitive interventions.

They seek to optimize the participant's potential for occupational achievement, goal setting, skill development and increased quality of life.

PSR programs are designed with two (2) primary rehabilitation service components:

- **Skill building groups** – Groups provided to members that are curriculum driven and developed to meet the needs of the membership and teach specific skills the member may need to work on.
- 

- Work units – provides an opportunity for members to practice skills they have learned in the skill building groups.

Work units are devised to complete only work functions that are needed to operate and benefit the PSR program (not busy work or work outside the program), and provide a real-world like setting for members to practice skills.

Some common work units include clerical, Food Services, Facilities/Environmental, outreach (contacting and supporting members who have not attended in a while), Education, Employment, and Housing.

In the units, members and staff work side by side in a unique partnership.

ICCD Clubhouse Programs

Clubhouse is a community intentionally organized to support individuals living with the effects of mental illness. Through participation in a Clubhouse individuals are given the opportunities to rejoin the worlds of friendships, family, important work, employment, education and to access the services and supports they may individually need.

Clubhouse programs are certified through the International Center for Clubhouse Development and follow the International Standards for Clubhouse Programs.

Click on the following link to learn more:

<http://www.iccd.org/quality.html>

Module Twelve

Psychiatric Rehabilitation:
Competencies &
Interventions

Interventions in Psychiatric Rehabilitation

- The focus of this phase consists of several steps: setting priorities; setting short-term and long-term goals and planning and implementation of the interventions.
- The practitioner must ensure that the interventions are concrete, functional, have a direct impact on their lives, are designed/implemented to help people in their educational, recreational, social, vocational, residential and psychological life areas.

Interventions in Psychiatric Rehabilitation

- Community resources and supports will facilitate progression toward normalized roles and responsibility in family and community life.



Interventions in Psychiatric Rehabilitation

- **Competency 1:** Demonstrate crisis diversion strategies
- Stabilize emergency situations
- Decrease stressors
- Mobilize resources/supports to prevent hospitalizations
- Improve their functioning above pre-crisis level

Examples: crisis plan, contracts, removing environmental threats, get family and friends involved

Interventions in Psychiatric Rehabilitation

Competency 2: Demonstrate relapse prevention intervention strategies

- Assist in developing a relapse inventory i.e. thoughts, events, feeling and other triggers that have caused relapses in the past
- Help diminish the negative feelings and internal and public stigma associated with a relapse

Interventions in Psychiatric Rehabilitation

Competency 3: Demonstrate individual supportive counseling intervention strategies (**THIS IS NOT THERAPY**)

- Empathic listening
- Engagement- building trust
- Empowerment- sharing responsibility
- Encouragement- supportive feedback to help them learn new ways of coping and viewing the world
- Evaluation- monitor progress, successes, setbacks and make sure that the goals remain mutual

Interventions in Psychiatric Rehabilitation

Competency 4: Demonstrate group intervention strategies

- preventative and educational purposes
- Support, socialization, rehabilitation and treatment
- Understand group dynamics- what does this mean?
What can happen in a group setting?

Interventions in Psychiatric Rehabilitation

The elements of group modalities: role playing, opportunities for leadership roles, peer feedback, problem solving, reality testing, improved coping strategies, learning opportunities, building self-esteem, reflection on strengths and progress and family involvement

Types of groups:

- Psychoeducational;
- Skill building;
- Support
- Active treatment- therapy or substance abuse
- Supporting self-help
- Health education

Interventions in Psychiatric Rehabilitation

Competency 5: Demonstrate skills training intervention strategies

- Teaching/educating on skills needed to function effectively
- Skills taught should correspond to the assessment and treatment plan
- Utilize educational principles- will review later

Interventions in Psychiatric Rehabilitation

Competency 5: Demonstrate skills training intervention strategies

- Prompting/coaching positive feedback
- Integrate teaching/learning principles
- Effective teaching strategies- learning styles, multimedia, participatory, narrative, etc.
- Involvement of the learner
- Effective application so the skills will transfer to their natural environment
- Continued reassessment of their progress

Interventions in Psychiatric Rehabilitation

Competence 6: Demonstrate family intervention strategies

- Increase knowledge and skills of the family so they effectively deal with their loved one experiencing mental illness
- Facilitate balance between the family's role in overall treatment, rehabilitation and recovery, and their capacity to meet their own individual needs and life roles
- Empower the family to act as an advocate
- Appreciate the family as a core for healing and recovery
- Appreciate the families emotional struggles and experiences
- Sustain open communication and include them in the multidisciplinary team

Interventions in Psychiatric Rehabilitation

Competency 7: Demonstrate community resource and environmental support intervention

Seven Practice Domains of Psychiatric Rehabilitation

- Within each domain, the core knowledge and skills needed to demonstrate competence in practice are identified.
- The examples given under each discipline are for guidance only; they are not inclusive of all aspects covered under each learning domain.

<http://www.psychrehabassociation.org/sites/default/files/images/2009CPRPEXamBlueprint.pdf>

- DOMAIN I. Interpersonal Competencies
- DOMAIN II. Professional Role Competencies
- DOMAIN III. Community Integration
- DOMAIN IV. Assessment, Planning, and Outcomes
- DOMAIN V. Interventions for Goal Achievement
- DOMAIN VI. Systems Competencies
- DOMAIN VII. Diversity and Cultural Competency

Activity:

1. Review assigned competency
 2. Provide the definition of your competency
 3. Provide brief information on the following:
 - Demonstrates knowledge of....
 - Demonstrates skills in.....
-
- Your group will have 5- 10 minutes to present
 - Each group member should participate in the presentation
- 

Module Thirteen

Adult Learning and Curriculum Building



Curriculum Design and Development

As mentioned earlier in this module, one of the primary service components of both individual and group rehabilitation, and PSR programs, is curriculum based education. And one of the most frequently asked questions by individuals who provide rehabilitation services is “Where can I find curriculum?.”

Although there is some existing curriculum out there that is appropriate to use, it is limited and does not meet all of the recovery needs of the individuals served. Therefore, it is important to learn how to develop curriculum.



When designing and developing programs that support recovery and provide the pathways to full productive lives, you will need to take a systematic approach that will assist in creating an effective and efficient learning environment for your target learner or learner group.

This section will provide you with a model to follow in order to critically think through each of the necessary phases of designing curriculum for the consumers that you serve.





Systematic Model

When developing curriculum for your consumers, it is recommended to follow the ADDIE model to design effective instruction. The intention behind designing instruction is to provide and construct intentional learning opportunities for your consumers.

The ADDIE model is comprised of five systematic phases during the development of curriculum. The five phases are:

A= Analyze

D= Design

D= Development

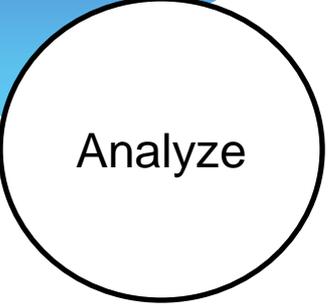
I= Implement

E= Evaluate



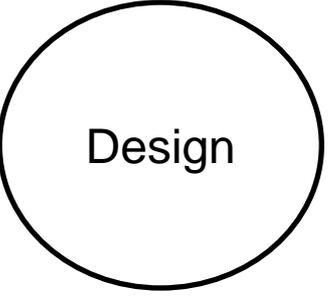


ADDIE Model



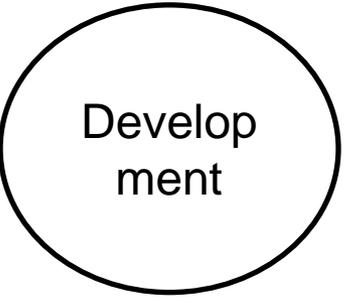
Analyze

The **first phase** of the process that you will follow is analyzing the learning task, learners, the needs of what the learners are required to know after participating in the instruction, and the context in which the instruction will be facilitated.



Design

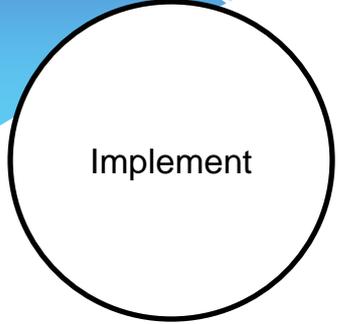
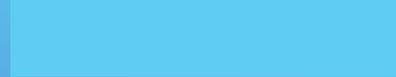
The **second phase** of the process that you will follow is the design phase. The design phase consists of learning objectives, assessment instruments, exercise, content, subject matter analysis, lesson planning and media selection.



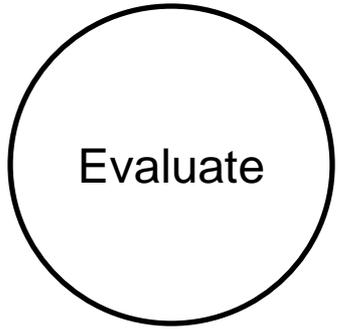
Development

The **third phase** of the process included creating and assembling the content resources that were blueprinted in the design phase.





The **fourth phase** of the process is where you will carry forward the instruction you have designed and developed in the previous phases.



The **fifth phase** of the process is assessing the learning and instruction. This phase is an ongoing phase each time the instruction is presented. Essentially, this phase will allow you to determine if the instruction developed was effective.



Analysis Phase

Prior to jumping in and putting together curriculum, you want to fully understand and analyze the content that you want to present, and identify what you will want the learner to walk away knowing.



Content & Task Outcomes

Required knowledge, skills and abilities (KSA); essential and peripheral features; level of difficulty; optimal and critical resource needs; measures of competence and criterion levels for judgment. The process of task analysis involves thinking deeply about what students are to learn, and what they should be able to do with it when they have learned it.

Reference: Dr. Patricia Hardre

Learners

Sensory/perceptual capacity and information processing capability; prior knowledge; prior experience; current knowledge, skill and ability (both domain/general and task/specific); psychological and psychosocial characteristics (how learners see themselves in relation to and others).

Reference: Dr. Patricia Hardre



The Analysis Phase is the phase in which you begin considering what type of training is needed, and what the initial parameters of that training will be.

Four (4) key considerations during the Analysis Phase:

1. What are the characteristics of the group/individuals who will receive the training?

- Who will your primary target audience (i.e. adults with Serious Mental Illness, children with Serious Emotional Disturbance, adult or children with substance use disorders, etc.)?
- What is their learning style (visual, auditory)?
- If a group, what are the similarities and differences between learners (i.e. age, gender, developmental, anything that might impact learning)?
- What are the values, beliefs, motivations and interests of the learner(s)?





2. What do you want the learner to walk away from the training with?

In general:

- What do you want them to learn?
- What skill(s) do you want them to have?



What will the learning environment be like?

- Individual setting?
- Group setting?

If group setting:

- Identification of traits that may impact a group learning situation (i.e. the level of communication skills of group participants, social anxiety, etc.)





What are the characteristics of the individual(s) who will be doing the training?

- What are their strengths?
- What are their weaknesses?
- What are their teaching styles?





Once you have uncovered the information from the Analysis Phase, it is time to begin designing the outline for instruction. This phase will be influenced by the type of learning instruction requires and how you create meaning from the content.



Influencing Learning

Acknowledge connections & perspectives; link to existing KSA; incorporate strategies that facilitate retention & transfer; provide clear & balanced feedback; organize information in meaningful ways; divide and deliver content in appropriate “chunks”; provide appropriate & effective interactions with content.

Reference: Dr. Patricia Hardre



The Design Phase is the phase in which you take the general training parameters identified in the Analysis Phase and use them to create a well developed outline for instruction.





The instruction outline should include the following components:

- Learning objectives – Using the general definition of what the learner needs to walk away with (defined in the Analysis Phase), create specific and measurable learning objectives that state the intention of what the learners should be able to do at the conclusion of the training.
- How the training content should be organized – Identify how the content should be ordered so that the knowledge will continue to build through the instruction, and what content needs to be “chunked” so that the learner can be best understand the information being presented. Should there be a different training sections or modules.



Types of learning to be used – Identify the types of learning you will want to include in the training (i.e. facts, concepts, principles, procedures).





- Types of instruction to be used – Based on the types of learning to be used, identify the types of instruction you will want to use in the training.
- Declarative knowledge – Involves “knowing that” something is the case. Facts.

Examples: Michael Crichton died November 4, 2008 after a battle against cancer. In 1907, Oklahoma became a state.





- Concept learning – “... a set of specific objects, symbols, or events which are grouped together on the basis of shared characteristics and which can be referenced by a particular name or symbol” (Merrill & Tennyson, 1977)

Examples: The idea of applying the concept of systems thinking to design instruction. As a leader, you strive to cultivate high-performing teams. When providing rehabilitation services, you strive to facilitate recovery.





- Principles – prescribe the relationship(s) among two or more concepts.

Examples: Do not solve the problems of your consumers, but train them to solve the problems themselves. The principles of change.





- Problem Solving – “ Problem solving is the ability to combine previously learned principles, procedures, declarative knowledge, and cognitive strategies in a unique way within a domain of content to solve previously unencountered problems” (Smith & Ragan, 2005)

Examples: Identify issue between two consumers. Applying technology within a lesson plan.





- Cognitive Strategies- Emphasizes the development of thinking skills and processes as a means to enhance learning. The objective is to allow learners to become strategic, self-reliant, flexible, and productive in their learning endeavors (Scheid, 1993)

Examples: Teaching critical thinking skills.
Teaching adolescents how to read or write.





- Attitude/Affect – Promoting a change or alternation in attitude.

Examples: Servant leadership; Health education

- Psychomotor – Psychomotor tasks involve skills that are physical by nature.

Examples: Learning to cook; playing the piano from sheet music



- Training medium- Will the training be all lecture based? Will there be videos used? Training exercises? Articles to be reviewed?



Some of the things to address when you are developing your instructional outline are the unique considerations for adult versus child/youth learners. The specific characteristics for each type of learner should help inform the type of learning, instruction, training medium, etc.



Primary Characteristics of Adult Learners:

Adult learners are volunteers. There is no coercion involved when teaching adults and therefore motivation is not usually a problem. Adults tend to seek out learning opportunities.

Adults often seek out learning opportunities in order to cope with life changes. They usually want to learn something that they can use to better their position or make change for the better. They are not always interested in the knowledge for its own sake. Learning is a means to an end, not an end in itself.

These adults bring a wealth of information and experiences to the learning situation. They generally want to be treated as equals who are free to direct themselves in the education process (Zemke, 1984)





Techniques for Teaching Adults:

- Use problem oriented instruction. Case studies, simulations, and problem solving groups make the instruction relevant to the situation.
- Instruction should be about tasks not memorization of content.
- Instructors need to put their egos aside and not be afraid to have ideas and instruction challenged. Don't be afraid to give up control.
- Make the environment comfortable and leave time for breaks (every 45-60 minutes).





Techniques for Teaching Children/Youth:

- Make sure the room is a safe place in which to take risks and participate during the learning.
- Obtain student input to establish rules and procedures.
- Presenting opportunities to move around and engage, kinesthetically.





- Presenting tasks that have multiple entry points to accommodate a range of thinkers, such as using auditory, visual, multimedia or written text.
- Built lessons using inquiry or problem-based learning in which students are encouraged to ask questions that interest them.
- Ask students to reflect on their learning experience at the end of sessions to strengthen the connection to the material.



It is important to note that the information on adult and child learning/teaching strategies is based on average learners within these age groups, and may not be true for all individuals.

For instance, all adults that are served may not be motivated to learn and may be better served with other strategies.





Other Considerations for the Design Phase

When designing learning objectives for rehabilitation curriculum you will want to consider the common skill areas that aid in the recovery process.



The skill areas listed below are some examples of what might be helpful to focus on, but is not a comprehensive list:

Social skills	Communication	Relationships
Relaxation/Stress Management	Organizational/Planning Prioritization	Self Motivation
Employment Education	Problem Solving	Money Management
Teamwork	Housekeeping	Memory
Food/Meals	Conflict Resolution	Attention Span
Diagnosis Related Education	Relapse Prevention	



The intent is to address those specific skill deficits that are preventing the person from functioning more effectively their living, learning, and/or working environment.





Instruction should be designed to address the skill area in a way that will translate to consumers daily life. Certainly knowledge can not be translated into practice and used by the consumer in their daily life to make movement toward their recovery, then it is not optimally functional for rehabilitation.

Overall learning objectives used for curriculum development can be translated into objectives that can be used on consumer service plan. This will be addressed in more detail later on this module.



Implementation Phase

Implementation involve successfully putting your instruction into use in the contexts for which they are intended (Smith & Ragan, 2005). Providing training utilizing the curriculum you have developed.



The following are some general rules to follow to ensure successful implementation:

Make decisions regarding implementation (e.g., types of tables, how material will be presented, technology used) at the beginning of designing your instruction. Thinking through this at the end when all material is designed and developed may cause unnecessary work.

Revised or new instruction can change the role of the instructors and the structure of the classroom.





Evaluation Phase

- Before designing and developing evaluation tools, you want to consider what the indicator of success is and how you can best determine if your instruction met the desired results.



Evaluations that can be used to assess your instruction include:

- Pretest & Posttest (which may include multiple choice questions)
- Attitudinal questionnaires that ask about the learner's attitudes toward learning, instructional material and subject matter (ex: rating scales completed by the consumer's after each training session).
- Observation from the facilitator that reflects on group engagement participation, connection with the content, etc.
- Individual checklist that allows learner to self-reflect on how well they feel they met the required objectives of the instruction.



Facilitating Educational Groups

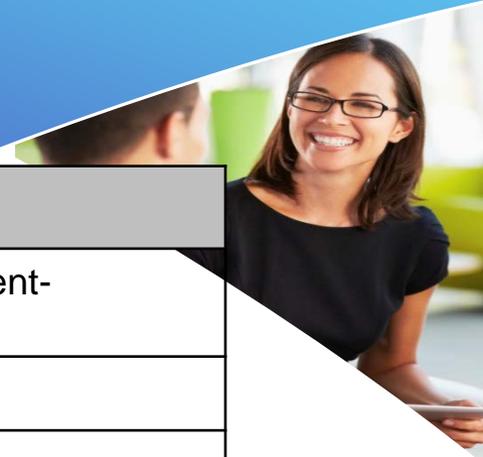
Ok, you have the curriculum developed and in hand, but before you begin providing rehabilitation services it is first important for us to talk about the dynamics of facilitating educational groups.

How you facilitate group is an important component to ensure that the curriculum content is applied throughout the group of learners. Appropriate application of facilitation will influence the learners to reach the objectives of the instruction.





There are a number of key elements to facilitation that you should keep in mind as you are delivering the developed content.	
Guide, model, encourage and support learner groups	Give and receive feedback
Be flexible, patient, friendly and enthusiastic	Reinforce the goals of instruction
Be prepared and organized	Require active participation by all individuals
Allow groups to think through content without jumping in to fill quiet space	Refocus the group when needed
Make short interventions- try not to jump in and start lecturing. The learning environment should be more student-centered	Encourage risk taking
	Discussing the problems that arise
Illustrates application of knowledge	Summarize the information at the end of the instruction



Qualities of an Effective Facilitator

Does not jump in and start lecturing. Makes the learning environment more student-centered.

Gives and receives feedback

Reminds learners of the goals of the instruction.

Is able to refocus the group

Encourages risk taking (i.e. join in group discussion re: educational content)

Discusses problems that arise.

Is able to summarize the information at the end of the instruction.

Requires active participation by all individuals

Does not dominate

Illustrates application of knowledge (gives examples).



As mentioned previously, rehabilitation is an education based service. As a rehabilitation specialist, you will not be facilitating free form discussion based groups regarding feelings and thoughts.

You will be facilitating educational groups based on well developed curriculum. Certainly, there will be some discussion related to the material taught, both to assess where the group is at in learning the information, as well as through group response to the information.





As the facilitator, you will want to take the pulse of the group periodically to see if you are providing the information in a way that makes sense, and to assess if the group is progressing through the material at the right pace (ex: you may want to slow down and allow more time to be spent on a certain topic if the group does not appear to be understanding the material).





Just Remember.....

Facilitation is to make the learning process as easy as possible, and requires a conscious effort (planning, observation and action) by the facilitator.





Clinical Documentation



Clinical Documentation

What is the purpose?

There are many reasons clinical documentation is important:

- Communication – Communication to other clinicians, physicians, auditors. Communication with the individual served when completing documentation together-making sure you are on the same page.



- Direction – Provides direction for treatment. Assessment directs the service plan, and the plan directs actual service provision. People who set goals and write them down, are more likely to achieve them.
- Motivation – When we set goals for ourselves and we accomplish steps toward the achievement, we get excited. Success breeds success





- Effectiveness of treatment – Not having a well thought out plan for treatment is like shooting in the dark; it is within the realm of possibility that you might hit the target but it's unlikely.

A well written assessment resulting from dialog with the individual being served helps both you and the individual identify more targeted goals and objectives.

The function of the progress note and the service plan review is to help you gauge how effective the treatment you are providing.



Types of Clinical Documentation

There are three (3) primary types of clinical documentation:

- Clinical Assessment – Documentation reflecting current and historical information which is typically used to make a diagnosis and direct the course of treatment.
 - Service Plan – Documentation that outlines the goals, objectives and services to be focused on during treatment. This documentation is also referred to as a treatment plan.
 - Progress Notes- Documentation reflecting what happens during each service provided (i.e. service plan goal/objective addressed, clinical intervention provided, consumer response to intervention, etc.).
- 



Clinical Assessment

Clinical assessment is not a service done by a Behavioral Health Case Manager (BHCM). This service, and documentation, is done by the Licensed Behavioral Health Professionals (LBHP). However, if a BHCM will be helping to write the rehabilitation and service plan goals/objectives, it will be important for the BHCM to review the assessment documentation and use the information to help direct the development of the service plan.





Service Plans

It is likely in your role as a BHCM, that you will be helping develop service plans for the consumers you serve. Although the LBHP is ultimately responsible for service plan development and must sign off on the service plan, other levels of practitioners can assist in writing goals and objectives.





There are two (2) types of service plans:

- Behavioral Health Service Plan Development Moderate Complexity – This service plan is a comprehensive service plan typically done upon admission for services. This is where the goals and objectives to be worked on, and the specific services to be provided are first identified.
- Behavioral Health Service Plan Development Low Complexity – This service plan is the review/update that is typically completed once every six months. During this process or lack of progress, and any new issues are reviewed, or the service plan goals and objectives are updated/revised accordingly.





When assisting with either the comprehensive service plan or the review/update, there will be a couple things that you will want to focus on:

- Developing a recovery focused service plan
- Developing goals and objectives that are in line with the clinical interventions for rehabilitation and case management services



Recovery Focused Service Plans

- The plan should be completed in partnership with the individual/family receiving services
- The plan should be created with consideration given to the strengths, needs, abilities and preferences identified by the consumer/family and clinician during the assessment
- Plan goals and objectives should be meaningful to the consumer/family and written in a way where it will be easy to determine when the objective has been accomplished





- The plan should be developed with objectives that are possible to attain within the service plan period.
 - It is important to create and build upon successes

- The consumer should always receive a copy of the plan.

- A process should be in place regularly revisit the plan – **not just at the 6 month review period**



- **Creating a vision of recovery** – In addition to dialog regarding usual service plan goals, you may find it helpful to work with the consumer to identify their vision of recovery (what they want or think their life will look like in recovery).

This in effect is the overarching long term goal (one that may start as a “dream”) that helps to put the overall service plan context.

This process may need to include discussion regarding recovery possibilities such as employment, education, independent living, relationships, etc., as individuals may not envision a world where these would be real possibilities for them.



Case Management Goals & Objectives

- Service plans should include case management goals and objectives that are both meaningful & individualized to the consumer, written in a way that is easily understood & attainable within the treatment plan period
- CM objectives may be written in a “broad-based” or more specific manner





SPECIFIC CASE MANAGEMENT ACTIVITIES

- Needs Assessment
- Service Plan Development
- Referral
- Linkage
- Advocacy
- Follow-up
- Monitoring
- Outreach
- Crisis Diversion



CASE MANAGEMENT GOAL & OBJECTIVES (SPECIFIC)

“ I want to have enough food to last all month and learn the best food for diabetics to eat every day.”

- CM will link consumer with local food banks and churches for grocery assistance.
- CM will follow up & monitor to ensure that the consumer’s nutritional needs are met each month.
- CM will link consumer with his PCP and advocate for a referral to a dietician to assist with dietary planning for diabetes.



CASE MANAGEMENT GOAL & OBJECTIVES (BROAD)

“ I want to have enough food to last all month and learn the best food for diabetics to eat every day.”

CM will refer, link, advocate, follow- up & monitor to ensure that the consumer is able to maintain an adequate & appropriate for his physical & behavioral health.





CASE MANAGEMENT OBJECTIVES

Monitoring/ Follow-up/ Outreach

- CM will follow-up with service providers regarding all scheduled appointments and aggressive outreach when any of those appointments are missed”.





CASE MANAGEMENT OBJECTIVES



Things to Remember

Case Management objectives do not need a numeric measure to be measurable.

Case Management treatment plan problems need to reflect the symptoms that interfere with the consumers/families ability to access resources and advocate on their own behalf.



DOCUMENTATION OF RECORDS

All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service plan documentation of each session must include, but is not limited to:



- (1)** date;
- (2)** person to whom services are rendered;
- (3)** start and stop times for each service;
- (4)** original signature of the service provider
- (5)** credentials of the service provider;
- (6)** specific service plan needs, goals and/or objectives addressed;
- (7)** specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;
- (8)** progress or barriers made towards goals and/or objectives;
- (9)** member (family when applicable) response to the service;
- (10)** any new service plan needs, goals, and/or objectives identified during the service; and
- (11)** member satisfaction with staff intervention.



PROGRESS NOTES

Consumer Name: (2) John Doe **Date:** February 12, 2012 (1)

(3) In 3:07pm Out 4:02pm (55 min= 4 units)

(6) Specific Objective Addressed, Staff Intervention, Member Response to Intervention & Progress Made Toward Goals:

Goal(s) 1&2; Objective(s) 1b & 2a

(7) John attended his scheduled case management session today. CM provided follow up on the referrals for housing and employment that were provided during the last session. (8) John shared barriers that hindered his ability to follow through with these referrals, such as his mother falling sick as she is his major source of transportation. He also stated that he had some unexpected expenses this month and was unable to afford fare for a cab or a bus. (7) CM offered to help link John with the identified resources by making the phone calls together in my office. In addition, we obtained a contact person at each location for John to talk to when he arrives.

(9) John said he is excited and agreed to follow up and share his progress during our next session in 1 week on February 19, 2012.

(10) No new needs identified during this session.

(11) Before this session ended, John stated "These are the things I still need your help with. I am happy we got this done today."

(4) Staff Signature (& Credentials): Dawn Talton, CM (5)

12345XYZ





PROGRESS NOTES

Consumer Name: (2) Jenny Doe **Date:** (1) October 3, 2011

In 3:00pm Out 4:30pm

(3) Specific Objective Addressed, Staff Intervention, Member Response to Intervention & Progress Made Toward Goals:

Goal 1 Objective 1a

(7) CM traveled to Jenny's home and met with her and her Mother to complete a strengths based assessment and develop a case management service plan. (9) Jenny was very quiet and did not contribute very much input to the process; although this CM attempted to engage her on multiple occasions. Most of the information for assessment and service plan development was contributed by Jenny's mom. She stated, "I think the goals and objectives on the service plan will be very helpful", and Jenny agreed. (8 & 10) The needs identified during this session were included in the strengths based assessment & service plan that were developed/completed during this session. (11) Before this session ended, CM verified that there weren't any immediate needs to be addressed during this session. Jenny stated "I'm really tired. I want to start working on this at our appointment next week (October 10, 2011).

(4) Staff Signature (& Credentials): Kodi Pollard, CM (5) 5678ADC





Rehabilitation Goals & Objectives

- Service plans should include rehabilitation goals and objectives that focus on long term recovery and maximization of self-sufficiency, role functioning, and independence as distinguished from the symptom stabilization function of acute care (shouldn't just focus on stabilization and staying out of the hospital or inpatient type care, but should focus on assisting with success in living, working and having relationships in the community outside off treatment).





- The clinical intervention provided by rehabilitation services is education and skill development. This translates into the following functions during rehabilitation during rehabilitation sessions:
 - Teach
 - Prompt consumer response to educational content to verify that learning is occurring
 - Prompt consumer practice of skills
 - Observe consumer practice, and provide feedback



- Rehabilitation objectives should reflect the measurable step that a client will accomplish during the rehabilitation sessions. The objectives should correlate with the rehabilitation interventions. For example, consumers receiving rehabilitation services will:
 - Learn
 - Share response to the educational content being addressed (which can include “restate to reflect learning”)
 - Practice skills





Some examples of what rehabilitation objectives might look like are as follows:

- Jane will learn and practice 4 general communication skills (ex: verbal, writing, reading, and listening).
- Jane will learn 3 benefits of setting goals, and restate to reflect learning.
- Jane will learn and practice 3 conversation starters.



Things to note:

- For each group rehabilitation session a list of participants and facilitating staff must be maintained.
- PSR program staff must maintain a daily, member sign-in/sign-out record of member attendance, and shall write a progress note daily or summary progress note.





The content of a group rehabilitation note might look something like this:

Barney attended rehabilitation group today to work on aggressive behavior. This focus of the group was assertiveness. This clinician taught the group 3 ways that assertiveness is different from aggressiveness. When asked to restate what was taught, to reflect learning, Barney presented somewhat agitated but, with support from this clinician, was able to restate 1 way that assertiveness is different from aggressiveness. Barney stated that he feels good that he was able to rename one thing he learned. Barney appears to be making some progress in decreasing the degree of his aggressiveness, but needs continues skill development.





The content of a PSR program daily note might look something like the content of a group rehabilitation note might look something like this:

Barney attended PSR program today. He participated in the Cooking Unit, and worked with the other unit members and staff on the preparation of lunch. During this time, Barney worked on aggressive behavior. This clinician prompted practice of an assertiveness technique to be specific and clear as possible about what Barney wants, thinks, and feels as he interacts with others; to provide an alternative to aggression. This clinician specifically encouraged Barney to practice 2 specific statements: “would you...? And “I have a different opinion, I think that... Barney practiced these statements a couple of times with prompting from this clinician. Although Barney utilized the s and Barney responded in a defensive manner. Barney reports that he does not know if practicing these techniques are helpful, but states that he is willing to continue to try. Barney is making some progress reflected in his willingness to practice alternate techniques, but needs continues assistance with follow through, along with manner and tone.





DOCUMENTATION ACTIVITY

Strengths Based Assessment
Treatment plan Goal(s) &
Objectives(s)





GROUP ASSIGNMENTS



FOUR	FIVE	SIX
1. Role Play	1. Role Play	1. Role Play
2. A, B, C	2. A, B, C	2. A, B
3. D, E, F	3. D, E	3. C, D
4. G, H, I, J	4. F, G,	4. E, F
	5. H, I, J	5. G, H
		6. I, J



DOCUMENTATION ACTIVITY

We will check on you to monitor your progress & to answer any questions.

When everyone is finished, you will be asked about the experience- SO BE PREPARED TO SHARE.

Use this experience to: 1) implement the strengths based approach from the information obtained today; 2) learn from each other- technique etc.; 3) think about your role as a CM & 4) how the consumer might feel during this process.





Take about **3-5 minutes** to complete each section of the assessment. (History; Current & Desired)

Each of you can write on your assessment or have one person be the scribe.

Do not worry if some of the information overlaps. If someone gets some information for your section, think about how you can gain more.

As a group, use the information from the assessment to develop @ least 1 CM goal & 1 CM objective.

Start time 1:55 Stop time 2:55



MODULE EIGHT QUIZ



1. Which is the primary service function of rehabilitation services?
 - a. Skill practice
 - b. Clinical assessment
 - c. Curriculum based education
 - d. Both a & c**
 - e. All on the above



2. Directly facilitating discussion regarding feelings is an allowed activity in the provision of rehabilitation services?

a. True

b. False



4. When developing curriculum, for your consumers, it is recommended to follow the ADDIE model to design effective instruction. The “A” in ADDIE stands for:

- a. **Analyze**
- b. Advocate
- c. Action
- d. Assess



5. Learning objectives are created during of the ADDIE phases of development?
- a. Evaluate
 - b. Design**
 - c. Development
 - d. Implementation



7. Which of the following are key elements to facilitation that you should keep in mind?
- a. Be prepared and organized
 - b. Give and receive feedback
 - c. Let the group go off topic as long as they want
 - d. Both a & b**
 - e. All of the above



8. A rehabilitation specialist can do a clinical assessment.

a. True

b. False