BEHAVIORAL HEALTH CASE MANAGEMENT TRAINING

Oklahoma Department of Mental Health
and Substance Abuse Services

Module One

Serious Mental Illness

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.

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.

- 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.

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.

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; and “lack of insight”—which can make treating or working with people who live with schizophrenia much more challenging

- **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

Schizophrenia: categories of symptoms

1. **Positive symptoms** – Acute symptoms that represent an excess or distortion of normal functioning

.

- **Hallucinations** cause a person to hear voices inside or outside their heads or, less commonly, see things that do not exist.
- **Delusions** occur when someone believes ideas that are clearly false, such as that people are reading their thoughts or that they can control other people's minds.

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.

Schizophrenia: categories of symptoms

2. **Negative symptoms** – Residual symptoms that reflect a loss functioning or deficits.

- Negative symptoms often include emotional flatness or lack of expressiveness,
- an inability to start and follow through with activities, speech that is brief and lacks content and a lack of pleasure or interest in life.
- Difficulties with social cues and relationships are common.
- These symptoms challenge rehabilitation efforts, as work and school goals require motivation as well as social function.

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

http://www.youtube.com/watch?v=Kjr82pzrVSY

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.

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.**

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***

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***

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

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

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

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

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

Module One Quiz

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

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

a) An example of a life domain is….

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

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.

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

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

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

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

8. Obsessive Compulsive Disorder is classified as a(n)

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

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

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

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

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

- **<u>psychological</u>** or
- **<u>physiological</u>** manifestations.

Module Two

Understanding the Effects of Stigma

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.

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.

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.

2. 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 chose 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).

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 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

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

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

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

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

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

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!

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.

Medical Model

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

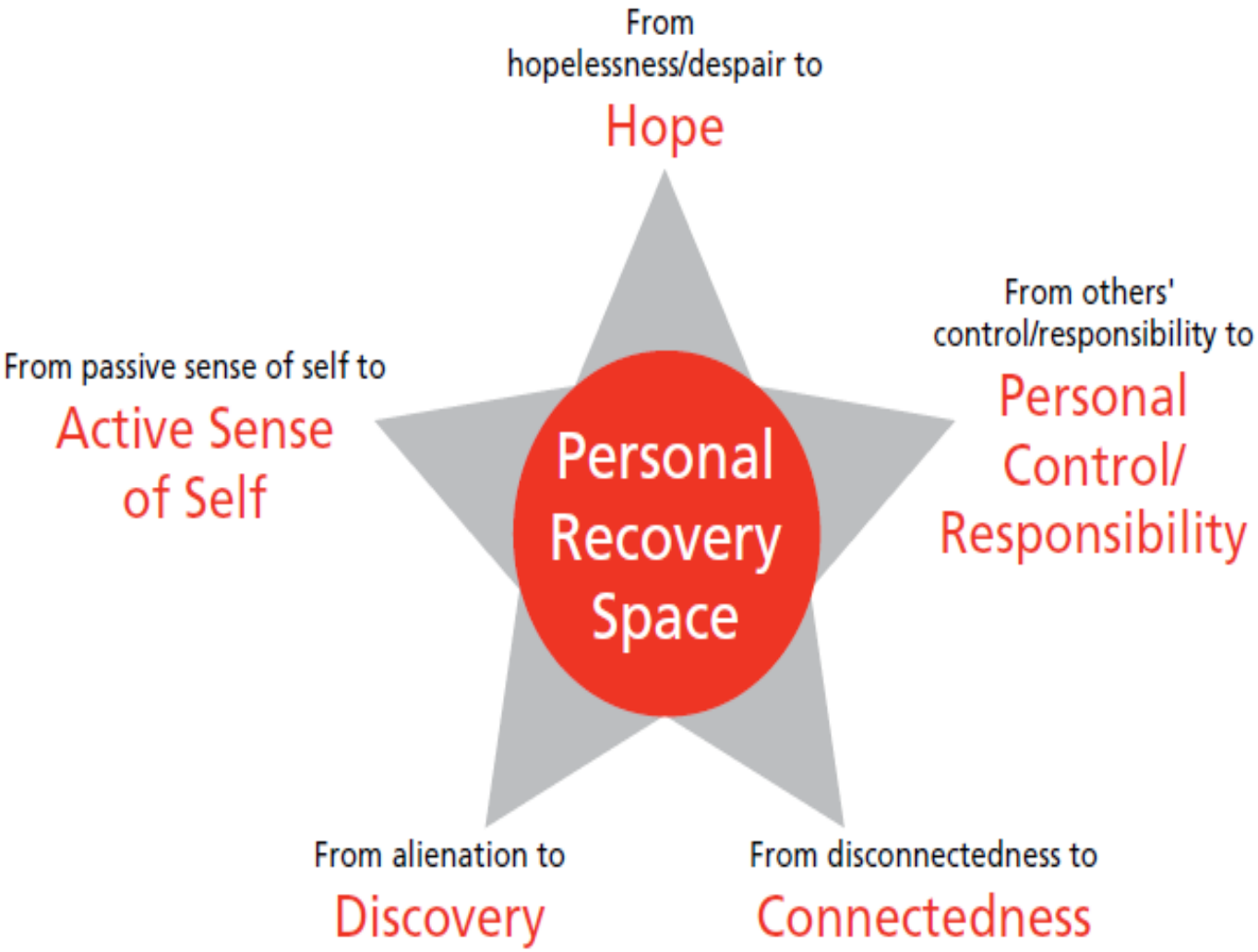
Traditional Task: Stabilization, Custodial care

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

Principles of recovery



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%
- Addition Treatment, 70%

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

- 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

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.

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=LekjVJkucyI&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:

http://www.samhsa.gov/samhsa_news/volumexiv_2/article4.htm

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

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)*

Resilience and Recovery for Children

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

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

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)

- **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.

- 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.

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 THREE QUIZ

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

a. True
b. False

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

4. Which of the following is ***<u>not</u>*** 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 ***<u>not</u>*** an example of People First Language

a. He is brain damaged

b. He has schizophrenia

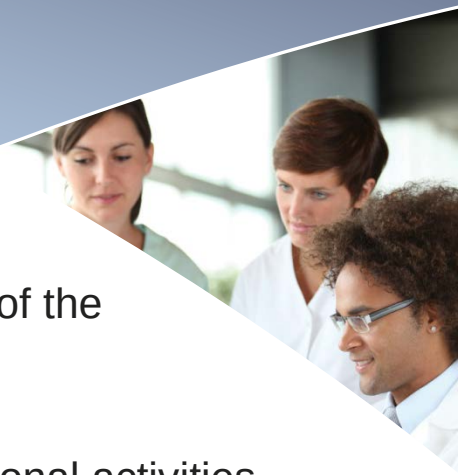
c. People with disabilities

d. People experiencing an alcohol and drug problem

Module Four

Case Management: Theory of Strengths

- The five factors that contribute to and manifest the oppressive life of people with psychiatric disabilities inhabit:



1. Mentalism- the tendency or compulsion to attribute and explain most of the behavior as a function of the illness
2. Poverty- government assistance, inadequate housing, limited recreational activities, education, relationships and employment
3. Fear- lack of confidence- self- efficacy, that symptoms will get worse if they try something that is out of their comfort zone
4. Professional practice- (Macroaggressions) use of chemical and physical restraints, forced in to police cars- (Microagressions)- low expectations and blame for failure
5. The structure of the mental health service system- entrapped niches

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

The **Strengths Model** is often described as a(n):

- *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;
- Different approach in the way a problem-
  - Not allowing the person to view the problem as a way that sets them apart from others and defining the cause and possible solutions. This allows the problem to exist in a new way and creates a sense of control.
- We will review how the strengths model has evolved and how it has changed the way we provide services in the behavioral health profession.

The strengths model posits that **ALL** people have goals, talents & confidence and **ALL** environments contain resources, people & opportunities. The strengths model is about providing a ***new perception***.

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**.

Although it was not intentional, deficit orientations toward the individuals & environments have created barriers and labeling and blaming the victim are part of the social processes 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
- Remain separate & excluded from the community i.e. segregate housing; sheltered employment and recreational activities with their service providers and other recipients of services

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

Continuum of Care & Transition

The mental health system has long been based on the continuum of care perspective,

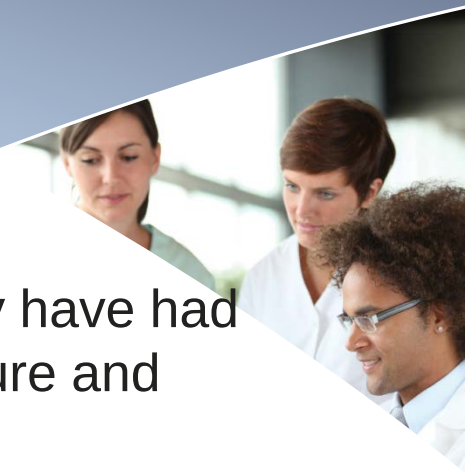
For example,

- A person wants to live in their own apartment or house must first demonstrate their success in other more restrictive living arrangements (residential care facilities, board and care, transitional living programs) or
- A person wants to get a job but must complete vocational testing, prevocational skills classes, a transitional/volunteer job slot or some other intervening status.

Continuum of Care & Transition Example:

A young man with a psychiatric disability was enrolled in 2 university classes and had a part-time job. The CMHC staff was concerned about his level of activity would prevent his participation in their day treatment program and sought to convince him (bordered on coercion) him to drop his classes or job.

During treatment team, it was suggested that he could participate in their “How to get a Volunteer” position class.



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.

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

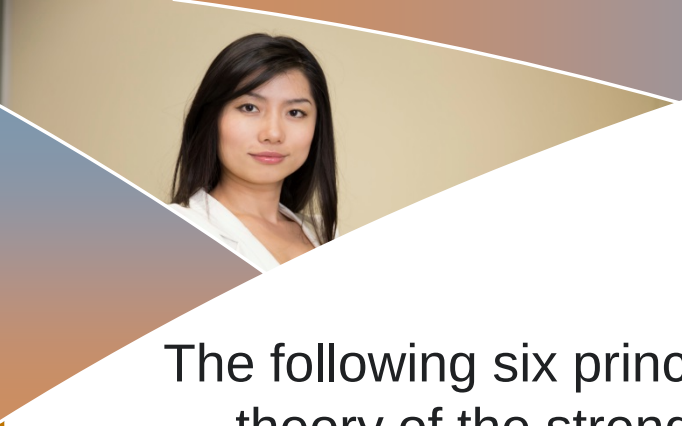
The Principles of the Strengths Model

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.

In the strengths model there are four types of strengths we can discover:

1. Personal Attributes

2. Talents and skills

3. Environmental

4. Interest and Aspirations

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 (cont.)

- 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.

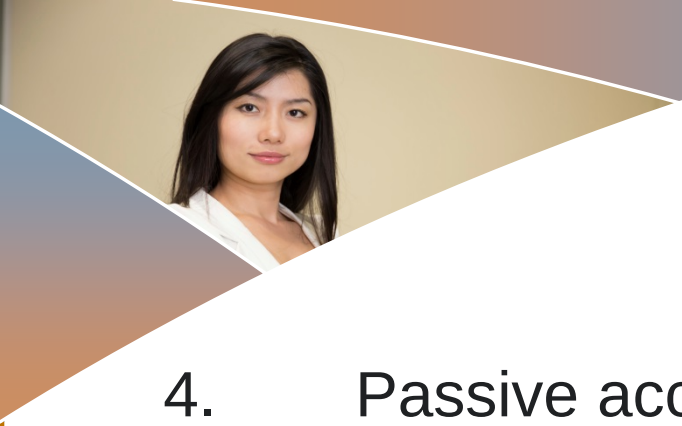
a. True

b. False

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

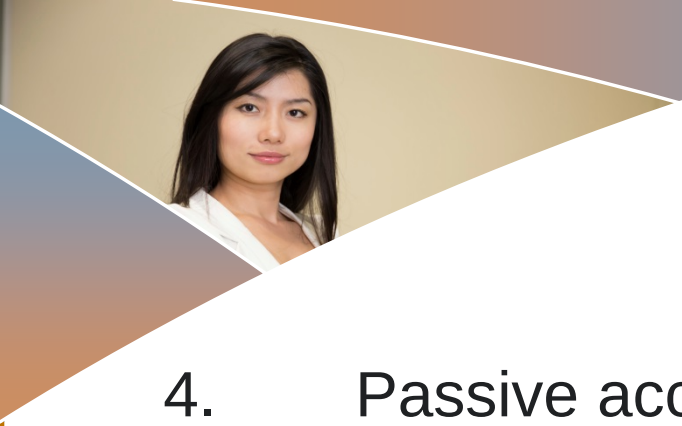
a. True

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

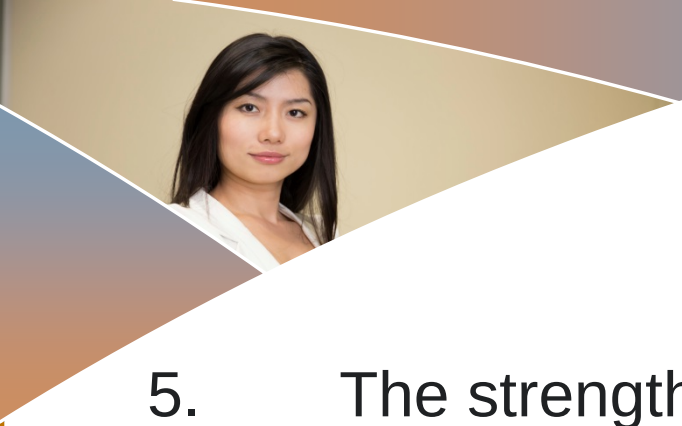
a. The consumer directs the helping process

b. There is a trusting relationship between the case manager and the client

c. The client reclaims and transforms their lives

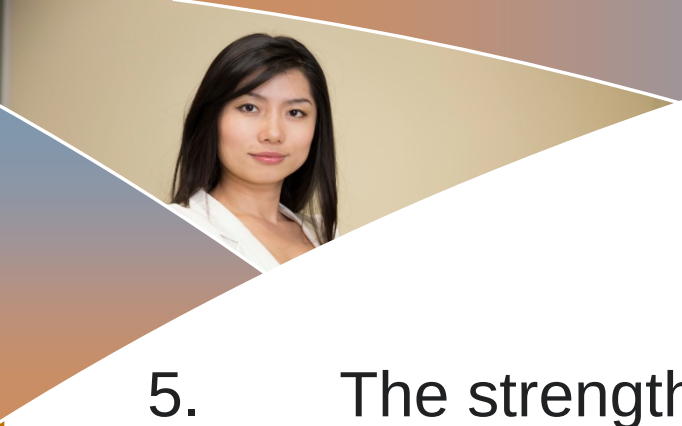
d. All of the above

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

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.

What are Ethics?

Click on the following link:

http://www.youtube.com/watch?v=ZIaHxC7BT0A

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

Question

You notice that a co-worker seems to favor some individuals over others and is not consistent in his actions. By doing this, he may be violating all of the following ethical principles **except**:

a. Non-maleficence
b. Beneficence
c. Justice
d. Autonomy

Question

You notice that a co-worker seems to favor some individuals over others and is not consistent in his actions. By doing this, he may be violating all of the following ethical principles **except**:

a. Non-maleficence
b. Beneficence
c. Justice
d. Autonomy

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.

<u>Examples:</u>

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

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*)]

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.

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.

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/aps/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 Six

Quiz

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

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

2. Competence includes knowing when a client needs to be referred to another professional.

a. True

b. False

2. Competence includes knowing when a client needs to be referred to another professional.

a. **True**

b. False

3. Are there any circumstances where a client’s confidentiality may be broken?

a. Yes

b. No

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

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

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.

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.

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:

<u>Certified Behavioral Health Case Manager (CBHCM)</u>

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

<u>Answer</u>

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

<u>Answer</u>

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

<u>Answer</u>

Yes.

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

Ethics in Action

Click on the following link:

http://www.youtube.com/watch?v=i2bRO3IGUUk

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

It is important to emphasize some of the things that came 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.

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; Chermiss & 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.

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…….*

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

8 DIMENSIONS OF WELLNESS

EMOTIONAL
Coping effectively with life and creating satisfying relationships.

ENVIRONMENTAL
Good health by occupying pleasant, stimulating environments that support well-being.

FINANCIAL
Satisfaction with current and future financial situations.

INTELLECTUAL
Recognizing creative abilities and finding ways to expand knowledge and skills.

SOCIAL
Developing a sense of connection, belonging, and a well-developed support system.

PHYSICAL
Recognizing the need for physical activity, diet, sleep, and nutrition.

SPIRITUAL
Expanding our sense of purpose and meaning in life.

OCCUPATIONAL
Personal satisfaction and enrichment derived from one's work.

SAMHSA

Emotional Wellness

The ability to understand ourselves and cope with the challenges life can bring and create satisfying relationships.

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.

Not being able to cope adequately with the wild emotional mood swings may result in the person resorting to using substances, either to dull or wipe out the pain or as just a way to get through the turbulent period.

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.

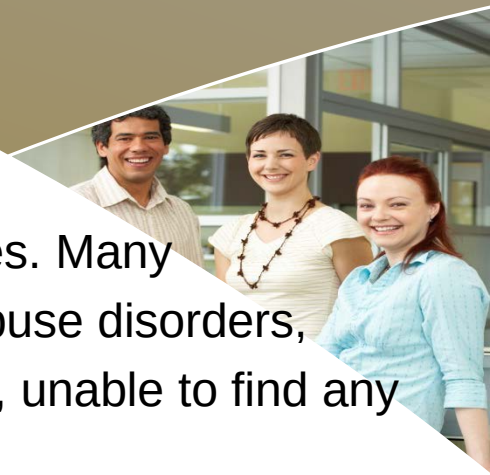
In substandard or inadequate surroundings, a person is bound to suffer deprivation of some sort. In addition to lack of safety and security, there may be inadequate heat and other utilities. The neighborhood may be rife with crime, subjecting the person to mounting stress and fear for his or her safety.

Financial Wellness

When you're poor and don't have enough money to properly care for yourself and your family, you aren't able to realize the financial dimension of wellness.

This is all-too common during the current uncertain economic climate, both for Americans in general and those with mental and substance abuse disorders in particular.

In such dire economic times, it's hard to feel satisfaction with current financial situations. It's potentially even more difficult to envision a satisfactory future financial situation. It is something to continue to strive for and look forward to.



Intellectual Wellness

Each person has his or her own unique talents and abilities. Many individuals with who suffer with mental and substance abuse disorders, feel trapped, invisible, incapable, shunned, and hopeless, unable to find any shred of value in whatever skill or ability they have.

It could be that they haven't ever had the opportunity to pursue something that they may be good at, or that they gave up on a skill long ago as a result of our addiction.

Discovering abilities, talents and skills needs a nurturing environment.

When we we're able to recognize our creative abilities and to find ways to expand our knowledge and skills, we start to feel good about ourselves, we're more encouraged to want to try something new, to venture off in a new direction and take on challenges we'd otherwise avoid. It also helps when we have the support and encouragement of others to help our motivation and to keep us going when we encounter temporary setbacks.

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.

When we feel a sense of participation and contribution as a result of our doing a good job. We’re more eager to greet each day with at least some amount of enthusiasm and look forward to going to work because we like what we do or gain some satisfaction from our efforts.

Physical Wellness

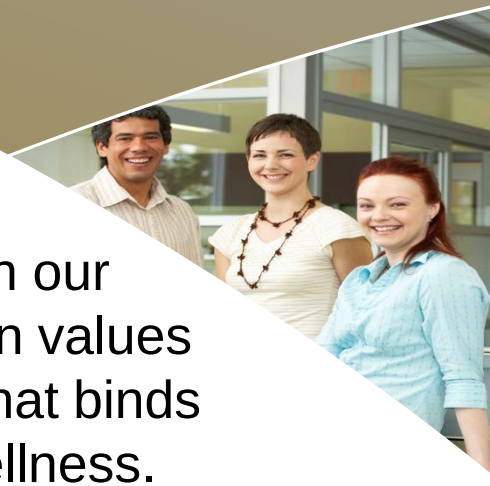
The ability to maintain a healthy quality of life that allows us to get through our daily activities without undue fatigue or physical stress. The ability to recognize that our behaviors have a significant impact on our wellness and adopting healthful habits (routine check ups, a balanced diet, exercise,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

Coming back from the physical consequences of substance abuse, coupled with mental health disorder, can be extraordinarily exacting. It may take an individual many months or years to restore his or her health following chronic addiction.

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.

Most human beings want and need to be with others in order to share experiences, conversation and to broaden their circle of acquaintances. It gives them a sense of belonging, and helps them develop a functional and helpful support system.



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.

Whether we believe in a Higher Power, or God as we know Him, or believe in the spirit of nature or mankind in general, we know instinctively that there is something beyond ourselves at work in the universe.

Being able to tap into our spiritual side, to derive comfort and peace from our meditation or prayer helps us expand our sense of purpose and meaning in life.

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)

Eastern Washington University
Counseling & Psychological Services

Steps to Self-Care and Wellness

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

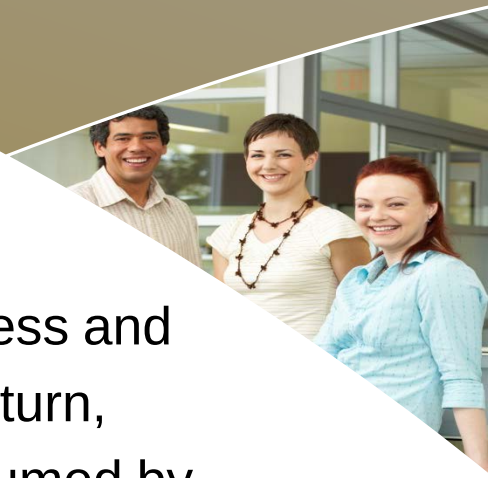
Take control of your life. Maintain a sense of humor. Delegate responsibility and combat perfectionism. Resist unreasonable demands on your time. Spend time with your family. Nurture your friendships and do things you enjoy. Always keep one foot in something comfortable. Live through your values.

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 Eight Quiz

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%

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%

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

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 Purpose of Helping in the Strengths Based Model

&

The Functions of Case Management

ODMHSAS believes that case management services

- enhances a path towards recovery;
- activates a hidden resource within an individual striving for change;
- reforms an individual’s state of mind;
- navigates an individual towards personal success.

- Assists the person in gaining control over their lives;
- Increases opportunities for participation in the community;
- Recognizes their interests, desires and dreams and
- Develops a plan to turn dreams into reality

The Helping Relationship is Primary and Essential

- 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 that serve 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

Purpose of Helping in a Strengths Based Model

The purpose of case management in the strengths model is to **assist people recover, reclaim & transform their lives** by *identifying, securing and sustaining the range of resources both environmental and personal* which are needed to **live, play and work** in an “normally” interdependent way in the community.

Purpose of Helping in a Strengths Based Model

Case management is individually tailored to the unique needs of each person who request services. Strengths model of case management helps people achieve the goals they set for themselves.

(Charles Rapp, 1993)

Purpose of Helping in a Strengths Based Model

- To make it **possible or easier** for someone to do something, by doing part of the work yourself or by providing avenues for that person to make changes for themselves. Emphasis on **creative individualized efforts** designed to promote permanent loving interpersonal interactions that in the consumers best interest.

- **Four A's** of helping to advocate for a consumer

Adequacy

Making sure that the resources consumer has or desires meets their needs:

1. Giving the person a sense of personal fulfillment & satisfaction

2. Affords decent and safe opportunities

Availability

The availability of opportunities is the first step:

1. Places for consumer to gather training or information

2. Locations to use this training

3. Locations in the community to offer chances to practice skill

Accessibility

Willingness to identify Obstacles and expectations:

1. More help in the initial phase to help person receive services or training

2. Recruiting non-formal systems to help consumer

3. Be responsive and supportive to consumers plan for help

Accommodation

- Consider the interaction and communication that the consumer will experience in using a new resource or skill:

  1. Assist consumer in talking with persons where he/she will use his/her skill

  2. Help identify special needs to make interaction most “normal” for consumer and those working with

Three concepts

- Motivation
- Problem
- Change

What do these three things mean to you ?

ACTIVITY

Motivation/ Problem/Change

- Take each concept and discuss how each is **used in your practice of work**.
- In your discussions, share how is **strengths based focused utilized & achieved**.
- **Share examples** of how you use this in **personal** and/or **professional** accounts.

ACTIVITY EXAMPLES

- Strengths Based vs. Not Strengths Based
- Who, What, Where, When, Why, How?
- About you or about consumer?
- Give examples of how you practice this in your line of work.

Motivation:
Need or reason for doing something

Strengths Based	Not Strengths Based
Acknowledging small accomplishments	Coercion to achieve compliance
Letting person set goals for achievement	Unmotivated: not doing what I want
Encouraging consumer to have a voice in services	Not using client words in documentation

Problem:

A situation, person or thing that needs attention and needs to be dealt with or solved

Strengths Based

- Allow person to have some ownership of event
- Change of event does not mean a problem

Not Strengths Based

- Telling person what is best for them without including their opinion
- All or nothing resolve for outcomes

Change:

When something becomes different, or the result of something becoming different

Strengths based	Not Strengths Based
Allow for individuality	One size fits all
Acknowledge not all changes will be the same some are subtle	Expectations of things happening on case managers time frame
Allow persons to be their own experts	Not allow variation in consumers plan for change

The strengths model is ***highly effective***. We 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**

Engagement and Relationship – 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?

Engagement and Relationship (cont.)

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 that serve an obstacle.

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:**

Thorough, Detailed and Specific

- Take into consideration that each person’s journey is unique and highlight the uniqueness of each person you are working with.
- Get specific details and examples of interest or likes.
- Find information that is useful to that person’s journey.

Ongoing Process

- Information should be updated on a regular basis. Always learn something new about the person you are working with.
- Take into account the people and experiences that you encounter in different settings with the person you are working with.
- This is not just a piece of paper that you fill out in one session and file away in a chart, but and ongoing information gathering source that shares information that you learn about the consumer.

Conversational Manner

- We do not take a piece of paper and fill out boxes. Information should be obtain out of the flow of natural conversation with people.
- Pay attention to a person’s words and nonverbal ques.

From consumers perspective and own words

- Use a person’s words and quotes. Getting a person’s words is a good way to show that we heard what they had to say and validates what they say in discussion. It is also a good reference point for future discussions.

Evolve at the Consumers Pace

- Recovery is viewed as a journey and people travel at different paces.
- Make sure that the timing is appropriate to document things said and comfortable for the consumer.
- Never allowing writing things down to be more important than the development of the relationship with the consumer.

Should Occur in Community

- Gathering information in the person’s natural environment provides for possibilities to acknowledge things around the person that may never be brought to attention in an office setting.
- It may also foster an opportunity to meet neighbors, friends & family that will be part of the person’s recovery.

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

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 a**nd guidance.

Resource Acquisition

The purpose is to acquire the **environmental resources** desires 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.

Collective Continuous Collaboration and Graduated Disengagement (cont.)

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 (cont.)

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 Nine Quiz

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

2. The engagement relationship should be a partnership that consists of…

a. Reciprocation
b. Trust
c. Collaboration
d. All of the above
e. Empowerment

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

4. The goal of resource acquisition is to acquire environmental resources to keep the consumer segregated in their community.

a. True

b. False

5. The main concern with client and the goals on their personal plan is modifying their behavior & compliance.

a. True

b. False

Module Ten

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**).

The CM II must present and ***interacting***, ***teaching*****, or** ***supporting*** the defined learning objectives of the consumer **FOR ENTIRE CLAIMED TIME.**

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

EXAMPLES OF AREAS TO TARGET FOR SKILL DEVELOPMENT

Communication
Organizational
Social
Employment
Money Management
Memory
Conflict Resolution
Attention Span
Relationships
Planning
Prioritization
Relaxation
Relapse Prevention

Self-Motivation
Problem Solving
Assertiveness
Coping
Self- Care
Leadership
Teamwork
Housekeeping
Menu Planning
Food Storage
Meal Preparation

The United States of Psychiatric Rehabilitation Association Definition:

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.

The United States of Psychiatric Rehabilitation Association Definition cont.

Psychiatric rehabilitation services are **collaborative, person directed and individualized**. These services are an essential element of the health care and human services spectrum, and **must 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.

Rehabilitation is **much more than re-learning to do something.** It also encompasses processes, **skills and strategies aimed at supporting individuals to develop skills for the first time**.

Strategies and interventions that assist individuals to acquire new skills and build on their current skills necessary to participate in all domains of their life are also vital components of rehabilitation.

Psychiatric Rehabilitation

Psychiatric rehabilitation practice is guided by the basic philosophy of rehabilitation that people with disabilities **need opportunities to identify and choose for themselves their desired roles** in the community with regard to living, learning working and/or social environments.

Psychiatric Rehabilitation

Psychiatric rehabilitation should provide both **informal and formal** structures through which participants can influence and shape program development. The practice of psychiatric rehabilitation, is comprised of three strategies:

1. helping persons identify goals;
2. helping persons plan strategies and acquire necessary skills to reach and maintain desired goals; and
3. helping persons develop necessary supports to maintain those goals.

Psychiatric Rehabilitation

Psychiatric rehabilitation activities/techniques are designed to provide the person with the opportunity to:

1. become informed about the illness;
2. assess what is needed to recover;
3. choose rehabilitation goal(s); and
4. plan for and obtain the experiences needed to develop the skills to achieve recovery.

A key element of rehabilitation is **experiencing a valued role** in the community and obtaining and **using the power to make choices about one's life.** Such experiences are **essential to the cognitive and behavioral change** that underpin the recovery process for **any person**.

Psychiatric Rehabilitation

- Focuses on quality of life vs. treatment outcomes
- Highlights the consumer’s critical life roles
- Instills hope, increases motivation, improves cognitive skills that support change promotes respect & values personhood
- Builds real, functional skills that the consumer needs to live a meaningful life
- Focuses on outcomes, growth & mastery of skills and values the consumer’s input and participation

Psychiatric Rehabilitation

- Focuses and builds on existing strengths & skills
- Focuses on assessing and teaching skills for needed social roles
- Develops resources and modifies external supports (people, places, things and activities) which support the opportunity for change

Engagement Strategies

What are some of the strategies that you use when teach individual rehab and group rehab?

What are some of the strategies that you use when you assist with skill practice?

Tips and Strategies

- Asking/listening to their story
- Stating: “How can I help you?”
- Listen with empathy- make them feel that their story matters
- Avoid giving advice and solutions
- Acknowledge strengths and supports (people, places, things, activities)
- Always ask about immediate concerns
- Develop an authentic relationship; warmth, acceptance, empathy, objectivity, genuineness and caring concern

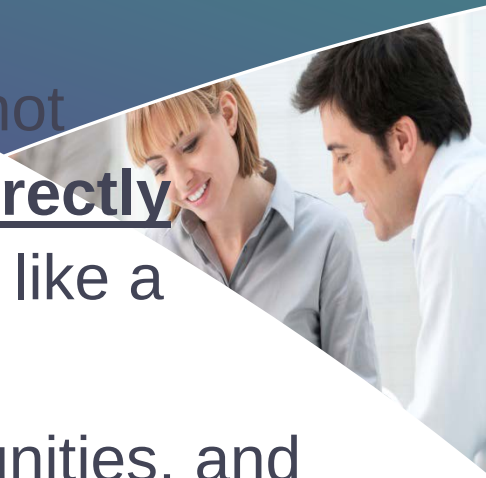
Module Eleven

The Principles & Practice of Psychiatric Rehabilitation

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.



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.

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.

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.

Question

What could be some of the issues or barriers when communicating with your consumer?

- 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)

- May not feel comfortable or willing to share information

Question

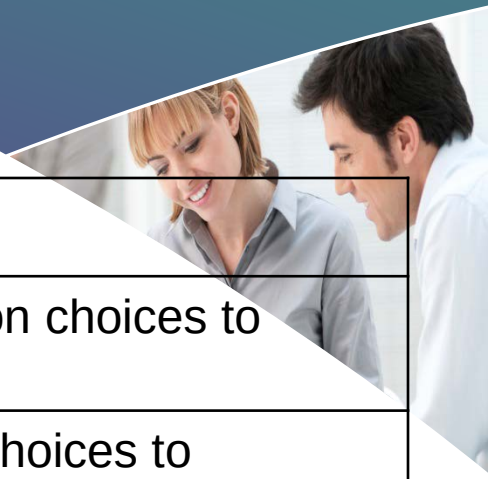
What are some skills or knowledge that would help you overcome these barriers when communicating with your consumer?

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- clarification, reflecting, reframing, paraphrasing & both verbal and nonverbal

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.

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

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

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.

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 individuals social environment and relationship with others. **What are some roles that your consumers have listed as value or that they would like to resume or improve?**

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.

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.

In the film clip from Module 3, Pat Deegan states that “medications can be a great tool in recovery but they can also **hinder** recovery and of this we must be very aware.”

http://www.youtube.com/watch?v=wXq8rd1IRHg

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.

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.

http://www.youtube.com/watch?v=qaXEbGW5mH4

Toolkit: http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

Illness Management and Recovery

- Recovery Strategies
- Practical Facts About Mental Illnesses
- Practical Facts About Schizophrenia
- Practical Facts About Bipolar Disorder
- Practical Facts About Depression
- Strategies and Resources f or Responding to Stigma
- The Stress-Vulnerability Model and Treatment Strategies
- Building Social Supports
- Using Medication Effectively
- Antipsychotic Medications

- Mood-Stabilizing Medications Illness Management and Recovery
- Antidepressant Medications
- Antianxiety and Sedative Medications
- Coping with Side Effects
- Drug and Alcohol Use
- Reducing Relapses
- Coping with Stress
- Relaxation Techniques
- Coping with Problems and Persistent Symptoms
- Getting Your Needs Met by the Mental Health System

Session Timeout
store.samhsa.gov/shi
store.samhsa.gov/shin/content//SMA09-4463/PractitionerGuidesandHandouts.pdf

Handout

Orientation to Illness Management and Recovery

The overall goals of IMR are to—

- Learn about mental illnesses and strategies for treatment;
- Decrease symptoms;
- Reduce relapses and rehospitalizations; and
- Make progress toward goals and toward recovery.

IMR practitioners will—

- Work side by side with you to help you move forward in your recovery process; and
- Provide information, strategies, and skills that can help you manage psychiatric symptoms and make progress toward your goals.

IMR includes—

- An orientation session to review the goals and expectations of the program;
- One or two sessions to get to know you better;
- Three to 10 months of weekly or biweekly sessions;
- Active practice of relapse prevention and recovery skills; and
- Optional involvement of significant others (family members, friends, practitioners, other supporters) to increase their understanding and support.

By participating in IMR, you agree to—

- Work side by side with the IMR practitioner to move forward in the recovery process;
- Learn about mental illnesses and principles of treatment;
- Learn and practice skills for preventing relapses and coping with symptoms; and
- Participate in assignments to practice strategies and skills outside of the sessions.

Throughout the IMR program, you and the IMR practitioner will strive for—

- An atmosphere of hope and optimism;

5:19 AM
2/21/2014

Session Timeout
store.samhsa.gov/shi
store.samhsa.gov/shin/content//SMA09-4463/PractitionerGuidesandHandouts.pdf

Topic 1: Recovery Strategies	
Introduction	This topic sets a positive and optimistic tone that is continued throughout the Illness Management and Recovery (IMR) Program. It conveys confidence that people who experience psychiatric symptoms can move forward in their lives. It introduces the concept of *recovery* and encourages consumers to develop their own definitions of recovery. In these sessions, IMR practitioners help consumers establish personally meaningful goals that will be followed up throughout the program.
Goals	■ Increase consumers' awareness of the concept of recovery and expand the possibilities of recovery in their own lives. ■ Identify personal recovery goals. ■ Develop a specific plan for achieving one or two personal recovery goals.
Handouts	Review and distribute IMR Handout—Topic 1: *Recovery Strategies* (for both individual and group sessions).
Number and pacing of sessions	This topic can usually be covered in two to four sessions. For each session, most IMR practitioners find that covering one or two topics and completing an exercise is a comfortable amount.
Structure of the sessions	■ Socialize informally and identify any major problems. ■ Review the previous session. ■ Discuss the homework from the previous session. Praise all efforts and problem-solve obstacles to completing homework. ■ Set goals or follow up on goals. ■ Set the agenda for today's session. ■ Teach new material (or review material from the previous session, if necessary). ■ Summarize progress made in the current session. ■ Agree on homework to be completed before the next session.
Strategies to be used in	■ Motivational strategies

5:21 AM
2/21/2014

store.samhsa.gov/shi ×
store.samhsa.gov/shin/content//SMA09-4463/PractitionerGuidesandHandouts.pdf

Topic 1: Recovery Strategies

Homework strategies	Ask consumers to do a homework assignment related to the topic. Say "Here are some ideas for homework assignments." ■ Write down what recovery means to you and bring it to the next session. ■ Design a cover for your IMR binder based on what recovery means to you. ■ Complete any exercises that you were unable to finish during the session. ■ After completing the exercise *Strategies for Recovery*, pick one strategy to try. For example, if you are interested in creative expression, sketch in a notebook every other day. ■ Ask a family member or other supporter to participate in a recovery strategy. For example, if you would like to play chess as a leisure activity, ask a sibling to play chess at least once during the week. ■ After completing the exercise *Step-by-Step Problem-Solving* and *Goal Achievement*, carry out one or more of the steps in the plan. For example, if your goal is to join a support group, contact the local peer support organization to find out about the schedule of their groups. ■ Review *Examples of recovery goals and strategies for pursuing them* in the IMR Handout—Topic 1: *Recovery Strategies*. Underline the parts that you find especially relevant. ■ Discuss the recovery examples with a family member or other supporter.

5:24 AM
2/21/2014

store.samhsa.gov/shi ×
store.samhsa.gov/shin/content//SMA09-4463/PractitionerGuidesandHandouts.pdf

Topic 1: Recovery Strategies

Tips for common problems

People may be reluctant to talk about recovery.

- Some consumers have been told, "You'll never get better," "You'll have to give up your goals," "You should never have children," or "You can't work." These messages are discouraging and often result in consumers' developing very low expectations for themselves. The notion that recovery is possible may not be consistent with consumers' self-concept of feeling like "a failure." You may need to help them challenge this view.
- Explore what consumers have heard from others and what they believe about recovery. Suggest alternative ways of looking at the future.

  If a consumer says, "When I first had symptoms they told me to give up on school," you could say, "I'm sorry someone told you that. They may have meant well, but it is not true that you should give up your goals. People with mental illnesses have skills and abilities they can use to accomplish personal goals in their lives."
- If consumers dwell on past setbacks and disappointments, gently re-direct them to think about the future. Express empathy, but do not remain focused on the past. For example, if consumers frequently talk about how they lost several jobs after becoming ill, you could say, "That must have been very difficult for you. Although you've had some setbacks, it doesn't have to be like that in the future. Let's talk about what might work better this time."

Consumers may find it difficult to identify goals.

- Before talking about goals, it may help to know more about consumers' lives. Consumers will provide substantial information when they complete the *Knowledge and Skills Inventory* at the beginning of the program. You can also ask:
  - "Where do you live? Do you like where you're living?"
  - "With whom do you spend time? Is there anyone you would like to spend more time with?"
  - "What is a typical day like for you? Is there anything you would rather be doing?"
- Discuss what consumers' goals were before they became ill by asking:

5:25 AM
2/21/2014

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.

http://cpr.bu.edu/research/completed/sustained-employment

http://www.youtube.com/watch?v=DoLO_p04uKY

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.

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.

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.**

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

http://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-Kit/SMA11-4654CD-ROM

http://cpr.bu.edu/wp-content/uploads/2011/09/Higher-Education-Support-Toolkit.pdf

Module Eleven

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

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 Twelve

Psychiatric Rehabilitation: Competencies

Competencies 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

A CM II demonstrates the following competencies

- **Communicate** with persons with psychiatric disabilities in order **to develop a collaborative relationship.**
- **Use collaborative relationships in order to facilitate personal change** in persons with psychiatric disabilities
- **Instill hope by engaging in positive interactions** (verbal and non-verbal communication) regarding an individual's potential for recovery from psychiatric disability

DOMAIN I. Interpersonal Competencies

Before entering the helping profession, a competent practitioner must consider:

a. Their initial motive for entering a helping profession
b. Personal biases that may influence the development of relationships
c. Personal values that may affect the services provided
d. All of the above

DOMAIN I. Interpersonal Competencies

Before entering the helping profession, a competent practitioner must consider:

a. Their initial motive for entering a helping profession
b. Personal biases that may influence the development of relationships
c. Personal values that may affect the services provided
d. **All of the above**

DOMAIN I. Interpersonal Competencies

Collaboration and partnership require:

a. Trust, an honest exchange of accurate information, and flexibility
b. Clarification of roles and responsibilities
c. Regular meetings to communicate effectively
d. Memorandums of understanding

DOMAIN I. Interpersonal Competencies

Collaboration and partnership require:

a. **Trust, an honest exchange of accurate information, and flexibility**
b. Clarification of roles and responsibilities
c. Regular meetings to communicate effectively
d. Memorandums of understanding

DOMAIN II. Professional Role Competencies

A CM II demonstrates the following competencies

- **Acquire knowledge** and skills in order to provide services that are **evidence-based and emerging best practices**
- **Facilitate informed decision making** by persons with psychiatric disabilities **by communicating information about laws and regulations affecting their rehabilitation and recovery**
- **Emphasize choices** for persons with psychiatric disabilities to help them achieve their goals

DOMAIN II. Professional Role Competencies

A CM II demonstrates the following competencies

- Provide **practical and meaningful activities** to persons with psychiatric disabilities to live in the environment of choice
- **Advocate** that persons with psychiatric disabilities **need to make informed choices to further their own recovery**
- **Promote the effectiveness** of psychiatric rehabilitation **with colleagues and the service delivery system**

DOMAIN II. Professional Role Competencies

A CM II demonstrates the following competencies

- **Maintain personal wellness** to ensure the effective provision of services to others
- **Take intentional personal action to support the recovery** of persons with psychiatric disabilities
- **Seek input and feedback from stakeholders** in order to **determine ways of improving services**
- **Recognize one's own role during conflict in order to facilitate resolution**

DOMAIN II. Professional Role Competencies

A consumer is looking for a job. He is concerned about losing his disability income and wants help in understanding his options. A practitioner can help by doing which of the following?

a. Send them to the Social Security office to ask questions
b. Give them a stack of regulations to read
c. Inform the consumer not to worry until after he gets employment
d. Make an appointment with the local vocational rehabilitation office, attend the appointment with them so you can learn about employment options

DOMAIN II. Professional Role Competencies

A consumer is looking for a job. He is concerned about losing his disability income and wants help in understanding his options. A practitioner can help by doing which of the following?

a. Send them to the Social Security office to ask questions
b. Give them a stack of regulations to read
c. Inform the consumer not to worry until after he gets employment
d. **Make an appointment with the local vocational rehabilitation office, attend the appointment with them so you can learn about employment options**

DOMAIN II. Professional Role Competencies

A consumer recently left their job as a recovery support specialist. After working for 3 or 4 years, they left because they did not feel respected and did not see any opportunities for advancement. You will do all of the following except:

a. engage in problem solving to plan how they will get a new job
b. provide supportive counseling, because they need to talk about being unemployed
c. refer them to a partial care program so they can work in the kitchen unit
d. encourage them to try whatever job they decide is best for them

DOMAIN II. Professional Role Competencies

A consumer recently left their job as a recovery support specialist. After working for 3 or 4 years, they left because they did not feel respected and did not see any opportunities for advancement. **You will do all of the following except:**

a. engage in problem solving to plan how they will get a new job
b. provide supportive counseling, because they need to talk about being unemployed
c. **refer them to a partial care program so they can work in the kitchen unit**
d. encourage them to try whatever job they decide is best for them

DOMAIN III. Community Integration

A CM II demonstrates the following competencies

- Develop linkages with a wide range of **community resources specific to meet the needs and goals** of persons with psychiatric disabilities
- Link persons with psychiatric disabilities to **appropriate entitlement and benefit programs**
- **Integrate community resources and entitlement programs into assessment, planning and outcomes**
- **Promote the use of natural supports** within the neighborhood and community of persons with psychiatric disabilities

DOMAIN III. Community Integration

A CM II demonstrates the following competencies

- **Challenge situations in the community that discriminate** against persons with psychiatric disabilities
- **Connect persons with psychiatric disabilities to legal and advocacy resources** as needed and/or requested in order to **promote self-advocacy**
- **Provide information on alternatives and complementary supports to traditional psychiatric treatment**
- **Develop community resources** to meet needs of persons with psychiatric disabilities

DOMAIN III. Community Integration

- A consumer lives with their parents and a supervised apartment becomes available. They ask the practitioner to find out if they can move into that apartment. The practitioner proceeds by:

- a. Tell them that it is a great idea and ask them to call you when they have made arrangements to move in
- b. Discussing all the problems with a supervised living environment so they know what they are getting themselves into
- c. Identifying all housing options that may meet their needs
- d. Encourage them to keep living with her parents because they take care of her

DOMAIN III. Community Integration

A consumer lives with their parents and a supervised apartment becomes available. They ask the practitioner to find out if they can move into that apartment. The practitioner proceeds by:

a. Tell them that it is a great idea and ask them to call you when they have made arrangements to move in

b. Discussing all the problems with a supervised living environment so they know what they are getting themselves into

c. **Identifying all housing options that may meet their needs**

d. Encourage them to keep living with her parents because they take care of her

DOMAIN III. Community Integration

A consumer lives with their parents and a supervised apartment becomes available. They ask the practitioner to find out if they can move into that apartment. The practitioner proceeds by:

a. Tell them that it is a great idea and ask them to call you when they have made arrangements to move in
b. Discussing all the problems with a supervised living environment so they know what they are getting themselves into
c. **Identifying all housing options that may meet their needs**
d. Encourage them to keep living with her parents because they take care of her

DOMAIN III. Community Integration

Which of the following is not an example of an informal support?

a. Family
b. Therapy groups
c. Church
d. Basketball league

DOMAIN III. Community Integration

Which of the following is not an example of an informal support?

a. Family
b. **Therapy groups**
c. Church
d. Basketball league

DOMAIN III. Community Integration

Advocates for community integration have cited several reasons for people with psychiatric disabilities to become engaged in civic life. Which of the following is a reason to engage in civic life?

a. Self-efficacy
b. Social integration
c. Personal interests
d. All of the above

DOMAIN III. Community Integration

Advocates for community integration have cited several reasons for people with psychiatric disabilities to become engaged in civic life. Which of the following is a reason to engage in civic life?

a. Self-efficacy
b. Social integration
c. Personal interests
d. **All of the above**

DOMAIN IV. Assessment, Planning & Outcomes

A CM II demonstrates the following competencies

- **Assist persons** with psychiatric disabilities **to identify personal priorities, preferences, strengths and interests in order to help them establish goals that are consistent with their worldview**

- **Perform holistic assessments across multiple life domains** with persons with psychiatric disabilities **in order to identify strengths, supports and barriers**

- **Collaborate with persons** with psychiatric disabilities to help them **identify their individual preferences in dealing with crises**

DOMAIN IV. Assessment, Planning & Outcomes

A CM II demonstrates the following competencies

- **Collaborate with persons** with psychiatric disabilities **to write goals with specific action steps in order to develop effective treatment/rehabilitation/recovery plans**

- **Identify opportunities that empower persons** with psychiatric disabilities **transition from professional provider service so natural community supports**

DOMAIN IV. Assessment, Planning & Outcomes

A CM II demonstrates the following competencies

- **Regularly evaluate** with the service recipient, his/her **satisfaction with progress toward rehabilitation goal**
- **Modify the rehabilitation plans based** on service recipient's **evaluation of progress toward rehabilitation goal**
- **Consult with individuals and their self-identified participants** in their recovery about the individual's satisfaction with current **progress toward rehabilitation goal**

DOMAIN IV. Assessment, Planning & Outcomes

What is the purpose of the functional assessment in rehabilitation services?

a. To set rehabilitation goals
b. To diagnose symptoms
c. To identify skill learning needs
d. To identify resource needs

DOMAIN IV. Assessment, Planning & Outcomes

What is the purpose of the functional assessment in rehabilitation services?

a. To set rehabilitation goals
b. To diagnose symptoms
c. **To identify skill learning needs**
d. To identify resource needs

DOMAIN IV. Assessment, Planning & Outcomes

What is the most important reason to get input from the person with whom you are working as you begin the process of goal setting?

a. To placate the person so he will want to follow the plan you make for them

b. To identify things that are not accomplishable

c. To recognize that the person is their own expert in what works and what is needed

d. Most jobs require that you get input from those you serve

DOMAIN IV. Assessment, Planning & Outcomes

What is the most important reason to get input from the person with whom you are working as you begin the process of goal setting?

a. To placate the person so he will want to follow the plan you make for them

b. To identify things that are not accomplishable

c. To recognize that the person is their own expert in what works and what is needed

d. Most jobs require that you get input from those you serve

DOMAIN IV. Assessment, Planning & Outcomes

Choose the best reason to modify a person's rehabilitation plan.

a. Your agency requires the plan to be reviewed every 6 months

b. The person says that they are tired of working on the current goals and wants to change. You suspect it's due to lack of progress

c. The person has just been released from the hospital and is not doing as well as everyone had hoped

d. Recovery is an ongoing process. The person is constantly developing new strengths/skills and reducing deficits. Plans need to be modified to accommodate these changes

DOMAIN IV. Assessment, Planning & Outcomes

Choose the best reason to modify a person's rehabilitation plan.

a. Your agency requires the plan to be reviewed every 6 months

b. The person says that they are tired of working on the current goals and wants to change. You suspect it's due to lack of progress

c. The person has just been released from the hospital and is not doing as well as everyone had hoped

d. **Recovery is an ongoing process. The person is constantly developing new strengths/skills and reducing deficits. Plans need to be modified to accommodate these changes**

DOMAIN V. Interventions for Goal Achievement

A CM II demonstrates the following competencies

- **Use outreach techniques,** including telephone, mail and personal visits**, in order to engage persons with psychiatric disabilities in interventions**
- **Teach communication skills** to persons with psychiatric disabilities **to help them achieve their goals**
- **Provide interventions for change** to persons with psychiatric disabilities in order to promote the recovery process

DOMAIN V. Interventions for Goal Achievement

A CM II demonstrates the following competencies

- **Develop relapse prevention strategies** for mental and physical health and co-occurring disorders
- **Utilize group formats to engage persons with psychiatric disabilities in a wide range of activities**

DOMAIN V. Interventions for Goal Achievement

A CM II demonstrates the following competencies

- **De-escalate crises** experienced by persons with psychiatric disabilities **in order to avoid negative outcome**
- **Modify environments** of persons with psychiatric disabilities strategies **to initiate and sustain the recovery process**
- **Use motivational enhancement and readiness** development strategies **to initiate and sustain the recovery process**

DOMAIN V. Interventions for Goal Achievement

A CM II demonstrates the following competencies

- **Encourage persons** with psychiatric disabilities to **continue fulfillment of desired roles**
- **Provide education on issues related to psychiatric disabilities** (e.g., etiology, course and biological factors of psychiatric disorders; psychiatric rehabilitation, psychotropic medication and other mental health approaches; and legal issues, benefits and entitlements)
- **Provide best-practice procedures, treatments, and approaches** which help persons with psychiatric disabilities achieve their goals.

DOMAIN V. Interventions for Goal Achievement

A female consumer is upset about her roommate always borrowing her clothes without asking. She is pacing and shouting. How should you react?

a. Call the local psychiatric emergency services
b. Ignore her so she they will calm down by herself
c. Ask the roommate to calm her down
d. Assess the situation by talking to her to help de-escalate the crisis

DOMAIN V. Interventions for Goal Achievement

A female consumer is upset about her roommate always borrowing her clothes without asking. She is pacing and shouting. How should you react?

a. Call the local psychiatric emergency services
b. Ignore her so she they will calm down by herself
c. Ask the roommate to calm her down
d. **Assess the situation by talking to her to help de-escalate the crisis**

DOMAIN V. Interventions for Goal Achievement

75. The following are steps in establishing goals. **First-** determine the individuals hopes and dreams; **second-** agree on the first step to take towards reaching the goal; **third**- identify barriers and address these first; **fourth**- set time lines for accomplishing steps toward the goal. Which steps does the practitioner use in setting goals with the individual?

a. All of the above
b. First & second
c. First, second & fourth
d. First & fourth

DOMAIN V. Interventions for Goal Achievement

75. The following are steps in establishing goals. First- determine the individuals hopes and dreams; second- agree on the first step to take towards reaching the goal; third- identify barriers and address these first; fourth- set time lines for accomplishing steps toward the goal. Which steps does the practitioner use in setting goals with the individual?

a. All of the above
b. First & second
c. **First, second & fourth**
d. First & fourth

DOMAIN VI. System Competencies

A CM II demonstrates the following competencies

- **Intervene to stop stigma, oppression, discrimination, and prejudice** against persons with psychiatric disabilities **in order to increase their access to jobs, housing and community activities**

- **Advocate for better access to public services and resources** for persons with psychiatric disabilities in order to **facilitate their recovery and full integration into the community**

- **Advocate for needed regulatory policies related to persons** with psychiatric disabilities in order to reduce discrimination and to increase resources for services and accommodations

DOMAIN VI. System Competencies

A CM II demonstrates the following competencies

- **Advocate for system integration among public resources and community resources** in order to **expand opportunities for persons with psychiatric disabilities**
- **Advocate for system changes** to make services **responsive to the needs of persons with psychiatric disabilities**
- **Advocate civil rights and protections as well as human rights and protection** for persons with psychiatric disabilities

DOMAIN VI. System Competencies

A CM II demonstrates the following competencies

- **Assist persons** with psychiatric **disabilities in their use of other service systems to meet their personal goals**

- **Develop leaders** among persons with psychiatric disabilities **in order to advocate for and work with peers**

DOMAIN VI. System Competencies

Your organization wants to improve its services to be more culturally sensitive. Which of the following should be included?

a. Individuals and family members
b. Staff members
c. Community leaders
d. All of the above

DOMAIN VI. System Competencies

Your organization wants to improve its services to be more culturally sensitive. Which of the following should be included?

a. Individuals and family members
b. Staff members
c. Community leaders
d. **All of the above**

DOMAIN VI. System Competencies

A veteran who has been homeless on and off for 5 years has been working a 12-step program and has not had a drink in 4 months. His psychiatric symptoms are under control and he is working busing tables. He wants to enter a supported housing program that will not accept him because he has not been sober for 6 months. What should you do?

a. Tell them that those are the rules and that he will have to stay in the shelter for 2 more months

b. Have them talk to their family and encourage them to take them for 2 months

c. Go to the program's funding source and advocate for the program to lose their funding because the rules aren't fair

d. Together, meet with the program director and to discuss the consumer's recovery program. Try to convince them that the consumer has demonstrated a stage in their recovery that is consistent with what they want and that the strict rule is not valid in this situation

DOMAIN VI. System Competencies

A veteran who has been homeless on and off for 5 years has been working a 12-step program and has not had a drink in 4 months. His psychiatric symptoms are under control and he is working busing tables. He wants to enter a supported housing program that will not accept him because he has not been sober for 6 months. What should you do?

a. Tell them that those are the rules and that he will have to stay in the shelter for 2 more months

b. Have them talk to their family and encourage them to take them for 2 months

c. Go to the program's funding source and advocate for the program to lose their funding because the rules aren't fair

d. **Together, meet with the program director and to discuss the consumer's recovery program. Try to convince them that the consumer has demonstrated a stage in their recovery that is consistent with what they want and that the strict rule is not valid in this situation**

DOMAIN VII. Diversity & Cultural Competency

A CM II demonstrates the following competencies

- Engage and include persons with psychiatric disabilities from all the diverse backgrounds (e.g., socio-economic status, race, ethnicity, gender, sexual orientation, age, nationality, disability status, religion, spirituality) that comprise the demographics of the community where services are provided.
- **Identify one's own culturally learned assumptions** (e.g., ethnocentrism, cultural encapsulation) **to promote culturally competent collaborative relationships** with persons with psychiatric disabilities and their natural support systems (e.g., families, significant others, friends, community supports)

DOMAIN VII. Diversity & Cultural Competency

A CM II demonstrates the following competencies

- **Assess cultural factors to ensure culturally competent diagnoses, goals, planning, and rehabilitative interventions**
- **Conduct all rehabilitation activities in the preferred language and communication style** (e.g., verbal and non-verbal, slang, eye-contact, personal space) of individuals and their natural support systems
- **Remove institutional barriers that sustain stigma, oppression, discrimination, add prejudice in order to provide culturally competent service**

DOMAIN VII. Diversity & Cultural Competency

A CM II demonstrates the following competencies

- **Teach persons with psychiatric disabilities and their natural support systems the skills to recognize and overcome cultural barriers**
- **Receive input and provide feedback to persons** with psychiatric disabilities and their natural support systems **in order to provide services that meet their needs**
- Evaluate service utilization rates to determine consistency with community demographics

https://uspra.ipower.com/Certification/2008_Multicultural_Principles.pdf

Module Thirteen

Psychiatric Rehabilitation: 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

- What is the individuals present and needed level of functioning for the defined critical skills?
- What community resources and supports will facilitate progression toward normalized roles and responsibility in family and community life.
- What methods will you use to measure level of functioning? (direct observation, report of others, self report, role plays)

What is a skill?

- An ability acquired by systematic effort to do something well. Skills may be physical, intellectual, emotional or social (behavioral)
- It can be observed, taught and measured
- It’s not a state of being: “having good self-esteem”
- Should increase success and satisfaction with the individuals roles and environments
- Requires knowing the role and environmental demand of the individual

EXAMPLES OF AREAS TO TARGET FOR SKILL DEVELOPMENT

- Communication
- Organizational
- Social
- Employment
- Money Management
- Memory
- Conflict Resolution
- Attention Span
- Relationships
- Planning
- Prioritization
- Relaxation
- Relapse Prevention
- Self-Motivation
- Problem Solving
- Assertiveness
- Coping
- Self- Care
- Leadership
- Teamwork
- Housekeeping
- Menu Planning
- Food Storage
- Meal Preparation

Critical Skills

Child:

- Asking for help
- Completing homework independently
- Conversing with classmates
- Sharing anxious feelings with teacher and family
- Waiting for a turn in class

Adult:

- Conversing with neighbors
- Managing Anger
- Improving Hygiene
- Managing Time
- Planning a balanced/nutritious meal
- Cooking a simple meal
- Managing money

Strategies to Provide More Effective Interventions

Objective: Consumer will learn/restate to reflect learning & practice 3 positive grooming habits.

Skill Measure: The number of times per week that you want the Individual to take a shower

1. Describe when, where, and with whom they need to practice the skill (circumstances)
2. Describe what they need to say when performing the skill (behavior)
3. Describe the way of measuring the skill (frequency)

Strategies to Provide More Effective Interventions

Skill:

Hygiene/Taking a shower

Consumer will take a **(# or frequency**) shower each day- in the morning when they wake up or at night before they go to bed (**when**).

Needed= 7 Present= 2 (measurement)

Strategies to Provide More Effective Interventions

Objective: Consumer will learn and practice 1 or more way(s) to express anger appropriately.

Measure skill: The number of times per week that you want the individual to use this skill

1. Describe when, where, and with whom they need to practice the skill (circumstances)
2. Describe what they need to say when performing the skill (behavior)
3. Describe the way of measuring the skill (frequency)

Strategies to Provide More Effective Interventions

Skill:

Expressing Anger:

Consumer will use “I statements” when they are upset at home and at school **(when/where)** @ least 1 time daily **(frequency)** to decrease anger outbursts that get him taken out of class and arguments with friends/family etc.

Measurement:

Use of “I statements”

Needed= 7 Present= 0 **or**

Number of anger outbursts

Present= average 3 per day Needed= 0 per day

Strategies to Provide More Effective Interventions

Other

Curriculum Objectives: (could be used in service plan)

1. Consumer will learn 3 elements of anger. (fear, hurt, frustration)
2. Consumer will learn 3 physical symptoms of anger and restate to reflect learning.
3. Consumer will learn 3 benefits of good anger control and restate to reflect learning.
4. Consumer will learn 3 anger management techniques.
5. Member will learn 3 ways to express anger appropriately.
6. Member will learn and practice 3 ways to reduce anger.

Example of Orientation

Today, we are going to work on the skill of expressing Anger. Remember during our last session we talked about The importance of expressing your anger with words in a calm way and not by screaming or with certain actions.

This will help you reach your goal of having more friends and not being asked to leave places when you go out in the community.

This is why we will work together and I will teach you how to express your anger and then you will practice using the skill with me.

Strategies to Provide More Effective Interventions

ROPES

Review-

- discuss prior positive or negative experience when using this skill
- connect learning the skill to the overall goal
- only talk about the skill name

Example: 1. " Today we are going to learn the skill of introducing yourself. Can you tell what it's been like when you have tried to do this in the past? Why would you like to learn this skill?

2. Today we are going to learn the skill of expressing when you're upset. Can you tell me what it has been like when you've tried to do this in the past? Why would you like to learn this skill?

Strategies to Provide More Effective Interventions

ROPES

Overview-

- Explain & demonstrate the skill
- Explain the benefits of learning the skill
- The skill behavior is an essential part of the larger skill and when done together result in the skill being done
- Demonstrated in a developmentally, educationally and culturally relevant way

Strategies to Provide More Effective Interventions

ROPES

Overview-

Write/say- 1. Introducing yourself means saying a greeting and your name (skill definition)

Discuss the reasons why learning the skill will be helpful (skill benefit)

Share- the 4 behaviors of introducing yourself that we are going to learn is making eye contact, smiling, saying a greeting and stating your name

Strategies to Provide More Effective Interventions

ROPES

Overview-

Write/say- 2. Managing or expressing your anger means saying an "I statement": I feel angry when and naming the event/behavior that has made you upset/angry listening to the other person and their response to your statement and following your anger control plan **(skill definition)**

Discuss the reasons why learning the skill will be helpful **(skill benefit)**

Share- the 5 behaviors of managing/expressing your anger that we are going to learn is making eye contact, saying an "I statement", stating what has made you upset/angry, listening to the other person's response an developing/following an anger control plan.

Sample: Anger Control Plan

1 Take a timeout (formal or informal)

2. Talk to a friend (someone you trust)
3. Use the Conflict Resolution Model to express anger
4. Exercise (take a walk, go to the gym, play basketball etc.
5. Attend 12-Step meetings, visit a friend, talk to parent(s),
6. Explore primary feelings beneath the anger

http://store.samhsa.gov/product/Anger-Management-for-Substance-Abuse-and-Mental-Health-Clients-Participant-Workbook/Most-Popular/SMA13-4210?sortBy=4

Strategies to Provide More Effective Interventions

ROPES

Overview-

Show- 1. Demonstrate how to introduce yourself
2. Demonstrate how to express when your upset

Ask- when do you think that this would be helpful? (should tie back to the goal/objective)

Talk about- 1. How lonely the individual has been and wants to meet other people
2. How do you feel when your asked to leave class, friends/family don't wan to be around you coach takes you out of the game etc.

Strategies to Provide More Effective Interventions

Presentation:

Tell- the components of introducing yourself are to make eye contact, saying a greeting

Show- demonstrate or show a video of how to introduce yourself

Tell- making good eye contact is important because it allows you to focus your attention, smiling puts people at ease **etc**.

Ask- what happens when someone makes eye contact and smile with you? What does it mean to you

Do- have them practice making eye contact, smiling and introducing themselves

Strategies to Provide More Effective Interventions

Presentation: how you do the behavior

Tell- The behaviors of managing/expressing anger are making eye contact, making an “I statement” stating the event that has caused you to be upset/angry, listening to the other person’s response and following your anger control plan. contact

Show- demonstrate the behaviors listed above

Tell- making good eye contact and stating your emotions are important because it will help to keep your job, stay in class, have better relationships at work/home/school/sports team etc.

Ask- what happens or would happen if /when someone expresses their emotions in this way? What does/would it mean to you?

Do- have them practice the behaviors listed above & provide feedback and praise- **ALWAYS START WITH THE POSITIVE & DON’T USE BUT… ☺**

Strategies to Provide More Effective Interventions

Exercise: how you do the behavior

Ask- now I want you to practice the skill of introducing yourself OR expressing your anger with me; remember to use all of the behaviors we learned

Ask: When you go… I want you to practice and tell me me how it goes at our next session. Give them a checklist, worksheet or even ask them to journal…..

*** Homework is great for the consumer & family! Even if they don't complete when you first meet w/ them- KEEP ASKING ☺

This can be a great way to measure progress as well.

Strategies to Provide More Effective Interventions

Summary:

Ask-

What did you learn? Can you tell me the steps of introducing yourself/expressing & managing your anger?

Can you tell what you think the benefits are of learning/practicing this skill?

(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.

**** **This allows you to measure progress & get accurate information for your progress note**

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

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

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

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?

Group
Intervention Strategies

Which of the following are key elements to facilitation that a practitioner 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

Group
Intervention Strategies

Which of the following are key elements to facilitation that a practitioner 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

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
- Prompting/coaching positive feedback
- Integrate teaching/learning principles

Skills Training
Intervention Strategies

- 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

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

Family Intervention Strategies

- 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

Family Intervention Strategies

- 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

http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423

Family Intervention Strategies

Which of the following **is not an example** of demonstrating best practices in family interventions?

a. Encouraging family members to balance meeting their own individual needs and life roles with the role of the family in overall treatment

b. Educating the individual on the meaning of the person's diagnosis and explaining the impact the their illness

c. Encouraging the family to be advocates for their family member in the community and treatment provider system

d. Discussing threats, intimidation, and violence openly. Developing action plans with family members

Family Intervention Strategies

Which of the following **is not an example** of demonstrating best practices in family interventions?

a. Encouraging family members to balance meeting their own individual needs and life roles with the role of the family in overall treatment

b. **Educating the individual on the meaning of the person's diagnosis and explaining the impact the their illness**

c. Encouraging the family to be advocates for their family member in the community and treatment provider system

d. Discussing threats, intimidation, and violence openly. Developing action plans with family members

Module Fourteen

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.

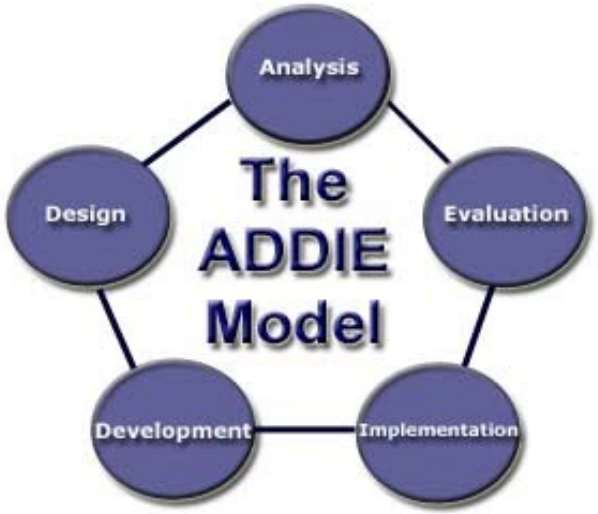
When designing and developing programs that support recovery and provide the pathways to full productive lives, you will need to take a systematic approach that will assist in creating and effective and efficient learning environment for your target learner or learner group.

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.

Implement

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

Evaluate

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**

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 Serous 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 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.

- <u>Principles</u> – 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.
- 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 it's 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**.

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.

Ex: In Achieving Goals 101 class, participant will learn the difference and potential benefits of being proactive versus reactive.

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.

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:

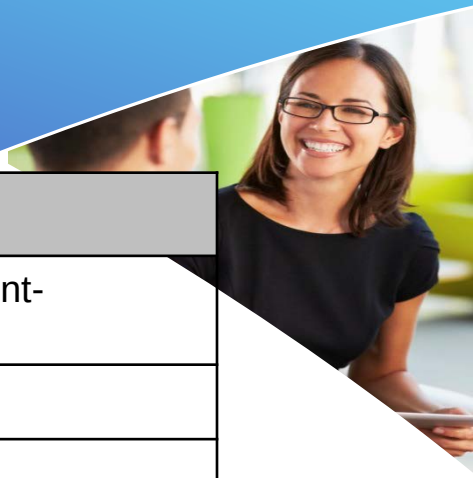
- **Pretest & Posttest** (which may **include multiple choice questions**)
- **Attitudinal questionnaires** that ask about the learner's attitudes toward learning, instructional material and subject matter (ex: **rating scales** completed by the consumer's after each training session).
- **Observation 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.
Encourages active participation by all individuals
Does not dominate
Illustrates application of knowledge (gives examples).

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

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:

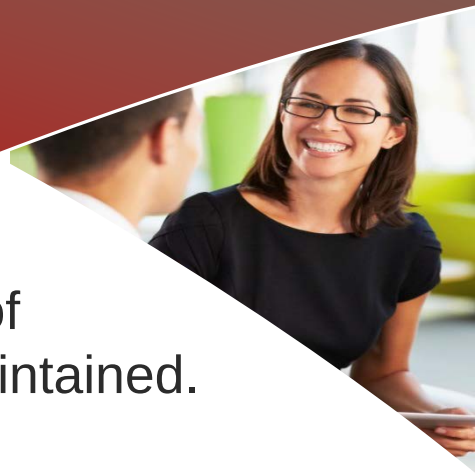
- Teach
- Prompt consumer response to educational content to verify that learning is occurring
- Prompt consumer practice of skills
- Observe consumer practice, and provide feedback

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.

Tying everything together

During the strengths based assessment, the individual shares information about how their mental illness has impacted their life.

Assessment

They share that they are having difficulty communicating with their PCP about their medical needs & their psychiatrist about the side effects of their medications & the symptoms they continue to experience.

They also share that they would like to have a girlfriend and go back to school and take a few college courses but they have limited social skills and have severe feelings of anxiety at the mere thought of approaching & interacting with people that they don't know.

" I have never been able to complete anything and fear that I never will. I get overwhelmed very easily, try to do too many things at once end and end up having and have panic attacks. "

In addition, they let you know that they had a very close relationship with their family but it is currently strained because of his actions while he experienced his psychiatric symptoms and was off his medications.

SERVICE PLAN

Goal: I want to have a girlfriend, go back to school and be close to my family again".

CM Objectives:

- John will participate in linkage efforts to access needed educational & financial aid resources to begin general education courses at the local community college.
- John will participate in advocacy efforts to help her access needed financial and ADA accommodations to be stay in school.
- CM will follow up with the consumer and monitor and advocate with school officials to ensure that the consumer has the needed resources to stay in school.
- John will participate in linkage efforts to find social outlets to meet women.

SERVICE PLAN

Problem: John is having difficulty setting and achieving goals

He has difficulty with time management and prioritizing his activities.

He also wants to have satisfying relationships.

Goal: I want to have a girlfriend, go back to school and be close to my family again".

Rehabilitation Objectives:

- Consumer will l learn the characteristics and differences between proactive and reactive.
- Consumer will learn 3 skills to manage and prioritize their activities. – **How can we break this down**
- Consumer will learn 1 or more characteristics of being a good student & restate to reflect learning.
- Consumer will learn 1 benefit of asking for help when it is needed and restate to reflect learning.

SERVICE PLAN

Problem: John is having difficulty setting and achieving goals. He has difficulty with time management and prioritizing his activities. He also wants to have satisfying relationships.

Goal: I want to have a girlfriend, go back to school and be close to my family again".

Rehabilitation Objectives:

- Consumer will learn 1 or more elements of safe sex and restate to reflect learning.
- Consumer will learn and practice 1 or more relaxation techniques.
- Consumer will learn 1 or more benefits of having good social skills and practice @ least one per session &/or restate to reflect learning.

Curriculum based rehab services

Curriculum: Achieving Goals 101- From Steven Covey's *7 Habits of Highly Effective People*

Objectives:

- Participant will learn 3 skills to manage and prioritize their activities

Habit 2- Put First Things First- "Create a clear, mutual understanding of what needs to be accomplished, focusing on what, not how; results not methods. Spend time. Be patient. Visualize the desired result."

Curriculum based rehab services

Curriculum: Achieving Goals 101- From Steven Covey's *7 Habits of Highly Effective People*

Objectives:

- Participant will learn the characteristics & the difference between being proactive and reactive.

Habit 1: Be Proactive- Being proactive can help eliminate problems before they appear and can make execution of your tasks more efficient. Taking initiative does not mean being pushy, obnoxious, or aggressive. It does mean recognizing our responsibility to make things happen." vs.

Reactive- can lead to unforeseen problems in execution that may require extensive time and effort to solve or correct.

Progress Note

(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.

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

John attended rehabilitation group today and the curriculum used for this group was Achieving Goals 101. This clinician taught the objective for this week: “Participant will learn the characteristics and differences between proactive and reactive individuals”. John presented somewhat agitated and unwilling to engage but, with support from this clinician, was able to appropriately interact with the group & restate 1 benefit of being proactive vs. reactive. “Being proactive could help me be successful in school and maybe even get close to my family again and get a girl. Having a plan might help me have more control, stay on track and become less frustrated so I won’t just stop this time.” John appears to be making some progress in improving his social skills, but needs continued skill development to obtain his desired goals.

Documentation Activity

- Strengths Based Assessment-
- Take notes from the video; complete the assessment based on the information that the “client’ provides the “CM”
- What are the strengths of the “client”?
- What are the strengths of the “CM”? Anything that you learn/could use ?
- What you do differently? Any suggestions?

Strengths Based Assessment Videos

- http://www.youtube.com/watch?v=RD4i3te8bK8
- http://www.youtube.com/watch?v=3asPVEafMDs
- http://www.youtube.com/watch?v=y-4nny7tSEU
- http://www.youtube.com/watch?v=Sf2nc5i7d5A
- http://www.youtube.com/watch?v=yI-0unDB3oo
- http://www.youtube.com/watch?v=0S42jPwP2p0

Documentation Activity

- Service Plan Development-
- Write one goal- use client’s own words
- Write @ least one CM objective
- Write @ least one rehabilitation objective

Documentation Activity

- Curriculum Development-
- Use the 7 Habits of Highly Effective People handout
- Choose a target skill development area (see handout) that would help the “client” achieve the goal/objectives that are on his service plan
- Name the curriculum (Ex: Achieving Valued Roles 101)
- Write @ least one objective from the Stephen Covey handout that would relate to the target skill area that you chose
- Progress Note- write a note based on your observations

Goal:

“ Be able to sleep, concentrate, get a job to support my family; calm voices and stop arguing with my wife’

Curriculum:

- Self Esteem 101

- Problem- consumer lacks the self-esteem/confidence. Their negative self-view impacts their ability to maintain positive relationships, try new things and function within his employment and familial roles.

Objectives:

MODULE Twelve 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