CourseBooks Series

Psychosocial Rehabilitation CourseBook

Spring 2018

Mark H. Kavanaugh, Ph.D. and Wendy St. Pierre, Ph.D.

The m-Learning Initiative

The multi-touch book that you have has been designed to house the content for a college course titled MHT 124: Psycho-social Rehabilitation at Kennebec Valley Community College. The course is part of KVCC's Mental Health Program which leads students to the attainment of the State of Maine's Mental Health Rehabilitation Technician / Community certification.

KVCC's Mental Health Program staff created the **m-Learning Initiative** and developed a 1:1 Apple iPad program. Curricula in the program has been geared to take advantage of the hard-ware and software tools of the iPad to:

- Enhance in-class teaching methods.
- Elevate assessment and evaluation of authentic artifacts that demonstrate student learning.
- Increase student-to-student interaction and student-to-teacher interaction.
- Prepare students for the mobile-computing based work-place emerging in Community Mental Health.

CourseBooks

The CourseBook series is a creation of Dr. Mark Kavanaugh. Dr. Kavanaugh created the Mental Health degree program at KVCC in 2006 and has taught in the program ever since.

This eBook series has been developed to enhance the delivery of course content across the entire program and take advantage of the tools within Apple's ecosystem in order to deliver more engaging course materials with embedded interactions, video, and links to apps and web content that support teaching and learning.

The content of these CourseBooks have been developed by the authors and represents independent scholarly activity on the part of each author who has contributed to the development of each CourseBook.

How to use this CourseBook

For the students within the Mental Health Program, the content of this CourseBook aligns with activities, expectations, and assignments that are found in the KVCC Learning Management System (LMS).

Students are expected to read and absorb the information in the CourseBook, review the Assessment expectations outlined in each Chapter, and participate in the expectations set by the Instructor of the course in the LMS.

Chapter Organization

Each (content) Chapter in the CourseBooks has been organized using the Instructional Design Method developed by Dr. Kavanaugh. This design model provides an outline of course materials that adheres to long-standing instructional design theory for adult learners. Namely, the model is greatly influenced by Gagne's Nine Events of Instruction.

ALOTA

The ID Method is called ALOTA.

ALOTA is an acronym for the four essential parts of a lesson plan (or, in this case, chapter).

Attention
Learning Outcomes
Teaching
Assessment

Each Chapter in the CourseBooks series is organized in this manner in order to guide students through the material they are expected to learn.

Here are brief descriptions of what you may find in each of these sections.

- **Attention**
  - Images, videos, and text that bring the reader into the focus of the lesson.
- **Learning Outcomes**
  - Adhering to the language of Blooms Taxonomy of Learning Objectives, this section outlines the performance-based learning outcomes for the lesson. These align with the Assessment section of each lesson.
- **Teaching**
  - This section can contain any variety of resources including text, lectures, recordings, videos, and links that provide a pathway through material to assist students in readying themselves for the Assessments.
- **Assessments**
  - This section outlines assignments for the student to engage in to demonstrate their learning.

Apps in the CourseBook

Because one of the central goals in the Mental Health Program is to develop advanced digital skills on mobile devices, we have included links to specific apps that students use in the context of their learning experiences.

These apps have been selected to enhance understanding of the material, to provide additional resources and information, and/or to challenge students to demonstrate their learning in innovative and creative ways.

In addition to direct links to the apps, there are additional links that have been included in the CourseBook that connect students to another resource in the CourseBook series.

When students encounter this button in a CourseBook...

...selecting it will open a corresponding chapter in a book titled **iOS and App Tutorials CourseBook**. This CourseBook has been designed to provide detailed introductions to and tutorials on all of the apps that have been integrated into the CourseBooks.

When you select this button for the first time you will be asked to download the **iOS and App Tutorials CourseBook** to your device.

Subsequent selections of the button will open the CourseBook to the corresponding chapter.

Download this book now by clicking the image of the CourseBook.

Text Link

Mental Health Core Content CourseBook

In order to remain consistent with some of the core content related to the courses in the Mental Health program, we have created an additional resources.

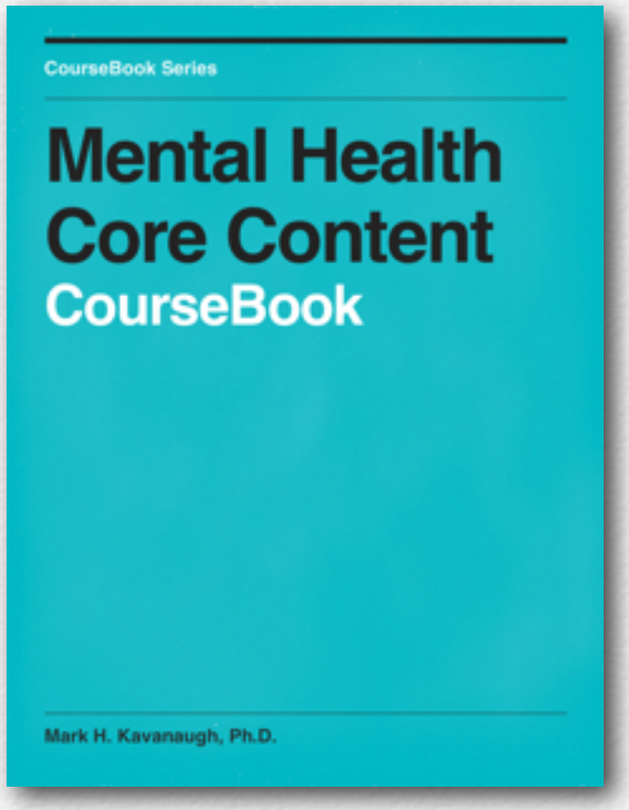
This CourseBook contains references to core concepts, material, practices, principles, standards, etc. that are used across every CourseBook and course in the program. Content in this reference will be accessed from within each CourseBook in a similar way you would access tutorials to apps in the iOS and App Tutorial CourseBook.

Look for this link when you are being guided toward looking at core content.

When you select this button for the first time you will be asked to download the **Mental Health Core Content CourseBook** to your device.

Subsequent selections of the button will open the CourseBook to the corresponding chapter.

Download this book now by clicking the image of the CourseBook.



Text Link

State of Maine MHRT/C Learning Outcome Guidelines

The content of this course is developed in line with the competency requirements for the State of Maine Mental Health Rehabilitation Technician / Community certification.

Below you will find a list of each of the Learning Outcomes associates with the competency and indication of the content and assessments related to those specific Learning Outcomes.

Competency - Psychosocial Rehabilitation

Learning Outcomes and Content/Assessment Map

1. Aware of outcomes-based research regarding people with psychiatric disabilities.
    - *Chapter 2 Assignment A - Part II: Outcomes-based Research on Treatment*
    - *Chapter 11 Assignment - Part II: Research on Housing and Mental Illness*
    - *Chapter 13 Assignment: Alternative Treatments*
    - *Chapter 15 Assignment: Motivational Interviewing*
2. Knowledgeable about collaborative planning with people with psychiatric disabilities including the following: goal setting, skill assessment and training, and linking with supports in the community.

- *Chapter 2 Assignment B - Part II: Informal Treatment Plan*
- *Chapter 7 Assignment: Treatment Planning*
- *Chapter 12 Assignment: Educational Resources Treatment Plan*

3. Identifies and respects consumer choice.

- *Chapter 2: PSR in the Context of Treatment*
- *Chapter 6: Values of PSR*

4. Knowledge of generic community resources including available natural supports.

- *Chapter 1 Assignment: Digital Resources Evaluation*
- *Chapter 5 Assignment: Personal skills that are applied to rehabilitation with clients.*
- *Chapter 9: Clubhouses*
- *Chapter 9 Assignment: Psycho-educational opportunities at Club Houses.*
- *Chapter 10: Vocational Rehabilitation*
- *Chapter 11: Residential Services and Housing*
- *Chapter 12: Educational Supports*
- *Chapter 14: Case Management and Community Integration*
- *Chapter 16: Family Supports*

5. Understands strategies that empower consumers.

- *Chapter 4: Goals, Values, Principles, and Practices of PSR*
- *Chapter 10 Assignment: Formal and Informal Workplace Culture*
- *Chapter 10 Discussion: Vocational Choices*

Mark H. Kavanaugh, Ph.D.

Mark Kavanaugh has been writing, teaching, and integrating technology into instruction for decades. He holds a Masters in Counseling, Masters in Instructional and Performance Technology, and a Ph.D. in Educational Psychology.

Mark lives in Maine with his wife Katie.

Visit Mark's Website

Text Link

Introduction to Psychosocial Rehabilitation

1

Attention

Mental Illness and PSR

Mental illness is a category of mental condition that is characterized by chronic, pervasive, and persistent symptoms that dramatically impact a person's life.

Understanding these three qualities of mental illness is key to understanding the need for Psychosocial Rehabilitation (PSR)-based services.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the role Psychosocial Rehabilitation-based services play in the provision of services for persons with mental illness.

Teaching

Mental Illness

According to the National Alliance on Mental Illness approximately 43.8 million (18.5%) of Americans experience mental illness in a given year. Mental illness manifests in many ways including symptoms that lead to the diagnoses of schizophrenia (1.1% of adults), bipolar disorder (2.6% of adults), major depressive disorder (6.9% of adults), and anxiety (18.1% of adults). In addition, among the 20.2 million adults in the US who experienced a substance use disorder, 50.5% of them had a co-occurring mental illness.

Of the 43.8 million, approximately 10 million of these experience mental illness that substantially interferes with or limits one or more major life activities. Persons with this degree of disorder are said to have mental illness that is chronic, pervasive, and persistent.

Chronic

For a disease to be chronic it needs to last for a long time. Most of the diagnostic criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) require that the symptoms be present for up to 6 months in order to meet the criteria for mental illness. Many of our clients have lived with their symptoms for most of their lives.

Pervasive

The term pervasive refers to the observation that the symptoms that manifest in mental illness often impact many major life functions in the person. The symptoms are often so severe that they interfere with the person's vocational, social, self-care, and financial life areas.

Persistent

Probably the most challenging aspect of mental illness is the persistence of symptoms. Our understanding of the brain is simply insufficient for us to consistently manage symptoms over time. The symptoms of mental illness, even when controlled by medications, often last a lifetime. This can be the most discouraging aspect of mental illness. While other diseases and disorders can be treated and effectively "go away" mental illness tends to remain a major part of a person's life.

Treatment of mental illness in the US is primarily accomplished through medical intervention (psychotropic medications), therapy, institutionalization and hospitalization, and community-based services. PSR-based services usually fall into the category of community-based services, but the philosophy of PSR can influence service provision in all of these areas.

Over the years there have been a number of approaches in the treatment of persons with mental illness. We will explore some of this history in Chapter 3.

Unlike any other Disease

Mental Illness is unlike other diseases because it is somewhat unpredictable and persons with the same diagnosis can exhibit very different symptoms. The course of illness varies as well… some will have one episode; others will relapse several times over their lives.

Our own perceptions of how and why mental illness exists plays a major role in how we will interact with a person with mental illness.

Etiology of Mental Illness

Looking at the etiology of mental illness means were are investigating the causes or origins of the mental illness which is considered a disease within someone' mental health. What causes mental illness? Important question because the etiology leads the practitioner to treatment choices.

- Personal history
- Family life
- Personal choices
- Biology and genetics

When we look at the etiology of mental illness being connected to brain structure and neurochemical imbalances we have to explore the concept that these may be inherited.

We examine the genetic role in mental illness by studying twins (same as we study many of the questions of genetic and environmental factors in human development and behavior).

There is strong evidence that mental illness is biological in cause along with other disorders like diabetes and Alzheimer's

Disease. This does not mean that life events and choices did not have an impact on the person, but it does point out that many of the symptoms that we see manifest have a biological correlate either in the genetics of the person, their brain structure, or in their brain chemistry.

The “Disease Model” of mental illness can be challenging to some who see the erratic behavior of someone as being a “choice.” How much personal “control” someone may possess over their own behavior has been debated (and continues to be debated) since we first recognized mental illness.

In the field of PSR we are better served by understanding that the illness is essentially biological. This allows us to more effectively separate the “person” from the “illness”.

Psychosocial Rehabilitation

Defining Rehabilitation

Rehabilitation comes from a latin term that means “restoration”. The part *re-* means “again” and *habitare* to “make fit”.

In a very real way, rehabilitation services strive to return a person to their previous independent level of functioning (and sometimes beyond that into functioning better than before.)

The basic issue in any aspect of rehabilitation is FUNCTION. We are concerned with how someone will be able to function in the many roles they have in the world (apartment renter, home owner, employee, wife, husband, father, mother, citizen, etc.). The assumption is that the disease or disability is going to be present, and we have to help the person find a way to function anyway.

The rehabilitative approach accepts the limitations set by a disability or disease and finds ways to live with them. As we will see in Chapter 2, rehabilitation is a bit different than treatment because the goal of treatment is to reduce the symptoms or degree of the disability in order to improve function.

When a person becomes injured or sick they often seek treatment in order to reduce or eliminate the symptoms as much as

possible. If some symptoms remain, they may go into rehabilitation in order to learn how to compensate for these limitations.

What is Psychosocial Rehabilitation?

Essentially, Psychosocial Rehabilitation (PSR) is a philosophy that guides professional practice when working with individuals with mental illness. In fact, it is a useful guide for working with any population.

PSR has had an impact on nearly every aspect of service delivery in the mental health field (doctors, nurses, social workers, etc.) but as the name entails, it has had the most influence on the field of rehabilitation.

Persons who are employed in Psychiatric Rehabilitation services work with individuals with chronic, pervasive, persistent mental illness to find ways to maximize their functioning in the world despite the fact that they often have debilitating symptoms that create substantial barriers.

Philosophy vs. Methods

A philosophy provides guidance on the expected approach and state of mind of the practitioner. In the case of PSR, it provides stated goals, values, principles, and specific PSR practices that have proven to be most effective when engaged with this population.

While specific practices are identified in the summary below, the philosophy can be applied to any methodology or approach that a practitioner can take. For instance, while the medical community is not bound by PSR, an effective psychiatrist could integrate values such as “self-determination” and “educational supports” regarding medications.

Goals, Values, Principles, and Practice of Psychosocial Rehabilitation

Kim Lane, Ph.D. and Mark Kavanaugh, Ph.D.

Goals

The goal of all PSR is to restore each person’s ability for independent living, socialization, and effective life management. It is a holistic approach that places the person at the center of all interventions.

Effective rehabilitation builds on a person’s strengths and helps the individual to the barriers created by the symptoms of their psychiatric condition.

Values

- Self determination and choice
- Strength based focus

- Dignity and worth of every individual
- Optimism
- Capacity of every individual to learn and grow
- Cultural sensitivity

Principles

- Hope is an essential ingredient in psychosocial rehabilitation. All people have an underutilized capacity to learn and grow that should be developed.
- All people should be treated with respect and dignity.
- Service provision strives to meet the client “where they are” and to assist them in moving forward toward their goals.
- Active participation and choice are the hallmarks of service planning and focus on the stated goals of the person receiving services.
- PSR focuses on “real world” everyday activities and facilitates the development of skills and supports for people to participate as fully as possible in normal roles within family and community settings.
- Assumption that persons who receive services have skills, talents, and qualities that can be leveraged to assist the person in the rehabilitative process.
- Multicultural diversity among PSR program staff, participants and the community at large is appreciated as a source of strength and program enrichment. Programs take active measures to respond in ways that are considerate and respectful.
- PSR is premised on self-determination and empowerment.
- An individualized approach to the development and provision of PSR services best meets the needs of people who choose to use these services.
- PSR practitioner role is intentionally informal and participatory in activities that are designed to engage the person with mental illness and cognitive disabilities in the real world.
- The prevention of unnecessary hospitalizations and the stabilization of community tenure are primary goals of PSR.

Practices

- Social rehabilitation
- Vocational rehabilitation

- Residential and housing services
- Educational supports
- Education about mental illnesses and medications
- Physical health
- Intensive case management
- Supportive counseling
- Family support
- Spiritual support

In Chapter 4 we will go into more detail regarding each of these areas.

Chapter 1 Review

Question 1 of 5

The persons most likely to receive our services have a mental illness that is chronic, pervasive, and _____.

- **A.** Severe
- ✓ **B.** Persistent
- **C.** Scary
- **D.** Incurable

◀ Check Answer ▶

Assessment

Chapter 1 Discussion

Briefly review the Goals, Values, Principles, and Practices of PSR. Discuss the important role any one of these may have on transforming the life of a person with mental illness. Share any personal experiences or stories related to how important this philosophy is.

PSR in the Context of Treatment

2

Attention

Treatment vs. Rehabilitation

We have already learned that PSR focuses on the rehabilitative side of interventions for persons with mental illness. Here we will explore this aspect of the field in more detail and attempt to define how PSR practices relate to other treatment-oriented interventions.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Identify the major barriers that persons with Mental Illness may face.
2. Describe the difference between rehabilitative approaches and treatment approaches.
3. Identify research literature that supports the implementation of PSR with persons with mental illness.

Teaching

It is important to make a distinction here between the concepts of “treatment” and “rehabilitation”. Keep in mind that these are gross generalizations of different services and should not be seen as defining or limiting the scope of these services.

Treatment

Although we may lump all of the varied interventions for mental illness into the category of treatment, for the sake of this book we will define treatment as those interventions that are specifically targeted at reducing symptoms. If, for example, a person suffers from schizophrenia, the treatment portion of the interventions provided would focus in reducing the person’s experience of hallucinations, delusions, and/or disordered thinking through the use of medication and/or psychotherapy. These services are “treatment-focused” in as much as the goal or desired outcomes of these interventions are to reduce symptoms.

Rehabilitation

Rehabilitation services, including those often associated with medical conditions such as Occupational and Physical Therapy, focus on the acquisition of skills, services, modification, and knowledge that will assist the client’s ability to live, work, play, and interact effectively in the environment of their choice with the limitations imposed upon them from their illness.

What this means, is that rehabilitation services focus on assisting individuals in living with the symptoms of their illness. For example, a person who has suffered a spinal cord injury that renders them unable to walk would receive rehabilitation services such as the following:

- Skill development on the use of adaptive mobility devices such as a wheelchair.
- Services into the home to assist with activities of daily living that the persons is unable to do independently.
- Modifications to the person’s home or workplace to allow for wheelchair access.
- Knowledge and education for the person so that they understand their rights as a person with a disability.

Rehabilitation services for those with mental illness are similar. For example, a person diagnosed with schizophrenia may receive the following rehabilitative services:

- Social skill development so the individual can interact with members of the community.
- Representative payee services who would monitor the individual's management of their money and assist in budgeting and bill paying.
- Advocacy to modify work expectations to account for cyclical manifestations of symptoms requiring breaks from work and/or hospitalization.
- Knowledge and education to the person related to the utility of psychotropic medications including the risks and benefits of this treatment.

As you can see, rehabilitation services do not focus on the reduction of symptoms but more on the barriers to effective living WITH the symptoms. In a way, we are assuming the symptoms are going to be chronic, pervasive, and persistent and we strive to assist the person in living the best life they can.

Persons with mental illness often receive a constellation of services across a broad spectrum of both treatment and rehabilitation modalities. Each provider is charged with contributing their expertise to the entire team of individuals and agencies working with a client. Different services (both treatment- and rehabilitative-focused) interact with each other often in order to assist the client in living as independently as they can in the environment of their choice.

Sometimes services can overlap and be conflictual, but service-providers are charged with remaining focused on the welfare of the client.

Diagnosis

When an individual seeks help for the symptoms of a mental illness the medical community will **diagnose** the person with the name of a mental illness (such as Schizophrenia or Major Depression).

The skill set for diagnosing someone is beyond the scope of this book but it involves the gathering of a lot of information. Namely the diagnosing clinician would be interested in the following attributes of the person:

- Current symptoms and their duration.
- Previous symptoms and their duration.
- Psychosocial history (May include a person's psychological or mental health history, social history as well as medical health, employment, finances, education, spirituality, stress and support network, including friends and family)

- Current stressors.
- Current status and history regarding substances such as alcohol and drugs.
- Current mental status.
- History of hospitalization.

Positive and Negative Symptoms

The symptoms of a mental illness involve the person's senses, emotions, and cognition. The symptoms of these disorders have physiological, psychological, and social consequences.

The psychiatric world focuses on two types of symptoms: Positive and Negative. This terminology does not refer to the subjective experience of the symptom but to the nature of the symptom itself and how it impacts the individual.

Positive Symptoms

- Positive symptoms add something to the person's experience. Something is now there that was not there before.
- In the regular medical world we might view "pain" as a "positive symptom" because it was not there before an injury.
- A psychiatric example might be the presence of hallucinations or delusions in a person with Schizophrenia. These hallucinations and delusions were not there before.

Negative Symptoms

- Negative symptoms take away some experience from the individual that would normally be there.
- An example in the medical world would be the inability to remember an accident because of a concussion or head injury. Normally a person would be able to remember the incident but because of the injury that ability is absent.
- An example in the world of psychiatry may be the absence of persons ability to enjoy entertainment or other fun things they used to do that may manifest in a person with Major Depression.

Based on this information the clinician will consult the Diagnostic and Statistical Manual of Mental Disorders (DSM) and assign a preliminary diagnosis (a more final diagnosis could be assigned later once more information is gathered.)

From this point the clinician can then develop a plan to address the persons symptoms and current mental status.

Once a person has been given a diagnosis by a clinician, they have a new **Social Status.** According to Sociologists, this can have all sorts of implications on the individual, both inside and outside of the medical/rehabilitation community.

Social Status, Social Role, and Labels

According to Sociologists, all of us have a number of social statuses and each of those statuses have defined social roles. You can imagine that the "social status" that someone has is a "job title" and the "social role" associated with that status is the "job description."

Text Link

Sociology tells us that the roles and expectations of specific social statuses can be very clearly defined. Consider this question: If someone has a "status" as a "person with a mental illness", what is the social role of that person?

When we begin to realize that the diagnosis becomes a **label** that defines a person's **status** and that a social group may have a very clear defined set of expectations for that individual, we can understand where prejudice, discrimination, and stigma comes from!

Consider the following question about some of the typical ways in which individuals with mental illness are viewed.

Because of the public's misunderstanding of mental illness and the largely negative portrayal of individuals with mental illness in the news and other media, there is are large number of people who have these negative expectations of persons with mental illness. These expectations can be held by nearly anyone including police, clergy, teachers, and even mental health workers and the clients themselves!

One of the major ways in which we combat this is by using "Person-first Language."

Person-first Language

Language is a powerful conveyor of culture and within culture lay the foundation of our own attitudes, values, and perceptions.

Language conveys more than simply a definition…the language we use to define something carries with it the assumptions and values that we have concerning these words. Over the transition to community based treatment individuals with mental illness have adopted a number of titles to describe who they are:

- Patients (of hospitals, doctors, psychiatrists)
- Consumers (of mental health services)
- Recipient (of mental health services)

- Client (of counselors, rehabilitation centers, and residential programs)
- Residents (of some residential programs)
- Members (of social clubs)

When you contemplate these labels do they conjure different images of the person? Different expectations of the person's role in their own treatment or even in the cause of their troubles?

"Person-first Language" is much more than simply the "politically correct" way to address a client. Person-first language arose from the advocacy of persons with disabilities to impress upon their caregivers the fact they are **FIRST** a person and **SECOND** a diagnosis.

Consider the notion of a doctor in a hospital relating to his patient load of the day as "three kidney failures and a possible heart attack."

Behind each of these diagnoses is a PERSON with his or her complexities, history, likes/dislikes, family, goals, dreams, etc. Sam, who has schizophrenia, is no more a "Schizophrenic" than is Mrs. Smith a "heart attack".

By being mindful of person-first language we maintain the value that our patient-load or caseload is full of **PEOPLE**, not diagnoses.

Disability

The symptoms that a person with a mental illness experience can be very distressing and can prevent the person from being able to live in, and interact with others, in society. When a symptom creates a problem for someone we say that it is causing a "barrier" or a roadblock between the person and what they want to do.

The term "disability" literally refers to the notion that someone is not able to do something. Dis- means "not" and ability means, well, the ability! So a disability means that someone can't perform a particular activity, has trouble performing that activity, or relies on adaptations in the environment or within themselves to be able to do the activity.

Examples of this are very clear in the world of physical disabilities. Consider a person who was born with Spina Bifida. This condition is complex and can interfere with many aspects of a

persons body, including their ability to walk. However, with attention to adaptive equipment and perseverance a person with spina bifida can lead a very fulfilling and wonderful life.

An Introduction to Enock Glidden

Enock's Adventures

Enock contemplates the next climb

Several years ago I had the pleasure of meeting and working with a gentleman named Enock Glidden. (Enock is aware of and has given me permission to tell a bit about his story here.)

Enock Glidden

I was born in July of 1978 with a birth defect called Spina Bifida. I am also a paraplegic due to this birth defect. Throughout my life I have had to learn to do things differently than others but with the use of adaptive equipment and help from friends and family, I have lived a very full life.

I have had the opportunity to experience a lot of things that people with two working legs may not even try. I am an avid skier, rock climber, and participate in many other sports. I have done tennis, basketball, skydiving, and most recently completed an ascent of El Capitan in Yosemite National Park.

So despite what some may call a setback in life I have made it my mission to inspire others to get out and try things and experience as much in life as they possibly can. - EnockI bring up Enock's story because he is such a great example of the principles that underly Psychosocial Rehabilitation.

Enock's condition is permanent and the barriers that he experience are permanent as well. However, by using adaptive equipment and his extremely positive attitude, Enock has been able to do some amazing things.

Text Link

Disability as a Legal Status

"Disability" is also a LEGAL term used to describe individuals who have a condition that is so severe that it renders them unable to work. This can be a particularly thorny issue in US culture because of the very high value we place on productive work. A person who does not work at gainful employment not only experiences financial and identity struggles, but can often be viewed as not "pulling their own weight" and can be relegated as a "burden to society".

Psychiatric Disability

Psychiatric symptoms produce barriers in people's lives as well. The symptoms of the illness may interfere with them doing the task (such as "hearing voices" interfering with concentrating in class). Having the illness may interfere with normal development of the person (such as a person being unable to develop appropriate social skills because they were shunned by peers when they were young.)

Developmental impacts such as these can have a profound impact. Having multiple hospitalizations, being shunned by pears, not being able to participate in normal school and social activities, and having little to no social friends can interfere with normal human development. Consider the kinds of experiences we need to have in order to develop in the following ways. How would having a mental illness impact these:

- Intellectual development
- Social development
- Vocational development
- Issues of identity formation

Diagnoses and Psychosocial Rehabilitation

So, what role does diagnosis and symptoms play in PSR?

PSR serves to assist people WITH MENTAL ILLNESS in developing the skills and resources necessary to LIVE, WORK, and PLAY in the ENVIRONMENT of their choice.

PSR techniques serve to assist individuals in living WITH the symptoms of their illness just as a person may learn to live with blindness or a hearing impairment. We don't necessarily CURE the illness or even treat the illness itself. PSR focuses on the barriers that exist within someone's life because they have a mental illness (symptoms) in order to maximize their independence.

So, in a way, the BARRIERS are more important than the DIAGNOSES or SYMPTOMS. We still need to know about diagnosing because it helps us understand what our clients are going through...but our focus is on the barriers these symptoms create.

Stigma and Mental Illness

Another set of barriers come from our environment and how people in our society think about and understand mental illness.

- Labels of mental illness can evoke feelings of fear and rejection in others
- Symptoms are not often attributable to causes
- Societal expectations of behavior are flexible…to a point… What is the breaking point where we identify someone as deviant or abnormal?
    - Work
    - Dress
    - Personal Hygiene
    - Language
- We lack a clear, well-known etiology for mental illness so people fear it

Stress and Mental Illness

Much has been made regarding the impact of stress upon the etiology of mental illness/disorders. The most commonly cited etiological explanation for mental disorders is the Diathesis-Stress Theory. This assumes that an individual who was already predisposed biologically to develop mental illness may do so under stressful conditions.

The impact of the stressor upon neurochemistry is thought to be one of the major causal factors in many psychological disorders. Of course, this is just one piece of the puzzle. Current models of etiology explore the interaction of multiple factors in determining the cause of mental disorders. These are termed, "integrative" models.

One major barrier that exists related to mental illness is the notion that stress causes or manifests the symptoms. This implies that if the person had better coping skills, they would not experience as much symptomology. While stress is an important factor, it is more likely that the stress of HAVING a mental illness is a barrier.

Rehabilitation vs. Treatment

Rehabilitation refers to the process of returning someone to a former state of constructive activity, or function. (Note: Habilitation refers to the process of moving the person to a new and higher level of functioning than they have ever been at before. Helping people to achieve a level of functioning they have never achieved before is sometimes our role when working with our clients!)

Consider the following:

The goal of psychiatric rehabilitation is to enable individuals to compensate for, or eliminate the functional deficits, interpersonal barriers, and environmental barriers created by the disability, and to restore ability for independent living, socialization, and effective life management.

Psychosocial Rehabilitation means that a person who before was afraid to go into a store to order an ice cream soda can now be an ice cream store manager.

PSR and Treatment

Even though we have been talking about the medical aspects of mental illness...we still see a role for the application of PSR activities.

For any given individual the constellation of treatment may include medications, housing, group work, vocational work, therapy, and exercise. Each aspect of the treatment plan contributes to the outcomes that the person may experience. This is highly individualized work.

Since PSR practices focus on the BARRIERS that individuals experience due to their symptomatology, it is often very effective at addressing the pragmatic, every-day issues that come up in a person's life. Every-day issues, when combined with mental illness can be devastating.

In addition, because of the course of many of the mental illnesses, individuals with diagnoses are often lacking specific social experience and social skills that many of us take for granted. Skill training on how to negotiate in the wider social world is some of the most important work we do.

Evidence-based Practice

These rehabilitative practices have been around for a long time and have proved to be very effective in achieving rehabilitation goals.

The fact that there has been research conducted on the effectiveness of the approach demonstrates what is known as “evidence-based practice.”

Evidence-based practice includes those strategies that have been developed by professionals in the field and have been demonstrated as being effective. In essence, you can “trust” these methods to work (a lot of the time, but not always).

This “evidence” can be found in peer reviewed research articles which are found in professional journals.

Examples of these journals include the following:

Journal of Psychosocial Rehabilitation and Mental Health

Psychiatric Rehabilitation Journal

Journal of Rural Mental Health

To access these publications, and others like them, you need to have a subscription. The library, however, can provide access to both digital and print copies of these articles.

Application of PSR to Barrier Removal

As an MHRT/C we are preparing you to function as a case manager for individuals with mental illness. This means that you will work with an individual to learn what their needs and barriers are in their communities. You will use that information to develop a treatment plan that outlines how to address those needs and barriers to help the clients achieve their goals for rehabilitation. As case managers we approach helping by doing the following:

Try to understand and document how the symptoms a person is experiencing is creating a barrier for them to perform in a specific environment.

We often make the assumption that this barrier is more a function of the environment than the actual symptoms.

Creatively come up with solutions as to how the person can perform in that environment even though they have the symptoms. These solutions may involve a change to the environment or a change in the person or both.

Consider these environments:

- School
- Work
- Church
- Relationships
- Grocery Store
- Movie Theater
- Social Club

Depending on the person's symptoms they may experience DIFFERENT barriers in these DIFFERENT environments.

Example 1

- Client: John Smith, 31 yrs. old
- Diagnosis: Generalized Anxiety Disorder (GAD)
- Symptoms include: Agitated movements and difficulty sitting still
- John has been invited to the movies with his sister, Sharon, and her children. What barriers might he encounter that could lead him to canceling his plans with Sharon?

This particular diagnosis/symptom may not produce any barriers for the person to perform in the Grocery Store or at the Social Club, however, it may produce a barrier at the Church and the Movie Theater

Your job would be to find creative ways for this person to attend church and/or go to the theater...

Possible Solutions:

- Watch the church service on TV and have rituals performed at home.
- Stand in the back of the church with permission to move about in the back and minimize disruption
- Watch movies at home
- Attend movies during the times when there is not a lot of people, sit at the back, and allow them to roam about during the movie

Example 2:

- Client: Tracey Thomas, 53 yrs. old
- Diagnosis: Major Depressive Disorder
- Symptoms include: Symptom Difficulty sleeping and has trouble getting up in the morning.
- Tracey wants to go back to work or go to college to train for a new career. What barriers might she encounter that could interfere with her job search or starting to take college classes?

This particular diagnosis/symptom may not produce any barriers for the person to perform in Relationships or at the Movie Theater

It may produce a barrier at the Work and School.

Your job would be to find creative ways for this person to work and/or go to school

Possible Solutions:

- Online classes
- Afternoon classes only...no morning classes
- Buddy system to make it to class on time
- Home based work opportunities
- Alternative schedules of work

PLEASE NOTE: None of these interventions involve doing anything to actual reduce the SYMPTOMS! We assume those are there and we try to work around them...THAT is Psychosocial Rehabilitation!

Chapter 2 Review

Question 1 of 5

Which of the following would be considered a treatment (direct symptom reducing intervention:?

- **A.** Transportation
- **B.** Housing
- **C.** Employment
- ✓ **D.** Medications

◀ Check Answer ▶

Assessment

Chapter 2 Discussion

Discuss the difference between treating symptoms (clinical applications) and treating the environment (removing barriers). Please use examples in your discussion.

Chapter 2 Assignment A

Treatment vs. Rehabilitation

In this Lesson you have learned about the nature and scope of mental illness along with the broad categories of interventions (treatment and rehabilitation.)

For this assignment you will submit a written paper.

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook

Text Link

Your paper will address the following topics:

Part I: Explaining Treatment vs. Rehabilitation

Place yourself in the position that you have been charged in explaining the variety of interventions to a client. In your own words, compare and contrast the concepts of treatment and rehabilitation as it has been discussed in this chapter. Write this out as you would describe the differences to a client.

Part II: Outcomes-based Research on Treatment

For this assignment you are going to conduct some research using the resources in our Library. Use the tutorial below to familiarize yourself with these tools. Feel free to contact one of our librarians for assistance.

Text Link

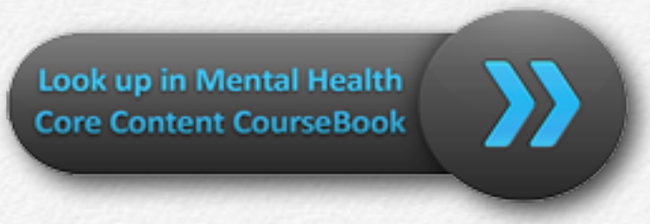
Review the results of your search and select a single article (full text) regarding a topic, treatment, or population that interests you.

Place yourself in the position that you would explain this research to your client (who may be considering the type of treatment described.) **Write out an explanation of the treatment in the words that you would use with your client.**

Include an APA formatted reference to the article.

Grading Rubric for Chapter 2 Assignment A

Check out the link to the Mental Health Core Content CourseBook for information about APA Format



Text Link

Chapter 2 Assignment B

Barriers and Treatment Planning

In this assignment you are going to select one of the following summaries regarding a diagnosis of Schizophrenia or Mood Disorder.

Part I: Identify Barriers to Functioning

Barriers are specific to the environment in which someone wants to be. When we identify barriers we need to FIRST pick an environment (such as “at college” or “while shopping”).

Then we examine the symptoms and determine how these symptoms may interfere with the person’s functioning in that specific environment.

Schizophrenia

The DSM 5 classifies the symptoms of Schizophrenia (S.). into two broad categories, negative (diminution or loss of normal functions) and positive (an excess or distortion of normal functions) symptoms.

Positive Symptoms

- Thinking and ideas (delusional)
- Perceptions and sensations (hallucinations and illusions)
- Language and communication (disorganized or bizarre speech)
- Behavior self-control (grossly disorganized or catatonic behavior)

Negative Symptoms

- The range and intensity of emotional expression (flat affect)
- The fluency and productivity of thought and speech (alogia)
- The initiation of goal-directed behavior (avolition)

How would each of these impact the individuals physiological, psychological, and social functioning?

When we encounter people with these symptoms what assumptions do we make about them (not knowing that they have a mental illness)?

Delusions

Delusions include bizarre beliefs or ideas that the person cannot be talked out of. A common one is that one's actions may be under the control of others. Others include grandiose ideas of the self. (These might include ideas of being famous, being close to famous individuals/God, or being targeted by others such as the FBI and/or Secret Service)

Delusions (and hallucinations) are "real" to the person…they will act in accordance to these belief systems as much as you and I react to any belief system we have.

Hallucinations

Hallucinations involve sensory stimulation or information that the person experiences as real. The most common are auditory in nature (hearing voices/instructions, command hallucinations---it is no surprise that we thought that individuals with Schizophrenia were possessed by demons!)

Thought Disorder

Disordered thoughts in a person with schizophrenia might include thought broadcasting, confusion, thought insertion, and racing thoughts.

The experience of Symptoms…

It is difficult for us to know how individuals really experience their symptoms. Do they hear a disembodied voice or is it something like self-talk? Different individuals react differently to these symptoms as well. But for the individual, these are very real.

Some individuals learn to live along with their symptoms by learning to manage their behaviors despite the symptomology.

Phases of Schizophrenia

- **Prodromal**
  - Suspicious that SOMETHING is going on, withdrawal from social contacts, etc.
- **Acute**
  - Full-blown symptoms.
- **Residual**
  - Symptoms are milder or perhaps the person has adapted to them.

A Mini-Lesson on Mood Disorders

Mood disorders impact a smaller number of individuals who are in psychiatric rehabilitation centers. Some symptoms are mild to moderate while others can be quite severe. Individuals sometimes "cycle" between periods of relatively normal functioning and dysfunction.

Symptoms

- Depressive episode (may end up with a diagnosis of Major Depression)
- Manic episode
- Mixed episode (may end up with a diagnosis of Bipolar Disorder)

Depressive Episode

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all, or almost all, activities
- Significant weight loss when not dieting or weight gain (appetite)
- Insomnia or hypersomnia
- Psychomotor agitation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive inappropriate guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death, suicidal ideation/plans/attempts

Manic Episode

- Inflated self-esteem
- Decreased need for sleep
- More talkative than usual
- Pressured speech
- Flight of ideas
- Distractibility
- Increased goal directed activity
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

To answer Part I

- Select one of the diagnoses in the mini-lessons.
- Identify the environment you want to consider.
- Based on the symptoms, list your concerns regarding how these symptoms may interfere with functioning in that environment.

Remember we look at how SYMPTOMS create BARRIERS to FUNCTIONING in a specific ENVIRONMENT.

Part II: Informal Treatment Plan

For Part II of this assignment you will select ONE of the major symptom/barrier combinations from Part I (either Schizophrenia or Depressive and Bipolar Disorder) and construct a treatment plan to address the barriers a person may encounter specific to an goal in an environment.

Based on the symptoms (in the mini-lessons), list your concerns regarding how these symptoms may interfere with functioning in that the environment you selected. These are the barriers a person may face in that environment.

Remember that your treatment plan will need to address changes you can make in the environment or expectations (rehabilitation) not changes in the symptoms or severity of the symptoms (treatment).

Here is an example:

One of the symptoms of Major Depression includes problems with concentration, thinking, or decision making. This would be a barrier to functioning at home (environment) because my client would have difficulty concentrating on the chores he or she would have to complete each week.

One possible treatment plan would be be to create a schedule of chores that hangs on the refrigerator. I would be sure that the chores could be done in a short period of time and that not too many chores are required each day.

You will need to write these assignments in a word processor and submit them to the appropriate drop box in Blackboard.

Grading Rubric for Chapter 2 Assignment B

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

History of PSR

03

Attention

Where we came from...

To understand where we are it is vital to understand where we have come from. Ideas, such as PSR, do not arise in a vacuum. Many individuals and many events in history led to the development of these ideas and the philosophies that describe our work.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Identify ways in which current PSR philosophy aligns with societal changes such as deinstitutionalization, the self-help movement, the civil rights movement, independent living, and medications.

Teaching

Deinstitutionalization and PSR

There is a connection between the emergence of PSR and the Deinstitutionalization movement of the 1960's and 1970's.

Deinstitutionalization is the process when individuals with serious mental health issues were allowed to consider a life outside of a psychiatric hospital (previously called mental hospitals). The term mental hospital is no longer considered an appropriate phase. Many of these individuals had spent many years of their life locked inside a psychiatric hospital, the term for long term hospitalization is institutionalization. In order to provide mental health/psychiatric services outside of the psychiatric hospital community mental health centers (CMHC) needed to be created.

- Establishment of Community Mental Health Centers (CMHCs) - Note: at the beginning, the Community Mental Health Centers were not specifically designed to deal with individuals coming out of long-term stays in psychiatric hospitals.
- Supplemental Security Income (SSI)
- Subsidized Housing
- Medicaid
- Independent Living Movement

Detailed History of Mental Health

1773: The first hospital for the mentally ill in the US opened in Williamsburg, Virginia.

1840: There were only eight "asylums for the insane" in the United States. Dorothea Dix crusaded for the establishment or enlargement of 32 mental hospitals, and transfer of those with mental illness from almshouses (houses built by a charity for poor people) and jails. First attempt to measure the extent of mental illness and mental retardation in the United States occurred with the U.S. Census of 1840, which included the category "insane and idiotic."

1900: The “mental hygiene” movement began; Clifford Beers, a mental health consumer, who shocked readers with a graphic account of hospital conditions in his famous book, The Mind that Found Itself

Inspection of immigrants at Ellis Island included screening to detect the “mentally disturbed and retarded”. The high incidence of mental disorders among immigrants prompted public recognition of mental illness as a national health problem.

1930: The US Public Health Service (PHS) established the Narcotics Division, later named the Division of Mental Hygiene, bringing together research and treatment programs to combat drug addiction and study of the causes, prevalence, and means of preventing and treating nervous and mental disease.

1944: During World War II, severe shortages of professional mental health personnel and the understanding of the causes, treatment, and prevention of mental illness lagged behind other fields of medical science and public health. Dr.William Menninger, chief of Army neuropsychiatry, called for federal action. A national mental health program was proposed, forming the foundation of the National Mental Health Act of 1946.

1946: On July 3, President Truman signed the National Mental Health Act, creating for the first time in US history a significant amount of funding for psychiatric education and research and leading to the creation in 1949 of the National Institute of Mental Health (NIMH).

1947-51: Governor Luther Youngdahl started development of community-based mental health services and humane treatment for people in state institutions.

1949: Lithium was discovered to treat and reduce symptoms for people diagnosed with a bipolar disorder (Ann Palmer’s 20th Century History of the Treatment of Mental Illness.) The FDA approved the drug in 1970.

1952: Chlorpromazine (Thorazine), one of the first psychotropic drugs, was discovered, greatly improving the condition of consumers with psychosis and delusion. In many cases, Thorazine alleviated symptoms of hallucinations, delusions, agitation and thought disorders.

1955: Congress authorized the Mental Health Study Act of 1955 and called for “an objective, thorough, nationwide analysis and reevaluation of the human and economic problems of mental

health.” The act provided the basis for the historic study conducted by the Joint Commission on Mental Illness and Health, Action for Mental Health.

1958: Governor Luther Youngdahl (Minnesota legislation-humane treatment of MI)

1956: Congress appropriated $12 million for research in the clinical and basic aspects of psychopharmacology and the Psychopharmacology Service Center was established The number of consumers in mental hospitals began to decline reflecting the introduction of psychopharmacology in the treatment of mental illness. The Health Amendments Act authorized the support of community services for the mentally ill, such as halfway houses, daycare, and aftercare under Title V.

1961: Action for Mental Health was transmitted to Congress. It assessed mental health conditions and resources throughout the United States “to arrive at a national program that would approach adequacy in meeting the individual needs of the mentally ill people of America.”

1963: President Kennedy proposed and signed legislation that started community mental health center movement to substitute comprehensive community care for custodial institutional care.

1965: The CMHC (Community Mental Health Center) Act Amendments of 1965, (P.L. 91-211), were enacted and included the following major provisions: Construction and staffing grants to centers were extended and facilities that served those with alcohol and substance abuse disorders were made eligible to receive these grants. Grants were provided to support the initiation and development of mental health services in poverty-stricken areas. A new program of grants was established to support further development of children’s services.

1969: Minnesota Association of Community Mental Health Centers forms. Around that same time the MN legislation on CMCH's (245.62-245.69) was passed.

1975: Coverage of Ambulatory mental health services (outpatient) by private health plans – The CMCH Act Amendments of 1975 (P.L. 94-63) mandated a more detailed community mental health center definition emphasizing comprehensiveness and accessibility to all persons regardless of ability to pay, through the creation of a community governing board and quality assurance. Required core services expanded from the 1963 levels from 5 to 12, which included the following: Children Services Elderly Services Screening Services Follow-up Care Transitional Services Alcohol abuse Services Drug abuse Services.

1978: Medical Assistance (MA) added for community MH services (outpatient and day treatment).

1980: The Mental Health Systems Act, (P.L. 96-398), restructured the federal community mental health center program by strengthening the linkages between the federal, state, and local governments. The Act was the final result of a series of recommendations made by President Jimmy Carter's Mental Health Commission. Per the Mental Health Systems Act, a litany of grant programs were mandated for the CMHCs to assist in expanding services to meet an array of priority populations. They included the following:

- An expansion grant for a wide range of services for the severely mentally ill (SMI) population;
- Grants for the severely emotionally disturbed (SED) population;
- Non-revenue producing services were also funded via a grant aimed at expanding education and consulting needs;
- Additionally, the commission sought to include consumer input and involvement in service and treatment.

1981-2: Federal Mental Health Systems Act repealed and replaced by the Alcohol, Drug Abuse and Mental Health (ADMS) Block Grant, and in 1982, ADMS block grant decreased by 30% resulting in dramatic service reductions. Despite passage of block grants, the federal share of funding decreased to 11% of the total while state and local funding share increased.

1985: By 1985, federal funds through the ADM block grant dropped to 11 percent of agency budgets. State funding grew substantially to 42 percent and local government sources increased to 13 percent Medicaid decreased slightly to 8 percent, Medicare remained at 2 percent, and patient fees had grown to 8 percent — double the amount from a decade earlier. (NCCMHCProfile Data)

1986: Mental Health Planning Act of 1986 (Federal law requiring state plans) passed; Case management established as a distinct benefit under Medicaid; Medicaid amendments improve MH coverage of community MH services, add rehabilitative services, and expand clinical services to homeless.

1987: Medicare adds to outpatient mental health benefit but retains large patient copayments and cost sharing.

1987: Minnesota's Comprehensive Mental Health Act for adults passed, describing array of mandated services, authorizing MN Department of Human Services (DHS) as the state mental health (MH) authority and counties as local MH authority.

1988: The concept of behavioral health managed care evolved from theory to practice. Massachusetts was the first state that utilized a managed care platform regarding service of its behavioral healthcare needs. The state "carved out" mental health from physical healthcare and awarded the contract for management of the mental health benefits to a private company whose responsibilities included service authorization, utilization, quality management, a provider network, claims processing and interagency coordination. The managed care platform was based on efficiency and effectiveness, and sought to take advantage of emerging technologies. However, capturing the cost savings proved to be a difficult task as managed care programs spread throughout different states. Population disparities in the rural and urban areas, unfulfilled technological promises, decreasing social service budgets in the states, and erosion in the areas of access and quality had a lasting effect on managed care systems

1988: Prepaid Medical Assistance Demonstration projects started in Minnesota in Hennepin, Dakota and Itasca Counties. Mental health included in comprehensive benefits.

1988: State grants provided for Community Residential Treatment Facilities (Rule 36). 1989: Minnesota Comprehensive MH Act for Children passes (paralleled adult act); MH

Coverage for outpatient mandated in private health plans if plan also covered inpatient care.

1990: MA coverage for services of independent psychologists and clinical social workers in Minnesota.

1990: Minnesota's Children's Health Plan includes limited MH benefits (limits were removed in 1992).

1991: Community Mental Health Centers authorized to provide partial hospitalization services under Medicare.

1993: MinnesotaCare legislation covers MH services.
1993: State closes Moose Lake Regional Treatment Center and makes region service changes.

1993 : The National Council for Community Mental Healthcare Centers changed its name to the National Community Mental Healthcare Council. The change was viewed as necessary since it excised the term "centers" and put more emphasis on the word "community" as the primary focus for providing a continuum of care.

1994: Minnesota statewide expansion of Prepaid Medical Assistance (PMAP) program authorized for all counties.

1994: Minnesota Child MH Collaboratives authorized.
1995: Minnesota one of first states to pass a comprehensive mental health and chemical

dependency parity bill regulating private health plans.

1996: The Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) was enacted. HIPAA's intent was to protect health insurance coverage for workers and their families when they change or lose their jobs. It was recognized that this new protection would impose additional administrative burdens on both public and private healthcare providers, payers, and clearinghouses.

An additional purpose of HIPPA was to devise a strategy that would regulate administrative functions including claim forms, privacy, and security. To achieve these goals, the law includes a section called Administrative Simplification. This section of HIPAA is specifically designed to reduce the administrative burden associated with the transfer of health information between organizations, and more generally to increase the efficiency and cost-effectiveness of the United States healthcare system. An additional purpose of HIPAA was to accelerate the move from certain paper-based administrative and financial transactions to electronic transactions through the establishment of nationwide standards.

The Temporary Assistance for Needy Families (TANF) Act was created as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104 – 193). The law contains strong work requirements, a performance bonus to reward states for moving welfare recipients into jobs, state maintenance of effort requirements, comprehensive child support, and supports for families moving from welfare to work, which includes increased funding for child care and guaranteed medical coverage.

The Social Security Administration terminated payments for Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) for persons listed as having a substance abuse disorder that is primary to their finding of disability.

Additionally, functional assessment procedures were created that provided for stricter medical listings imposed on children receiving SSI benefits.

1996 also saw the passage of the first parity law. The law prohibited insurers or plans serving 50 or more employees from setting lower annual or lifetime dollar caps on mental health benefits than for other health benefits. However, the legislation did not address many of the limits insurance plans frequently apply to the coverage of behavioral healthcare services. These restrictions include limits on the number of treatment visits, days of treatment, co-pays, and deductibles.

Temporary housing rental vouchers for people with SPMI funded, called Bridges.

1997: Congress passed the Balanced Budget Act of 1997 which achieved substantial reductions in federal spending by decreasing funds allotted to both Medicaid and Medicare through a five year restructuring that saved $130 billion over five years.

The federal government expanded health coverage through the State Children's Health Insurance Program (SCHIP), which seeks to provide healthcare for uninsured minors. SCHIP marked the first time that mental health services were mandated by a federal entity and administered by the states.

However, severe cuts were made in programs that affected our members. The federal Social Services Block Grant (SSBG) was created in 1975 and provides assistance to states that enables them to furnish services directed at self-sufficiency, abuse prevention, abuse remediation, delivery of community based care, and securing institutional based care when it is deemed appropriate.

The SSBG was cut under the Balanced Budget Act (BBA), from over $2 billion to $1.7 billion in FY 2002.

Medicaid also encountered decreases in funding given the BBA.

Ten billion dollars were slashed from the program as a result of the cutbacks. In addition, the Medicaid Disproportionate Share (DSH) payments were also affected. DSH payments were created in 1982 and used as a vehicle to adjust payments to hospitals for the higher operating

costs they incur in treating a large share of low-income patients. The BBA reduced DSH payments by 5 percent, with the reduction to be implemented in one percentage point increments between fiscal years 1998 and 2002. The BBA cut DSH payments by $10 billion (a figure which is included in the overall $13 billion decrease in the Medicaid program) and set a large restriction on the amount of DSH dollars that states could transfer to their inpatient facilities.

Furthermore, the BBA mandated that states enroll beneficiaries into managed care programs through HCFA's 1915(b) waiver program. 1915(b) waivers seek to utilize cost savings to provide additional services within the Medicaid program. If the state saves money using the managed care option under the 1915(b) waiver, then it can provide an enhanced package of additional services for Medicaid beneficiaries

Also in 1997, the National Community Mental Healthcare Council changed its name once again to reflect our evolving membership base. The National Council for Community Behavioral Healthcare was chosen to recognize the efforts of many of our members who provide services aimed at treating addictive disorders

Medical Necessity for mental health defined in Minnesota statute.
Prescription privileges for mental health clinical nurse specialists, with special training 1998: First Prepaid MA program in Hennepin, Dakota and Itasca Counties

1999: The Supreme Court issues its opinion on Olmstead v. L.C which held that it is a violation of the Americans with Disabilities Act to keep individuals in restrictive inpatient settings when more appropriate community services are available.

The National Council for Community Behavioral Healthcare helped to secure passage of the Ticket to Work and Work Incentives Improvement Act (TWWIIA, P.L. 106-170). TWWIIA removed many of the disincentives that faced people with disabilities receiving SSI or SSDI benefits but wished to return to full-time employment. In the event of a reoccurrence of an acute episode, the law includes presumed eligibility for immediate continuation of SSI or SSDI cash payments.

The Clinton White House held a conference on mental health issues in June 1999 that focused on dispelling the myths about mental illness and decrying prejudices against behavioral health consumers, one of which was insurance coverage that excludes behavioral health services. The conference also brought together the mental health community in anticipation of the Surgeon General's Report

Mental Health: A Report of the Surgeon General was published in late 1999 and sought to eradicate the stigma surrounding mental health and simultaneously encourage the use of innovative pharmaceutical and psychotherapy treatments

2000: By the dawn of the 21st Century, behavioral health providers' revenue streams were of a much different nature than when they began nearly 40 years before. A key example of this has

been the funding provided under the Medicaid program, which currently accounts for 80 percent of the average revenue stream. This is in sharp contrast to the levels

seen in the late 1980s, where Medicaid funding accounted for only 16 percent of the average revenue stream

In October 2000, President Clinton signed the Children's Health Act (P. L.106-310) into law. The law establishes national standards that restrict the use of seclusion and restraint in all psychiatric facilities that receive federal funds and in "non-medical community-based facilities for children and youth." The act also mandated that a report be submitted to Congress on co- occurring disorders

Minnesota Attorney General sues BlueCross/BlueShield Minnesota; parties agree to settlement aiming to improve/reform MH system.

2001: Minnesota advocates proposed Mental Health Act of 2001. Due to that effort, additional MH services and funding were added or expanded for adults and children.

In August 2001, the Department of Health and Human Services provided guidance to states on Medicaid 1115 demonstration waivers that allowed them to expand the program to include uninsured individuals by incorporating unspent SCHIP block grant funds through a new demonstration initiative: The Health Insurance Flexibility and Accountability (HIFA) Waiver. Chief among the National Council's concerns, is the role that behavioral health consumers play as the waivers are comprised in each state. There is concern that these stakeholders are being removed from the process, and as a result, optional benefits and the populations receiving them could be eliminated. Furthermore, HIFA waivers could facilitate an increase in cost sharing among beneficiaries

2002: An in-depth study on co-occurring disorders, mandated under the Children's Health Act of 2000, was delivered to Congress.

The National Council for Community Behavioral Healthcare, along with several coalition partners, played a prominent role in the writing of this report.

President Bush increased funding for Community Health Centers that provided appropriations for the construction of additional centers and offered more services, including behavioral healthcare benefits

President Bush forms the New Freedom Commission on Mental Health, which will seek "to conduct a comprehensive study of the United States mental health service delivery system, including both private and public sector providers." The Commission is charged with a set of objectives that includes reviewing the current quality and effectiveness of private and public providers, identifying innovative services, treatments, technologies, and issuing a report on its subsequent recommendations.

Minnesota State Legislature approves copays and adjusts GAMC eligibility, decreasing eligible populations.

2003: President Bush's New Freedom Commission on Mental Health issued final report, "to conduct a comprehensive study of the United States mental health service delivery system, including both private and public sector providers." Objectives include reviewing the quality and effectiveness of private and public providers, identifying innovative services, treatments, technologies, and report on its subsequent recommendations.

Facing 4.5 billion dollar deficit, MN State Legislature approves copays, adjusts GAMC eligibility, and decreases eligible populations, creating a direct impact on the MH system.

The MH Action Group is created to recommend strategies to improve and reform the Minnesota MH system across both private and public sectors.

History of the Independent Living Movement
by Maggie Shreve

This account of the history of independent living stems from a philosophy which states that people with disabilities should have the same civil rights, options, and control over choices in their own lives as do people without disabilities.

The history of independent living is closely tied to the civil rights struggles of the 1950s and 1960s among African Americans. Basic issues--disgraceful treatment based on bigotry and erroneous stereotypes in housing, education, transportation, and employment--and the strategies and tactics are very similar. This history and its driving philosophy also have much in common with other political and social movements of the country in the late 1960s and early 1970s. There were at least five movements that influenced the disability rights movement.

Social Movements

The first social movement was deinstitutionalization, an attempt to move people, primarily those with developmental disabilities, out of institutions and back into their home communities. This movement was led by providers and parents of people with developmental disabilities and was based on the principle of "normalization" developed by Wolf Wolfensberger, a sociologist from Canada. His theory was that people with developmental disabilities should live in the most "normal" setting possible if they were to expected to behave "normally." Other changes occurred in nursing homes where young people with many types of disabilities were warehoused for lack of "better" alternatives (Wolfensberger, 1972).

The next movement to influence disability rights was the civil rights movement. Although people with disabilities were not included as a protected class under the Civil Rights Act, it was a reality that people could achieve rights, at least in law, as a class. Watching the courage of Rosa Parks as she defiantly rode in the front of a public bus, people with disabilities realized the more immediate challenge of even getting on the bus.

The "self-help" movement, which really began in the 1950s with the founding of Alcoholics Anonymous, came into its own in the 1970s. Many self-help books were published and support groups flourished. Self-help and peer support are recognized as key points in independent living philosophy. According to this tenet, people with similar disabilities are believed to be more likely to assist and to understand each other than individuals who do not share experience with similar disability.

Demedicalization was a movement that began to look at more holistic approaches to health care. There was a move toward "demystification" of the medical community. Thus, another cornerstone of independent living philosophy became the shift away from the authoritarian medical model to a paradigm of individual empowerment and responsibility for defining and meeting one's own needs.

Consumerism, the last movement to be described here, was one in which consumers began to question product reliability and price. Ralph Nader was the most outspoken advocate for this movement, and his staff and followers came to be known as "Nader's Raiders." Perhaps most fundamental to independent living philosophy today is the idea of control by consumers of goods and services over the choices and options available to them.

The independent living paradigm, developed by Gerben DeJong in the late 1970s (DeJong, 1979), proposed a shift from the medical model to the independent living model. As with the movements described above, this theory located problems or "deficiencies" in the society, not the individual. People with disabilities no longer saw themselves as broken or sick, certainly not in need of repair. Issues such as social and attitudinal barriers were the real problems facing people with disabilities. The answers were to be found in changing and "fixing" society, not people with disabilities. Most important, decisions must be made by the individual, not by the medical or rehabilitation professional.

Using these principles, people began to view themselves as powerful and self- directed as opposed to passive victims, objects of charity, cripples, or not-whole. Disability began to be seen as a natural, not uncommon, experience in life; not a tragedy.

Independent Living

Text Link

Ed Roberts is considered to be the "father of independent living." Ed became disabled at the age of fourteen as a result of polio. After a period of denial in which he almost starved himself to death, Ed returned to school and received his high school diploma. He then wanted to go to college. The California Department of Rehabilitation initially rejected Ed's application for financial assistance because it was decided that he was "too disabled to work." He went public with his fight and within one week of doing so, was approved for financial aid by the state. Fifteen years after Ed's initial rejection by the State of California as an individual who was "too" disabled, he became head of the California Department of Rehabilitation--the agency that had once written him off.

After Ed earned his associate's degree at the College of San Mateo, he applied for admission to the University of California at Berkeley. After initial resistance on the part of the university, Ed was accepted. The university let him use the campus hospital as his dormitory because there was no accessible student housing (none of the residential buildings could support the weight of Ed's 800-lb. iron lung). He received attendant services through a state program called "Aid to the Totally Disabled." This is a very important note because this was consumer- controlled personal assistance service. The attendants were hired, trained, and fired by Ed.

In 1970, Ed and other students with disabilities founded a disabled students' program on the Berkeley campus. His group was called the "Rolling Quads." Upon graduation, the "Quads" set their sights on the need for access beyond the University's walls.

Ed contacted Judy Heumann, another disability activist, in New York. He encouraged her to come to California and along with other advocates, they started the first center for independent living in Berkeley. Although it started out as a "modest" apartment, it became the model for every such center in the country today. This new program rejected the medical model and focused on consumerism, peer support, advocacy for change, and independent living skills training.

In 1983, Ed, Judy, and Joan Leon, co-founded the World Institute on Disability (WID), an advocacy and research center promoting the rights of people with disabilities around the world. Ed Roberts died unexpectedly on March 14, 1995.

The early 1970s was a time of awakening for the disability rights movement in a related, but different way. As Ed Roberts and others were fighting for the rights of people with disabilities presumed to be forever "homebound" and were working to assure that participation in society, in school, in work, and at play was a realistic, proper, and achievable goal, others were coming to see how destructive and wrong the systematic institutionalization of people with disabilities could be. Inhuman and degrading treatment of people in state hospitals, schools and other residential institutions such as nursing facilities were coming to light and the financial and social costs were beginning to be considered unacceptable. This awakening within the independent living movement was exemplified by another leading disability rights activist, Wade Blank.

ADAPT

Wade Blank began his lifelong struggle in civil rights activism with Dr. Martin Luther King, Jr. to Selma, Alabama. It was during this period that he learned about the stark oppression which occurred against people considered to be outside the "mainstream" of our "civilized" society. By 1971, Wade was working in a nursing facility, Heritage House, trying to improve the quality of life of some of the younger residents. These efforts, including taking some of the residents to a Grateful Dead concert, ulti-

mately failed. Institutional services and living arrangements were at odds with the pursuit of personal liberties and life with dignity.

In 1974, Wade founded the Atlantis Community, a model for community-based, consumer-controlled, independent living. The Atlantis Community provided personal assistance services primarily under the control of the consumer within a community setting. The first consumers of the Atlantis Community were some of the young residents "freed" from Heritage House by Wade (after he had been fired). Initially, Wade provided personal assistance services to nine people by himself for no pay so that these individuals could integrate into society and live lives of liberty and dignity.

In 1978, Wade and Atlantis realized that access to public transportation was a necessity if people with disabilities were to live independently in the community. This was the year that American Disabled for Accessible Public Transit (ADAPT) was founded.

On July 5-6, 1978, Wade and nineteen disabled activists held a public transit bus "hostage" on the corner of Broadway and Colfax in Denver, Colorado. ADAPT eventually mushroomed into the nation's first grassroots, disability rights, activist organization.

In the spring of 1990, the Secretary of Transportation, Sam Skinner, finally issued regulations mandating lifts on buses. These regulations implemented a law passed in 1970-the Urban Mass Transit Act-which required lifts on new buses. The transit industry had successfully blocked implementation of this part of the law for twenty years, until ADAPT changed their minds and the minds of the nation.

In 1990, after passage of the Americans With Disabilities Act (ADA), ADAPT shifted its vision toward a national system of community-based personal assistance services and the end of the apartheid-type system of segregating people with disabilities by imprisoning them in institutions against their will. The acronym ADAPT became "American Disabled for Attendant Programs Today." The fight for a national policy of attendant services and the end of institutionalization continues to this day.

Wade Blank died on February 15, 1993, while unsuccessfully attempting to rescue his son from drowning in the ocean. Wade and Ed Roberts live on in many hearts and in the continuing struggle for the rights of people with disabilities.

These lives of these two leaders in the disability rights movement, Ed Roberts and Wade Blank, provide poignant examples of the modern history, philosophy, and evolution of independent living in the United States. To complete this rough sketch of the history of independent living, a look must be taken at the various pieces of legislation concerning the rights of people with disabilities, with a particular emphasis on the original "bible" of civil rights for people with disabilities, the Rehabilitation Act of 1973.

Civil Rights Laws

Before turning to the Rehabilitation Act, a chronological listing and brief description of important federal civil rights laws affecting people with disabilities is in order.

1964--Civil Rights Act: prohibits discrimination on the basis of race, religion, ethnicity, national origin, and creed; later, gender was added as a protected class.

1968--Architectural Barriers Act: prohibits architectural barriers in all federally owned or leased buildings.

1970--Urban Mass Transit Act: requires that all new mass transit vehicles be equipped with wheelchair lifts. As mentioned earlier, it was twenty years, primarily because of machinations of the American Public Transit Association (APTA), before the part of the law requiring wheelchair lifts was implemented.

1973--Rehabilitation Act: particularly Title V, Sections 501, 503, and 504, prohibits discrimination in federal programs and services and all other programs or services receiving federal funding.

1975--Developmental Disabilities Bill of Rights Act: among other things, establishes Protection and Advocacy services (P & A).

1975--Education of All Handicapped Children Act (PL 94-142): requires free, appropriate public education in the least restrictive
environment possible for children with disabilities. This law is now called the Individuals with Disabilities Education Act (IDEA).

1978--Amendments to the Rehabilitation Act: provides for consumer-controlled centers for independent living.

1983--Amendments to the Rehabilitation Act: provides for the Client Assistance Program (CAP), an advocacy program for consumers of rehabilitation and independent living services.

1985--Mental Illness Bill of Rights Act: requires protection and advocacy services (P & A) for people with mental illness.

1988--Civil Rights Restoration Act: counteracts bad case law by clarifying Congress' original intention that under the Rehabilitation Act, discrimination in ANY program or service that is a part of an entity receiving federal funding--not just the part which actually and directly receives the funding--is illegal.

1988--Air Carrier Access Act: prohibits discrimination on the basis of disability in air travel and provides for equal access to air transportation services.

1988--Fair Housing Amendments Act: prohibits discrimination in housing against people with disabilities and families with children. Also provides for architectural accessibility of certain new housing units, renovation of existing units, and accessibility modifications at the renter's expense.

1990--Americans with Disabilities Act: provides comprehensive civil rights protection for people with disabilities; closely modeled after the Civil Rights Act and the Section 504 of Title V of the Rehabilitation Act and its regulations.

The modern history of civil rights for people with disabilities is three decades old. A key piece of this decades-long process is the story of how the Rehabilitation Act of 1973 was finally passed and then implemented. It is the story of the first organized disability rights protest.

The Rehabilitation Act of 1973

In 1972, Congress passed a rehabilitation bill that independent living activists cheered. President Richard Nixon's veto prevented this bill from becoming law. During the era of political activity at the end of the Vietnam War, Nixon's veto was not taken lying down by disability activists who launched fierce protests across the country. In New York City, early leader for disability rights, Judy Heumann, staged a sit-in on Madison Avenue with eighty other activists. Traffic was stopped. After a flood of angry letters and protests, in September 1973, Congress overrode Nixon's veto and the Rehabilitation Act of 1973 finally became law. Passage of this pivotal law was the beginning of the ongoing fight for implementation and revision of the law according to the vision of independent living advocates and disability rights activists.

Key language in the Rehabilitation Act, found in Section 504 of Title V, states that: No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Advocates realized that this new law would need regulations in order to be implemented and enforced. By 1977, Presidents Nixon and Ford had come and gone. Jimmy Carter had become president and had appointed Joseph Califano his Secretary of Health, Education and Welfare (HEW). Califano refused to issue regulations and was given an ultimatum and deadline of April 4, 1977. April 4 went by with no regulations and no word from Califano.

On April 5, demonstrations by people with disabilities took place in ten cities across the country. By the end of the day, demonstrations in nine cities were over. In one city--San Francisco--protesters refused to disband.

Demonstrators, more than 150 people with disabilities, had taken over the federal office building and refused to leave. They stayed until May 1. Califano had issued regulations by April 28, but the protesters stayed until they had reviewed the regulations and approved of them.

The lesson is a fairly simple one. As Martin Luther King said,

It is an historical fact that the privileged groups seldom give up their privileges voluntarily. Individuals may see the moral light and voluntarily give up their unjust posture, but, as we are reminded, groups tend to be more immoral than individuals. We know, through painful experience that freedom is never voluntarily given by the oppressor, it must be demanded by the oppressed.

Leaders in the Independent Living Movement

The history of the independent living movement is not complete without mention of some other leaders who continue to make substantial contributions to the movement and to the rights and empowerment of people with disabilities.

Max Starkloff, Charlie Carr, and Marca Bristo founded the National Council on Independent Living (NCIL) in 1983. NCIL is one of the only national organizations that is consumer-controlled and promotes the rights and empowerment of people with disabilities.

Justin Dart played a prominent role in the fight for passage of the Americans with Disabilities Act, and is seen by many as the spiritual leader of the movement today.

Lex Frieden is co-founder of ILRU Program. As director of the National Council on Disability, he directed preparation of the original
ADA legislation and its introduction in Congress.

Liz Savage and Pat Wright are considered to be the "mothers of the ADA." They led the consumer fight for the passage of the ADA.

There are countless other people who have and continue to make substantial contributions to the independent living movement.

REFERENCES

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Wolfensberger, Wolf. The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation, 1972.

The mission of the IL NET is to provide training and technical assistance on a variety of issues central to independent living today--understanding the Rehab Act, what the statewide independent living council is and how it can operate most effectively, management issues for centers for independent living, systems advocacy, computer networking, and others. Training activities are conducted conference-style, via long-distance communication, webcasts, through widely disseminated print and audio materials, and through the promotion of a strong national network of centers and individuals in the independent living field.

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Failure of Deinstitutionalization

- CMHC were poorly prepared to deal with Chronic Mental Illness.
- Poor training of the staff who were working in the community on how to deal with individuals coming out of the institutions.
- Treatment approaches did not take into account the evidence of the biological connection in mental illness.
- Institutionalized identity and behavior patterns on the part of the clients.
- Functional deficits related to independent living outside the institution.
- Atypical or atypical or inappropriate behaviors that may have been “OK” or tolerated in the institution, but less so in the community.

- Due to long-term care in the institutions, clients developed extreme dependency on support staff with little experience in independent self-management and self-care.

Psychosocial Rehabilitation as a Science/Profession

From its “humble” roots in the creative efforts of those first CMHC workers to the science of PSR and the profession of Psychiatric Rehabilitation the field has undergone a mercuric change

The science of Psychology wants to “Describe”, “Explain”, “Predict” and “Control” human behavior…the science of PSR wishes to do this with each of the techniques it develops

Licensing of Professionals

When you enter the mental health field you will encounter a lot of “letters” after people’s names...sometimes a single person will have a LOT of letters!

These letters usually refer to someone’s educational background and specific licenses that they possess that signal their qualifications and skill set. Some of these you might be familiar with and this is certainly not an exhaustive list.

MHRT

MHRT stands for Mental Health Rehabilitation Technician. The MHRT was created as a result of the Consent Decree that found conditions in the State Hospitals to be inadequate. The MHRT has always referred to a specific set of competencies that the Decree writers felt were necessary for employees to have if there were going to work with clients coming out of the State Hospital system.

MHRT-I

- Education - Trainings including the following:
- MHSS (Mental Health Support Specialist) Training
- First Aid
- CPR
- Certified Residential Medication Aid
- Crisis Intervention training such as MANDT or NAPPI.
- What can you do? - These technicians usually provide services in group homes, supported apartments, and in other day-programs or rehabilitative housing programs.

MHRT/C

- At the time of this writing the MHRT/C guidelines are changing. These changes will be in full effect, state-wide, in the Fall of 2019.
- For the sake of this section, we will cover both the “2008 Guidelines” and the “New Guidelines”.

2008 Guidelines

- Education - The MHRT/C represents completion of academic courses or non-credit trainings in the following areas:
  - Introduction to Community Mental Health*
  - Psychosocial Rehabilitation*
  - Interviewing and Counseling*
  - Crisis Identification and Resolution*
  - Cultural Competency / Diversity*
  - Vocational Aspects of Disability
  - Substance Abuse with a Dual Diagnosis Component
  - Sexual Abuse, Trauma, and Recovery
  - Case Management
  - Mental Health and Aging
- Provisional MHRT/C Level A certification is provided for individuals who have an associates, bachelors, or masters degree in a human services field. This certification is valid for ONE YEAR during which the individual needs to complete the courses for their Provisional MHRT/C Level B.
- Provisional MHRT/C Level B certification is granted when students have completed the 5 courses in the previous list with the *
- What can you do? - You need an MHRT/C to do community integration, intensive case management, assertive community treatment, skills development, day support services, and family psycho-educational support.

Visit the Muskie Center for Learning for all the details!

New Guidelines

- Education - The MHRT/C represents completion of academic courses or non-credit trainings in the following areas:
  - (After September 2019) All MHRT/C recipients will need to complete an Online training module produced by the State called “Maine’s Mental Health System 101: An Introduction to our History, Values, Services, and Roles”

- Behavioral, Psychological, and Rehabilitation Intervention Models*
- Community Integration and Inclusion*
- Ethics and Professional Conduct*
- Trauma and Resiliency
- Policy Knowledge
- Mind-Body Connection
- Cultural Competency
- Vocational Support

Provisional Certification is granted when students have completed the 3 courses in this list with the *, and ONE additional class from the rest of the list.

In addition to these changes in the competencies, MHRT/C certifications will now have to be renewed. They are valid for 2 years from the date of issue. When an MHRT/C is renewed, the person will need to provide proof of at least 18 hours of continuing education with 4 of those hours being related to ethics.

MHRT/CSP

This particular type of MHRT focuses on becoming a Crisis Support Provider. Along with the rest of the requirements of a full MHRT/C, this certification requires that you complete the state Crisis Training Curriculum.

LSW-CC

This Social Work license is granted as a conditional Licensed Social Worker. It is referred to as the Licensed Social Worker - Clinical Conditional.

- Education - Bachelors degree in Social Work or another related field. Successfully pass the LSW exam.
- What can you do? - Your work must be supervised by a full LSW (or above). You have to document two years of experience and the pass another test to become an LSW. Your job duties are the same as the LSW but with supervision.

LSW

Licensed Social Worker

- Education - Bachelors degree in Social Work or another related field. Successfully pass the LSW exam.
- What can you do? - LSWs can work as medical social workers in hospitals and home health, hospice social work, and nursing home/long-term care facilities.

LMSW

Licensed Masters in Social Work

- Education - Masters in Social Work and has passed a Social Work exam (but not the clinical level)
- What can you do? - Social Work at this level is very diverse. Depending on the employer you may hold supervisory roles, program management, social work (similar to an LSW), etc. This is a non-clinical degree but you are allowed to engage in private/independent practice.

LMSW-CC

Licensed Masters in Social Work - Clinical Concentration

- Education - Same as LMSW, has passed one exam. Needs to work under the supervision of an LCSW or CSW-IP (Certified Social Worker - Independent Practice.
- What can you do? - You cannot engage in private practice, but under supervision you can work in an agency/hospital/school setting.

LCSW

Licensed Clinical Social Worker

- Education - Masters in Social Work and additional years of experience (at least two years while they were an LMSW-CC). Passed two Social Work Exams.
- What can you do? - As an LCSW you can engage in clinical social work practice, supervise social workers, psychotherapy, group psychotherapy, family psychotherapy, etc.

LCPC

Licensed Clinical Professional Counselor

- Education - Masters in Counseling, years of supervision and passing the LCPC Exam.
- What can you do? - Clinical work, psychotherapy, group psychotherapy, family psychotherapy, etc.

Substance Abuse Treatment

All licenses for substance abuse treatment are managed by the Board of Alcohol and Drug Counselors in the State of Maine.

The licensing of Alcohol and Drug Counselors has a long history connected with the self-help movement and validates the personal experiences of those in recovery and how they may

be able to provide professional services to others with substance use issues. To this end, the regulations for substance abuse counselors is framed differently and not as dependent on degrees or specific college classes (though these can also play a role in licensing.)

Within this framework you will find the following licenses (please visit the Board of Alcohol and Drug Counselors for more information on the qualifications and capabilities of each of these licenses.)

- Alcohol and Drug Counseling Aide
- Certified Alcohol and Drug Counselor
- Licensed Alcohol and Drug Counselor
- Certified Clinical Supervisor

Psy.D.

Doctor of Psychology/Psychologist

- Education - Different from a Ph.D. in Clinical Psychology, the Psy.D. focuses more on applied/clinical aspects of psychology. Less emphasis on research.
- What can you do? - You can practice as a Licensed Psychologist. All sorts of counseling and clinical applications.

Ph.D.

Doctor of Philosophy

A Ph.D. is considered the “terminal” or highest degree attainable in a given field. You can obtain a Ph.D. in nearly every field there is, including Psychology, Social Work, Nursing, Biology, History, etc.

The emphasis of a Ph.D. can vary and focuses primarily on a research topic selected by the candidate. The candidate performs original research in the process of the writing of their “Dissertation.”

A Ph.D. in Clinical Psychology is widely considered the highest credential within the field of clinical mental health.

MD - Psychiatrist

A Psychiatrist is a Medical Doctor (just like a surgeon) but they competed their residency in Psychiatry.

Psychiatry focuses on the treatment of mental health disorders primarily with medications. As medical doctors, psychiatrists are uniquely qualified to prescribe psychotropic medications. Some psychiatrists also engage in counseling and other clinical practices.

Psychosocial Rehabilitation and the Consent Decree

The MHRT designation arose out of a lawsuit that occurred in the State of Maine. The State of Maine was found negligent in the care of patients at the State Hospitals in Augusta (AMHI) and Bangor (BMHI). In accordance to the decree from the court, the State of Maine had to provide training to community-based providers in order to reduce the overall patient population at both hospitals and begin to focus on community-based provision of mental health services.

The title and certificate of the Mental Health Rehabilitation Technician arose from this mandate.

Maine.gov

Click here to visit the official web page of the Consent Decree

Professional Journals

One of the most important sources of information on the "latest in the field" can be found in professional journals. These are "magazines" that are published by professionals in the field for other professionals in the field. In addition, the work that is published has been reviewed by a set of people who work and do research in the field to ensure that the article is well written, uses appropriate and reliable methods, and contributes to the field. These articles are said to be "peer reviewed."Some professional research journals related to mental health include:

International Journal of Psychosocial Rehabilitation

Psychiatric Rehabilitation Journal

Psychiatric Services

Community Mental Health Journal

Journal of Rural Mental Health

Chapter 3 Review

Question 1 of 5

Which of the following was NOT a factor that contributed to deinstitutionalization?

- **A.** Medication
- **B.** SSI
- **C.** Community Mental Health
- ✓ **D.** Changes in Public Perception

◀ Check Answer ▶

Assessment

Chapter 3 Discussion

Discuss the different credentials that are outlined in the tables in this Chapter. What are you goals in this field?

Chapter 3 Assignment

History of PSR

For this assignment you are going to create a presentation with a voice over an app called Adobe Spark Video. Keep in mind that your graphics should be minimal (not a lot of words on the screen) that support your audio.

Click the app icon below to get this app!

Text Link

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Your presentation will summarize significant historical facts and events for ONE of the following social changes (your instructor will assign your area to you):

- Deinstitutionalization
- Self-help Movement
- Civil Rights Movement
- Independent Living Movement

- Medications

Your presentation should reflect RESEARCH into these areas and include key legislation (federal and/or state) and people (pictures and bio information).

In addition, you will summarize your findings by explaining how this particular set of historical circumstances is related to the overall development of the Psychosocial Rehabilitation philosophy. **Limit your presentation to 5 minutes**.

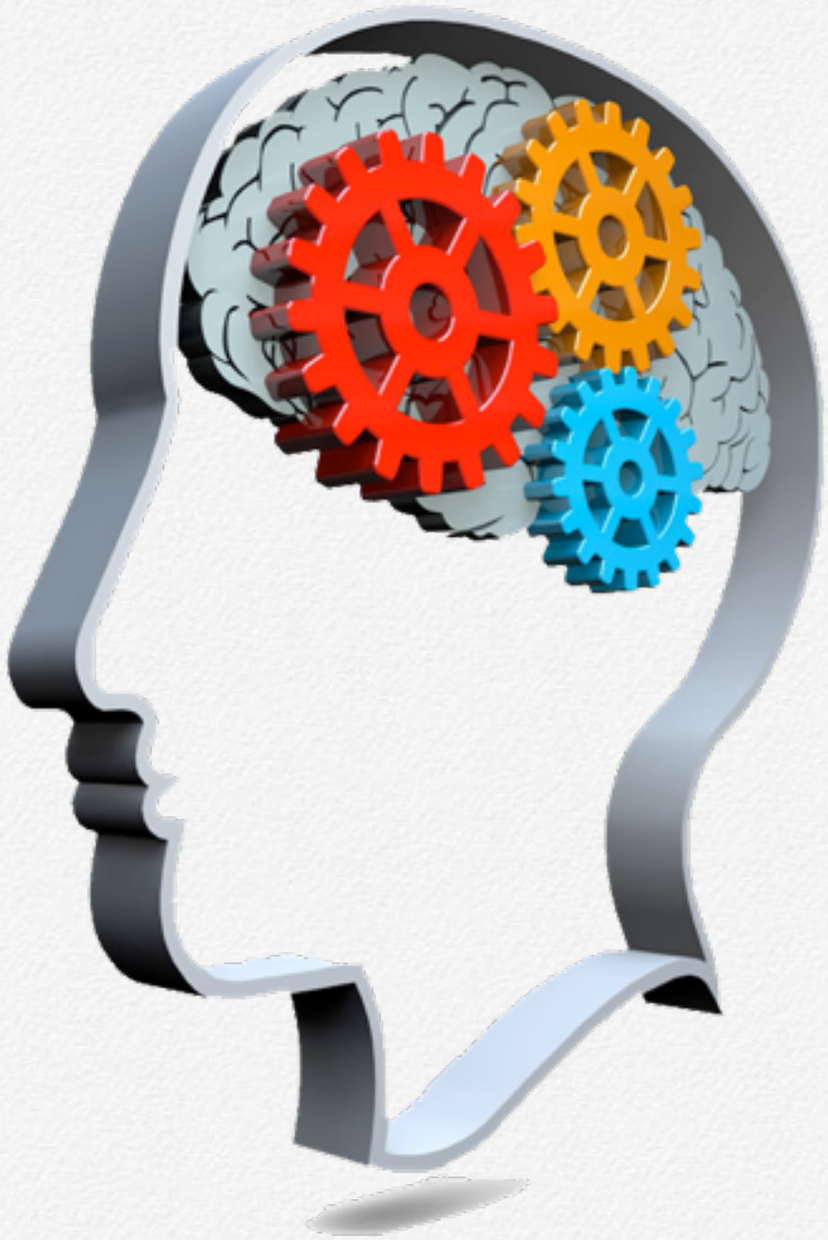
Follow the instructions in the tutorial on obtaining a LINK from your Adobe Spark Video page and post that link into the Drop Box in Blackboard.

Grading Rubric for Chapter 3 Assignment

Goals, Values, Principles and Practices of PSR

4

Attention



Discipline

The word “discipline” has many meanings. In this context we call upon two of them. One is that the word can be used to identify a field of knowledge, such as, in this case, the Discipline of Psychosocial Rehabilitation. A related use of the word is to describe the routine and self-imposed limits upon one’s own thinking and acting, such as to be disciplined about your exercise routine every day.

Both of these meanings are relevant to our discussion here. We are now examining the Discipline of the field of Psychosocial Rehabilitation and introducing the discipline of thought that is expected by practitioners. We will learn about the goals, values, principles, and practices of the field and explore how these align with our own goals, values, principles, and practices. Dramatic conflicts between the two can render a mental health worker highly ineffective.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Identify the goals, values, principles, and practice of Psychosocial Rehabilitation and how these align with personal goals, values, and principles
2. Discuss challenges to the implementation of these goals, values, and principles on a pragmatic and personal level.

Teaching

A Philosophy

Essentially this course is a PHILOSOPHY course.

This particular philosophy guides our practice in the field of Mental Health Rehabilitation. We will explore the origins of this philosophy later in the text.

For some this can be a very challenging time in their education about mental illness and psychosocial rehabilitation. These goals, values, principles and practice are the shared guides that we use to conduct our practice. They should pervade our thoughts and our daily interactions with clients, other providers, and the public.

Some of these guides may be challenging to your own personal values prior to entering this field. For example, the Value of "Dignity and worth of every individual" is all encompassing. This means EVERYONE. You may encounter people who have committed acts that you find horrendous, yet you must engender a base value of that person's dignity and worth! You are not required to be "OK" with what they have done, but to be effective in this field, you need to be able to see the person as somewhat separate from their actions.

This can be a very challenging task.

What follows is the same set of Goals, etc. that you encountered earlier but for each one there is some additional commentary for you to consider.

Goals, Values, Principles, and Practice of Psychosocial Rehabilitation

Kim Lane, Ph.D. and Mark Kavanaugh, Ph.D.

Goals

The goal of all PSR is to restore each person's ability for independent living, socialization, and effective life management. It is a holistic approach that places the person at the center of all interventions.

Goals represent major guideposts that shape and inform our practice. First in this particular goals is that we strive to restore a person to the highest level of independence they are capable of. Regardless of how much history we might have on the individual, we are never really sure just how independ-

ent they can possibly be until we try. Even in the face of failure, we still hold on to the hope that a higher degree of independence is possible.

The second part of this major goal is that the client is in the center of the process. This really operationalizes as the client is the one who makes choices and decides what is important. This can sometimes run counter to our logic, the client's best interest, and even their safety...yet we need to still honor the perspective of the client in all we do.

The implication of this "centered-ness" of the process also means that the planning and work we do with clients needs to be participatory. The client has to have a central role not only in being there and agreeing to it...but services are provided where the client lives and with them leading the discussion on the planning of their own lives.

Effective rehabilitation builds on a person's strengths and helps the individual to compensate for the negative effects of the psychiatric disability.

When someone is sick and seeks help, the focus is often on defining specifically what is WRONG (symptoms) and addressing the issue to FIX what is wrong. In the rehabilitation world we understand symptoms and the barriers that they produce, but we are also focused on the strengths that the client possess that they can use to help adapt to their circumstances.

These strengths are located in the person themselves (skills, knowledge, awareness, personality, education, attitude) their history (jobs, experiences, military history, personal survival with mental illness), and in their environments (housing, money, friends, family, connections).

When we are trying to help someone solve a problem, whatever that problem may be, we are best served to explore the strengths a person has and start there rather than focus exclusively on the challenges and barriers the person has due to their mental illness.

The rest of these lists build upon these basic premise of these goals.

Values

- Self determination and choice

Values describe what we feel are important and often unchangeable attitudes that we bring to the table. Even in the presence of those who do not hold these values we are often the advocates that the process comply with them.

There is probably no more closely held attitude that we advocate for than the right for someone to be able to make choices in their lives. This is not only a civil right, but a method of assuring that the plan is not contrary to the personal goals and motivations of the client. Incidentally, this also assures a higher degree of "buy in" by the client.

- Strength based focus

Similar to the goal we have already discussed, the strategies that we use to help our client's to achieve their goals are based on THEIR strengths, not ours or anyone else's. We keep in mind that our goal is a greater degree of independence. When we help clients realize the strengths that they have and empower them to use their own skills, knowledge and experience to solve problems, we are encouraging even more independence.

- Dignity and worth of every individual

Sometimes our clients come to us with some pretty checkered history! Sometimes the client's current attitude and behavior may not endear them to us...we may not even like our client! We are free to hold our own opinions on the clients that we serve, but at all times we must treat them with the dignity and respect that every human being deserves.

This can be challenging!

However, this philosophy arises from the work of Carl Rogers and his concept of "Unconditional Positive Regard". There is a deep-seeded human value in everyone on Earth. Our client's do not have to "earn our respect".

Text Link

Click HERE to learn more about Roger's Six Conditions mentioned in the video.

- Optimism

Optimism is represented by the positive, upbeat, hopeful attitude that we take when we are working with clients. This comes across in the choices of words we make, our body communication, and our tone of voice. We have to bring "energy" into the conversation and provide a substantial amount of energy to our clients in order to help them realize the power of choices they have.

This is not to say that we are always playing the cheerleader. There are times where we have to face the grim reality of the circumstances that a person has found themselves in and work within those boundaries. A constant cheerleading can also lead to a degree of un genuine positiveness that will create a barrier between you and your client.

We strive to be honest and straight-forward while being assured that we can work through some situations with our combined skills.

- Capacity of every individual to learn and grow

This attitude is actually the source of our strength to be optimistic. We have to be able nurture within us a sense that with supports, encouragement, and motivation, change can happen. This can be quite a challenge when you encounter someone who is refusing to make good choices or seems to sabotage efforts.

Yet, the capacity remains in the individual to change.

Still, we must be careful to not fall into the trap that client motivation is at the core of all failure. We can become rather invested in the growth and change in our clients and we formulate a degree of our perceived effectiveness in our work based on their success. This is natural. We can, however, attribute our clients failure solely to attributes of our client when in fact it may be our own failings have contributed to the situation, or the "tough to swallow" fact that WE may not be the ONE to help THEM. We, individually, may not be the person to help them. Someone else may be more successful.

- Cultural sensitivity

When we talk about culture we often thing about such diversity as race, ethnicity, and language. While these do formulate parts of culture they are not the sole recipients of our cultural sensitivity.

Aspects of our culture that make us different may involve our opinions and values on things:

- Religion
- Money
- Work ethic
- Honesty
- Personal space

- Sexuality
- Personal hygiene, dress, grooming
- Morals
- Politeness
- Respect
- Family, Children, Discipline
- Diet and nutrition
- Substance use

I'm sure you can see where you have very specific thoughts and how these may be different from the thoughts of your clients. Yet we need to be sensitive to these differences. In fact, many of the barriers that our client's face may be linked to "unconventional" cultural norms that they ascribe to that are not acceptable in some places or to some people. Seeing these as "cultural barriers" rather than indifference can be a breakthrough in helping someone understand why they are experiencing they barriers.

Principles

Principles go a little deeper than values and inform our day-to-day interactions with everyone we meet. Others may not know our values, but they recognize our principles because we act on them. They formulate our public self, the personality that we reveal through our actions.

So, the key questions we ask ourselves regarding our principles is "Am I acting in a way that is consistent with this principle? Is my behavior in congruence with this principle? If I was being charged in a court of law for having this principle, would there be enough evidence to convict me?

- Hope is an essential ingredient in psychosocial rehabilitation. All people have an underutilized capacity to learn and grow that should be developed.

Does our behavior convey that we truly have hope for a situation changing? Many of our clients have had a lot of hopeless times in their lives. They may have given up hope themselves. Can we add our own hope to the situation?

- All people should be treated with respect and dignity.

Does our behavior reflect that we have respect for our clients, co-workers, doctors, they mental health system...even if we don't agree with them? When we are in conflict with our family members and/or co-workers do we practice the Golden Rule and make effort to "treat them as we would like ourselves to be treated?"

- Service provision strives to meet the client "where they are" and to assist them in moving forward toward their goals.

Do we try to understand our client's world view? Do we demand our clients to do things in order to win our appreciation or even our help? Can we develop an understanding and empathy for how difficult personal change is and how easy it is to simply give up?

- Active participation and choice are the hallmarks of service planning and focus on the stated goals of the person receiving services.

Do we resist the temptation to do the planning FOR our client? Do we do things ourselves because it gets done faster when it would be better to have the client do it themselves? Do we use our personality of influence to move our client in our direction (sometimes a good thing) too much so that the plan represents more of OUR goals for them rather than THEIR goals for themselves?

- PSR focuses on "real world" everyday activities and facilitates the development of skills and supports for people to participate as fully as possible in normal roles within family and community settings.

Do we envision our clients in independent roles such as "father" "worker" "friend" "renter" etc. and strive to teach them the kinds of skills that are needed in each one of these roles?

- Assumption that persons who receive services have skills, talents, and qualities that can be leveraged to assist the person in the rehabilitative process.

Can we see how the different experience our clients have are actually strengths simply because they have survived them? Can we work with clients to help them realize that they have important skills that can be applied to personal problem solving in areas such as personal care, developing social connections, work, and happiness?

- Multicultural diversity among PSR program staff, participants and the community at large is appreciated as a source of strength and program enrichment. Programs take active

measures to respond in ways that are considerate and respectful.

Just as we are expected to recognize and honor cultural differences in our clients, can we do the same to everyone around us? Can we do so with our co-workers, our bosses, people of different backgrounds that we meet? Do we harbor negative perceptions and prejudices that interfere in our work (realizing that we may not always be aware of how these interfere)?

- PSR is premised on self-determination and empowerment.

Can we recognize that sometimes the empowerment of a client is dependent on us NOT doing something (our own efforts to help can undermine a client's ability to be in charge of their own lives)? Do we value the experience of failure as a tool provided it is supported and processed as such. Can we see the connection between helping too much and the lack of opportunity to experience and learn from failure?

- An individualized approach to the development and provision of PSR services best meets the needs of people who choose to use these services.

Do we have pre-conceived notions as to what is "best" for a client with a particular diagnosis or a situation? Do our personal experiences overcoming our own challenges get in the way of us having a fresh approach to the unique qualities of our clients' situations?

- PSR practitioner role is intentionally informal and participatory in activities that are designed to engage the person with mental illness and cognitive disabilities in the real world.

Are we TOO professional? Are we attached to the difference in status that implied by one person (us) being the service provider and the other (our client) being the recipient of our services? Can we be "real" with our clients? While still maintaining professional relationships with our clients can we sometimes fail ourselves, own up to it, and admit when are unsure?

- The prevention of unnecessary hospitalizations and the stabilization of community tenure are primary goals of PSR.

One of the most devastating things that can happen to a client is for them to lose their independence and go into the hospital. IF someone needs to be in the hospital that is where they need to be, but it can cause a great deal of upheaval in their lives. They can lose their jobs, housing, friends, family and all the progress they have made on any goals. We keep this front and center in our minds through our work. We ask ourselves, can we do anything that can help this person remain as independent as possible?

Practices

The following practices identify the areas in which we practice this philosophy. Each of these has a rehabilitative slant to them and each are enhanced by the application of PSR philosophy.

The approach is holistic and responsive to the individual needs of the client in any one of these areas.

It can be our role to ask about these areas of their lives as we work with them. Each of these areas is interconnected into one whole...our client...so work in any one of these areas could have influence on the others.

- Social rehabilitation
- Vocational rehabilitation
- Residential and housing services
- Educational supports
- Education about mental illnesses and medications
- Physical health
- Intensive case management
- Supportive counseling
- Family support
- Spiritual support

Text Link

This section is replicated in the Mental Health Core Content CourseBook

Chapter 4 Review

Question 1 of 5

Effective rehabilitation builds on a person's _____.

- ✅ **A.** Strengths
- **B.** Goals
- **C.** Barriers
- **D.** Diagnosis

◀ Check Answer ▶

Assessment

Chapter 4 Discussion

Describe your own personal views as to what it takes for some-one to "get better" or "recover" from mental illness. Can ANY-ONE get better as is described in the Principle of Hope?

What about those who have substance use disorder, or have a long history of abusing children or their spouse?

Do you see any instances in the provision of services where it might be difficult to consistently apply this philosophy?

Chapter 4 Assignment

PSR Values

In this assignment you will create a document.

The paper will consist of a title page and then a list of each “Value” that was discussed in this class...just the Values.

Write the value down in bold type font. Then, write a paragraph with a brief summary of your thoughts, concerns, and potential conflicts between your own personal values and those held by the field of psychosocial rehabilitation.

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Grading Rubric for Chapter 4 Assignment

Goals of PSR

5

Attention

Goals

Goals represent the highest level of practice we strive to achieve. We set goals, and often write them down, because by keeping our eye on where we want to be we can make better choices where we are.

Each day we are confronted with choices in our practice. The task is to continually evaluate if our decisions are moving us TO-WARD our goals or AWAY from our goals. Often the easier, or even “encouraged and expected” manner of working, actually leads us away from our goals.

Here we will examine the Goals of PSR and how they may guide our practice and how they can be challenging to actually achieve.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Describe how these goals align with their own personal goals for success.
2. Discuss how personal history, experiences, and skills impact their effectiveness as a mental health worker.
3. Identify specific challenges related to a client-centered approach.

Teaching

Goals of PSR

Consider the following points that are covered in the two goals set out in Chapter 4:

- Independent Living
- Socialization
- Effective Life Management
- Client as Center of Interventions
- Strengths
- Compensation

When we examine these goals it is clear to see that these are very similar to the goals we may have for ourselves. We may not often think of them this way, but we all strive to live as independently as possible, to socialize and have satisfying relationships, to effectively manage our lives (bills, jobs, friends, etc.), to feel in control of our own lives, to focus on our strengths, and to compensate for our weaknesses by building on our strengths.

Put this way; we can clearly see that our own goals are nearly identical to our clients' goals. The difference might only be that our clients experience more barriers than we do!

Rehabilitation provides empowerment to individuals with disabilities, allowing them to maximize their capabilities while minimizing limitations. A skilled mental health professional utilizes rehabilitation skills and strategies to maximize the potential for independent living. The psychosocial philosophy emphasizes a multidisciplinary approach to guide people with disabilities to their pre-injury potentials of physical, mental, social, educational, vocational, and recreational status. There is a continuous interaction between the person and their environment. Viewing rehabilitation from a holistic perspective enhances the probability of a successful outcome.

One of the critiques of courses like this is that we present ideals that are not always able to manifest in the "real world". I stand guilty as charged!

We describe the ideals as to what the field SHOULD be like so that you may be able to go out there and contribute a bit to the

achievement of some of it! We are well aware that these goals are often not met and that we can become very discouraged by this. At the same time, by knowing the ideal, we can exhibit practice that moves our work closer to these ideals. That is how each of us contributes to a betterment of the field.

Barriers to the Goals

Persons with mental illness have symptoms and, in some cases, a lack of knowledge, skills, or experience in a particular area. Maybe many areas.

These circumstances create what we call barriers. These barriers are real hinderances to the successful attainment of a goal. Let's look at each aspect of the two major goals of PSR and examine how symptoms, and/or a lack of knowledge, skills, or experience create barriers that we can address with our plans.

Independent Living

Sometimes we may encounter a person who we fill will "never" be independent. While this may seem to be a failure we need to remember that none of us are really "independent"…at least not totally. What we want to do is maximize a person's independent to the limit of their ability. We want to help people take risks while at the same time not giving up on them no matter how many times they may fail.

For many, independent living is the process of discovering the kind of supports you need to be successful in life. Each of us depends on others to some degree to help us with challenges.

Socialization

Remember than many of our clients were not raised in environments where positive social role models were present. Abuse,

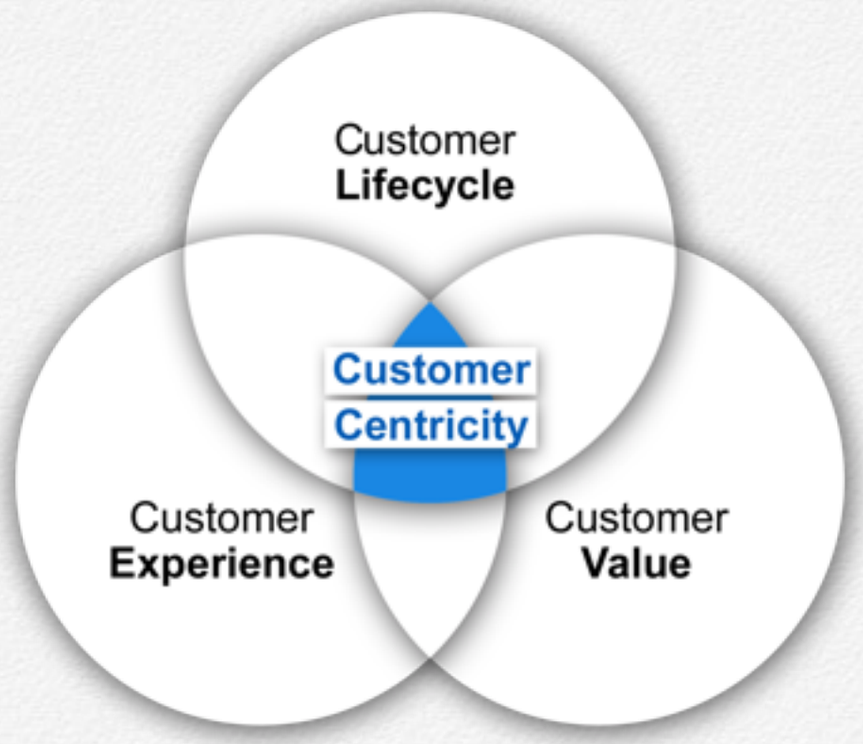
absence, and violence often characterize our clients' early (and often current) living situations. Many of us learned these skills and we didn't even realize we were learning them.

Effective Life Management

Similar to independent living, effective life management may be challenging for some. This is particularly frustrating when our client's may have patterns of poor decision making that continually get them in "trouble." Again, it is vital that we attempt to maximize effective life management.

Client as Center of Interventions

A deep value of PSR is that the client is in charge of their own lives, and hence they are in charge of their own plan. This is a challenge when someone also lacks the skills they need to manage their own lives and engage in effective life management.



This "Customer Service" graphic is a great representation of how services can be delivered in mental health.

Strengths

Related to the value of worth in every person, every person has strengths. Because our interventions often focus on the negative aspects of someone's mental health (reducing unwanted symptoms, preventing suicide, stemming substance use) we often lose sight as to the very real and useful strengths our clients possess. Indeed as we will see in Compensation below, if we recognize and build on these strengths we will be more successful in assisting our client.

Compensation

It is important to recognize that individuals with mental illness often have a long personal history of compensating (acting in ways to hide or minimize the impact) for their symptoms and mental illness. In some circumstances these patterns can be devastating (even though they may have helped the person survive to this day.)

Chapter 5 Review

Question 1 of 5

Independent living means that you have your own apartment.

- ✅ **A.** True
- ⚪ **B.** False

◀ Check Answer ▶

Assessment

Chapter 5 Discussion

Why do you think some providers find it a challenge to keep the client as the "center" of all interventions?

Chapter 5 Assignment

Strengths

For this assignment you are going to create a presentation with a voice over using Adobe Spark Video. Keep in mind that your graphics should be minimal (not a lot of words on the screen) that support your audio.

Click the app icon below to get this app!

Text Link

Use the link below to access the tutorial on how to use this app in the iOS and App Tutorial CourseBook.

Text Link

Your presentation should cover the following points:

Part I: Reflect on what specific skills and experiences **you** have that will enable you to be an effective helper to someone who seeks independence, socialization, and effective life management. (Break these skills down a bit to answer this question...what does it take to live on your own, to make friends and socialize, and to manage your life?)

Be sure to focus on the skills you feel that you possess and have helped you to be successful.

Part II: In the first question you reflected on your strengths...describe a situation that you were able to **overcome** because of one of these strengths.

Specifically I am looking for a story from your life where you actually used some of the skills that you described in Part I to accomplish a personal goal or overcome a particular barrier. Be sure to make it clear which skills you are covering.

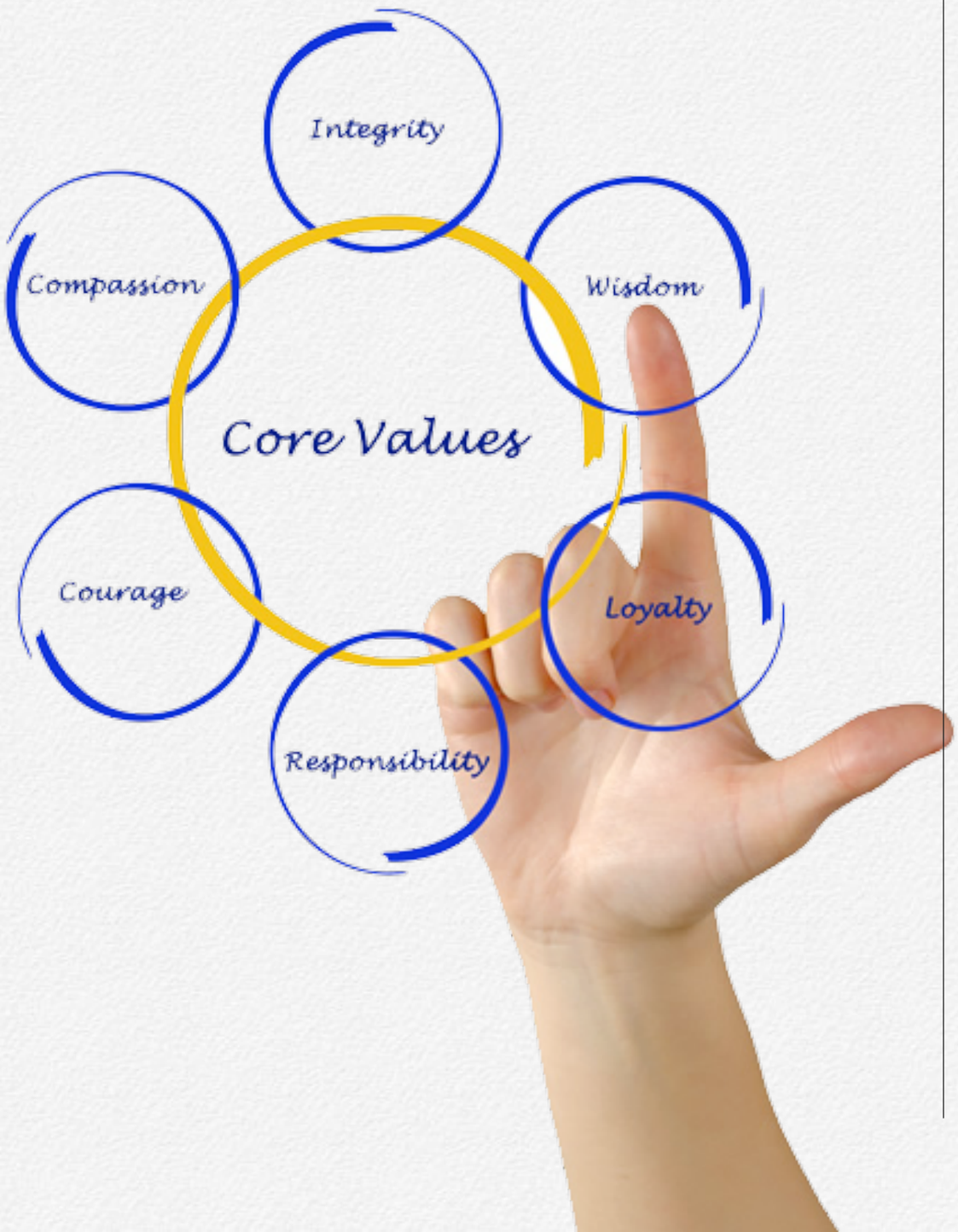
Follow the instructions in the tutorial on obtaining a LINK from your Adobe Spark Video page and post that link into the Drop Box in Blackboard.

Grading Rubric for Chapter 5 Assignment

Values of PSR

6

Attention



Values

Values refer to those things we believe are “important” and the priority in which we feel they are more important than other things. More than anything in this class, the Values of PSR define the “culture” of service provision. These define what we think is most important for us as practitioners. Our values guide us on how we determine right and wrong, despite any pressure or temptation to do otherwise.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss differences of core values from diverse coworkers that may interfere with the provision of PSR services.
2. Apply an understanding of personality type to an analysis of your personal workplace behavior and needs.

Teaching

Review the Goals, Values, Principles, and Practices Information from Chapter 2

Core Values of PSR

- Self determination
- Dignity and worth of every individual
- Optimism
- Capacity of every individual to learn and grow
- Cultural sensitivity

Each of these of these characteristics are deeply imbedded in the PSR philosophy and permeate all applications of our work.

Self Determination

Being able to make informed choices as to what happens in your life is a quality of our existence that we often take for granted.

Can you think of circumstances around the world where this is not the case:

- Political Dictatorships
- Child Rights (or lack of)
- Women's Rights
- Jail
- Slavery

Issues of self-determination are key in areas of health care such as treatment decisions, end of life issues, parenting, schooling, and civil liberties. Although this is related to "empowerment" it really embodies that the "power" we speak of is already within the person.

Dignity and Worth of Every Individual

This might be a handful for some people (some clients and some practitioners!)

Carl Rogers presents in his theory of Person Centered Counseling the ethic of "Unconditional Positive Regard".

"Unconditional" means that there is no need to "earn" the regard...and it is present regardless of what a person has done, will do, or can do

"Positive Regard" does NOT mean that you support every action that a person does...it DOES refer to the basic idea that you view the individual as essentially worthy of existing

While this is one of the most challenging of Roger's concepts it has also been very effective. Charged to work with a number of individuals with various histories of victimization and perpetration we are challenged to see beyond the circumstances of the present and into the larger picture.

Optimism

This particular quality is often seen as a "personality" construct as much as anything else. Do you see the glass "half full" or "half-empty."

Nurturing a sense of optimism and hope is critical to personal survival in the field and for your overall effectiveness as a practitioner.

It is not to be confused with being naive, though many will accuse you of being so!! There is a lot of negativity in the field of Mental Health.

Self-fulfilling Prophecy

One of the most manifest dangers of negativity is self-fulfilling prophecy. When we lower our expectations, even when it serves to protect us from disappointment, we actually increase the likelihood of failure.

We often couch our negativity in the guise of "keeping clients' goals reasonable and not getting their hopes up"

Why not get their hopes up? When hope is all you have…

Capacity of Every Individual to Learn and Grow

Each and every individual has strengths that directed, can bring about profound change in their world and the world around them. Our task is really to assist individuals on directing their energies in these directions.

One challenge of personal growth is change, change of habits, friends, behaviors, etc.

Cultural Sensitivity

Personally I find that the concept that we are all "essentially the same" to be not only misguided, but insensitive. We are not all equal, we are not all the same.

The path to cultural sensitivity does not rest in focusing on the ways in which we are the "same" but on the ways that we are "different". This focus however, is based in the "Dignity and Worth" value!

In the movie "Robin Hood: Prince of Thieves" with Kevin Costner and Morgan Freeman, Azeem, the Muslim character played by Freeman is asked by a young girl why "God painted" him (likely Azeem was the first black man she had encountered)

Our world is made richer by the diversity of our people...this extends into differences that you might find uncomfortable or offensive. In our work we evaluate the ways and means of people's behaviors by their function...does this work where they want it to work to accomplish what it is they want to accomplish...rather than by the assumption of a universal code.

Personally we can ascribe to our code, but in our work we remain sensitive that we are not all alike...and we honor it.

So in what ways do we sometimes differ from others:

- Looks
- Money
- How to raise kids
- Value of knowledge and learning
- Personal history
- Work ethic
- Sex related issues
- Religion
- Politics
- Preferences

- Food
- Dress
- Marital status
- IQ
- Emotionality
- Health
- Wellness

need I go on...???

Personality

Have you ever heard someone say “There are two types of people...” and then go on to explain the two types?

Well, the term “type” is one of the ways the world of psychology describes our understanding of personality.

Personality is technically defined as the “relatively consistent pattern of behaviors that you engage in.” This relatively dry definition exposes the fact that the field of psychology has not really come up with a definitive way to describe such a complex characteristic of who we are.

Most explanations of personality are based on different theories that have been put forth that seek to explain patterns in human behavior (positive and negative). Some personality theories (such as Freud’s Psychodynamic Personality Theory) emphasize the inner workings of the mind and how energy is translated between internal needs, societal demands, and the individual experience of these energies.

Other theories (such as Behaviorism) attribute personality to a lifelong series of reinforcements and punishments from the environment that have shaped who you are today.

An entire category of theories are known as Personality Type Theories. These theories tend to categorize individuals along a number of dimensions which result in global assumptions we can make about how that person behaves.

The bottom line is that all the theories of personality are useful in some way or another. As we have learned in this course so far, individuals are complex and unique. Sometimes the best use of a theory is to simply provide some additional insight into yourself not so much to categorize you and define who you are.

Personality Differences

Since we are talking about individual differences and honoring those in ourselves and others, we can use these theories to explore our own selves. Understanding our unique personality

patterns allows us to both appreciate our own uniqueness and to also appreciate the uniqueness of others.

Myers-Briggs Personality Type

One of the most famous and utilized personality typologies was developed by Isabel Briggs Myers and her mother, Katherine Briggs in an effort to measure the personality types identified by C.G. Jung (the famous student of Freud.)

Carl Gustav Jung

Jung's theory (and the Myers-Briggs Typology) are based upon four dimensions, these include:

Favorite World - do you prefer to focus on the outer world or your own inner world? This is called Extraversion (E) or Introversion (I).

Information - Do you prefer to focus on the basic information you take in or do you prefer to interpret and add meaning? This is called Sensing (S) or Intuition (N).

Decisions - When making decisions, do you prefer to first look at logic and consistency or first look at the people and special circumstances? This is called Thinking (T) or Feeling (F).

Structure - In dealing with the outside world do you prefer to get things decided or do you prefer to stay open to new information and options? This is called Judging (J) or Perceiving.

(these descriptions are from the website of the Myers & Briggs Foundation.)

Based on these four dimensions, the test provides you with a sequence of letters (one for each dimension) making up 16 possible combinations, or types.

Research and correlations between these types and relationships, career, social interactions, ambition, and many other aspects of the human experience are plentiful. But, the results of your test are only as useful as you want to make them.

In the Assessment section of this Chapter, you will be introduced to an app that provides a version of this test for you to take in order to arrive at your particular personality type.

The best way to approach this test is to consider the questions in light of ONE of your social roles. So, if you want to know your typical personality patterns at HOME then consider your role in your family. If you want to know more about how you behave at work, then answer the questions in regard to how you would act at work or with co-workers. These different perspectives may give you different results, making the test even more fun and useful.

Click HERE for a brief description of all 16 different types

Chapter 6 Review

Question 1 of 5

Being able to make your own informed choices in as example of:

- **A.** Allowances
- **B.** Risk
- **C.** Self-determination
- **D.** What everyone does

◀ Check Answer ▶

Assessment

Chapter 6 Discussion A

Let's review some of the ways in which we may differ from our clients and coworkers. How might these differences impact our ability to hold true to the values presented in the PSR philosophy?

Review in what ways you may cope with these differences. Are there any that you would not be able to deal with very well? What role might clinical supervision play in dealing with these differences?

Chapter 6 Discussion B

You will be using an app called **Jungian Type Questionnaire** to obtain information about your personality. Specifically, you will be learning about your personality type.

Click the app icon below to get this app!

Text Link

Use the link below to access the tutorial on how to use this app in the iOS and App Tutorial CourseBook.

Text Link

This app is based on the Myers-Briggs Typology and will give you a series of 4 letters and categorize you as one of 16 different personality types.

Visit the TypeLogic website and read up on your personality.

Discuss how your personality defines how you process information, make decisions, and deal with conflict. Discuss how these personality traits could be both a strength (something that helps

you) or a liability (something you need to watch out for when dealing with certain kinds of people.)

To add another dimension to your self-analysis, visit this page on Functional Pairs. This page explores the combinations of certain pairs of letters in your results.

Principles of PSR

7

Attention

Principles

You may notice a significant amount of cross-over between the goals, values, and principles of PSR and this is purposeful. The very important aspects of our practice should reflect in each of these, respect & dignity and self-determination, for instance.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Review the basic principles of the practice of PSR
2. Analyze how a treatment plan can be applied in line with each of these principles

Teaching

Review the Goals, Values, Principles, and Practices Information from Chapter 2

Principles of PSR

- Hope
- Respect and Dignity
- Real World
- Multicultural
- Self-determination
- Individualized
- Informal and Participatory
- Preventive

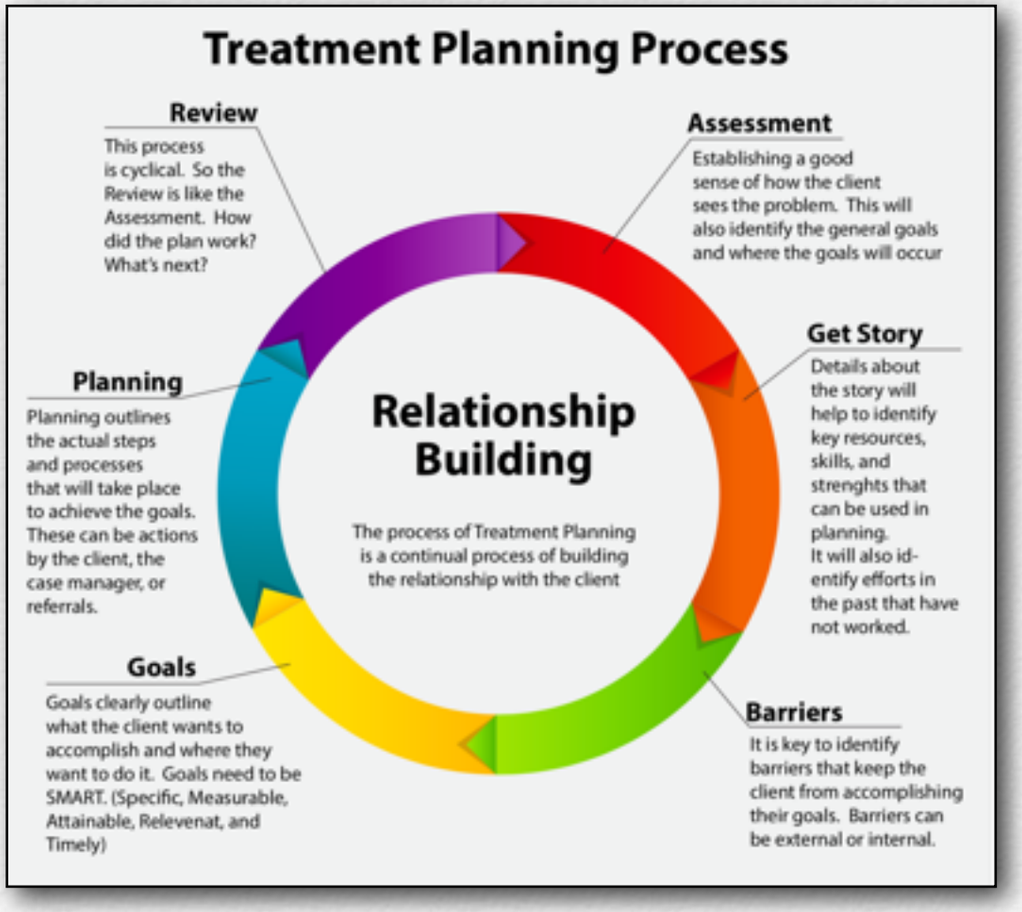
These principles guide our practice when we develop plans to work with individuals to help them solve real world problems.

For this Lesson you are going to be presented a detailed case study. You are to work to develop a realistic treatment plan for the individual that can truly be implemented if this were a real case.

You will then reflect on how the plan, the environment, and your behavior in implementing the plan will provide strengths and challenges associated with complying with the principles associated with PSR.

Treatment Planning

Treatment planning is a challenging task, but it can be broken down into fairly straight-forward steps. These steps take you through the process of determining a client's strengths and needs (assessment), setting goals (what do they want to change), barrier identification (what is getting in the way), planning (identifying the individual steps and responsibilities of each person involved), and then back to assessment (evaluating the effectiveness of the plan and moving forward on to other needs.



Assessment - This process involves the gathering of information related to the identified problem(s). Areas that we may encounter in our work included:

- Housing
- Social
- Safety
- Career
- Financial
- Relational
- Health
- Educational
- Spiritual

Goal Setting - This involves the establishment of workable goals that identify where the person "wants to be" in relation to this area of their life. Keep in mind that the goals need to be measurable so we can know when they are achieved

Barrier Identification - Based on both the symptoms and the specific environment in which your client wants to apply these changes, you can identify barriers to their success.

For example: Let's say that a person with Major Depression wants to get a job working at Walmart. One issue that may arise with Major Depression is "difficulty sleeping", which in some cases makes it difficult for people to get up early. The barrier that Major Depression creates at Walmart is that the client will be less likely to succeed if the job starts early in the morning.

Naturally, you would develop a treatment plan that identifies these barriers and you would help the client locate a job that

starts in the afternoon when it is more likely they will make it to work.

Planning - This process involves delineating a "to do list" as to activities that the client and case manager are going to engage in to bring about resolution of the goal.

- Timeline and lists of what the **Client** is going to do
- Timeline and lists of what the **Case Manager** is going to do
- **Referrals** to other services and descriptions of the expectations that are to come about from these referrals

Assessment - This process involves the manner in which the achievement of the goals will be assessed. How are you going to KNOW that the goal was achieved...? This should be intimately tied to the identified Goals in Step Two.

Evaluating the Principles

Now consider how your plan will remain in compliance with the principles of PSR...what are the strengths and challenges that are in your plan related to these principles?

In the planning process you want to make sure that, as much as possible, your plan reflects hope, respect, dignity, multicultural perspective (remember how broad this is), self-determination, individualized treatment (specific to the needs, goals, barriers, and environments that the person is dealing with), and preventive (designed in a way that will maximize the likelihood of success...while failure can happen, and sometimes it is a good thing, we don't want to "set someone up" for failure.

We should be able to review our plans and see these principles exemplified throughout. However, not ALL plans will necessarily reflect ALL of the principles.

In the Assignment section, you will be writing a plan for Anne. Make an effort to ensure that the plan you make up exemplifies each of these principles. It is not unheard of to actually use the terms themselves in the plan.

Chapter 7 Review

Question 1 of 5

An example of a goal that is NOT “real world” based would be:

- **A.** Tim will complete two job applications for existing positions by August 1, 2017.
- ✓ **B.** Tim will practice his driving skills using his XBox 360 system 4 times a week.
- **C.** Tim will attend an adult education class on photography starting in January 2018.
- **D.** Tim will attend yoga class at the local YMCA once per week.

◀ Check Answer ▶

Assessment

Chapter 7 Discussion

Reflect and share on the process of writing this treatment plan. In the treatment plan you identified the client's goals, the barriers to these goals, and finally the actual steps that would be taken. Why is it important to structure your planning this way?

Chapter 7 Assignment

For this assignment you are going to develop a comprehensive treatment plan and then evaluate and reflect on how the plan, the environment, and your behavior in implementing the plan will provide strengths and challenges associated with complying with each of the principles associated with PSR.

You will produce a document that meets the criteria outlined in the example and in the rubric below and send the finished document to me through the online drop box.

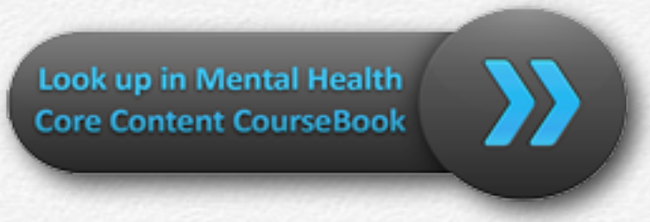
Here is the Case Study of Anne

Anne is a 27-year-old woman with severe mental illness living in Augusta, ME. She has spent much of the last 8 years in and out of psychiatric hospitals. In between hospitalizations she has been living with her parents. She is about to be discharged from the hospital and the family has communicated that while they want to remain involved in her life, Anne cannot move back into the home.

Anne states she would like to live in her own apartment but has very few practical skills on how to manage her life outside her parent's home. She receives a Social Security check, SSI, Medicaid, but has not applied for Food Stamps or Subsidized Housing services. Anne carries a diagnosis of depression with occasional ideations of suicide.

For the purposes of this assignment I want you to make some presumptions about the details of Anne's life that are beyond the description here. Consider which skill areas you would look at and which services you might refer her too...take some creative license to "fill in the blanks" based on what you know is typical in this field of work.

Look up Chapter on Treatment Planning in the Mental Health Core Content CourseBook.



Text Link

Following the treatment plan I then want you to write a reflection on how your treatment plan meets each of the Principles of PSR described in this chapter. You should write a short review on EACH of the Principles evaluating how your plan meets or does not meet these Principles.

Grading Rubric for Chapter 7 Assignment

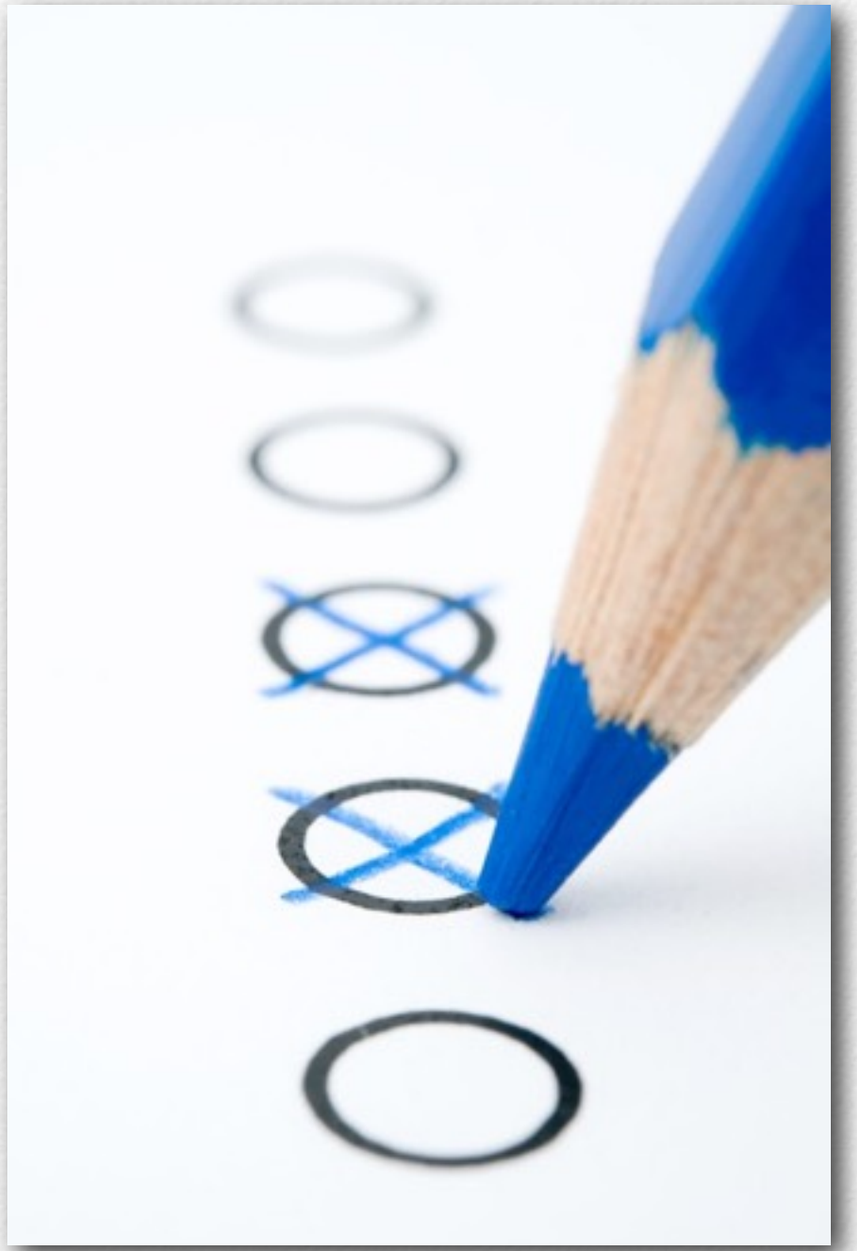
Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

MHRT/C Course Review and PSR

8

Attention



Degree Review

At this point in the course we want to take some time to review the actual content and structure of the program you are in. Take some time to reflect on your progress in the program, your goals for work after the program, and any ambitions you have for continuing your education beyond your degree.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Describe the course requirements for the Associates in Applied Science in Mental Health
2. Relate each course description to fundamental components of the PSR philosophy
3. Outline their career plan.

Teaching

Your Program

Here we will be examining the actual curriculum of the Mental Health program at KVCC.

You may have been in this program for a while or you may be just starting out. Either way, it is always good to look at what we are doing.

MHRT-1 and MHRT/C

Let's take a look at the official information from the Maine Center for Learning, the organization that oversees the MHRT certifications.

Here are the guidelines for the MHRT-1

At this point we only provide parts of the MHRT-1 certification. Our SOC 103: Introduction to Social Services Systems has a curriculum made up of the MHSS (Mental Health Support Specialist) training.

The other certifications that you need for the MHRT-1 can be met outside of KVCC.

Here are the guidelines for the MHRT/C

The Mental Health program at KVCC is designed to meet the competencies of the MHRT/C certification.

The Curriculum at KVCC

The curriculum that defines the Mental Health core program courses was designed to meet each of the 10 competency areas defined by the Maine Center for Learning.

As you can see in the link for the MHRT/C above, the actual names of our classes align well with the names of each of the competency areas.

Transfer Opportunities

We very much encourage our students to consider continuing their education at a 4-year college or university when they have completed their work here at KVCC.

To that end we have formulated a number of “articulation agreements” with area schools. Namely we have agreements with the University of Maine at Augusta, the University of Maine School of Social Work (Orono), and with Husson University’s Psychology degree program.

This content aligns with the Lifelong Learning Signature Assignment described in the Signature Assignments chapter in this CourseBook.

Changing Curriculum

As you discovered in Chapter 3, the State has refined the MHRT/C competencies. This means that the Mental Health Program at KVCC is also going to undergo some dramatic changes.

As with the 2008 Guidelines, we will be creating an academic course that aligns with each of the new competencies. You can expect to see courses with the following titles:

- Behavioral, Psychological, and Rehabilitation Intervention Models
- Community Integration and Inclusion* (Case Management)
- Ethics and Professional Conduct
- Trauma and Resiliency (Incest, Sexual Abuse, and Trauma)
- Policy Knowledge
- Mind-Body Connection
- Cultural Competency (The Changing Workplace
- Vocational Support (Vocational Aspects of Disability)

In parentheses you can see that some of the CURRENT classes in the curriculum will align easily with the new outcomes. Although we will be using material from the courses such as Interviewing and Counseling, Crisis, and Substance Abuse, the rest of the courses will be brand new.

Chapter 8 Review

Question 1 of 5

If you have a Masters in Social Work you still need to take the MHSS training to get your MHRT-I

- ✅ **A.** True
- ⚪ **B.** False

◀ Check Answer ▶

Assessment

Chapter 8 Discussion

Discuss your career goals and ambitions in the field of mental health. What will you need to do to fulfill these goals?

Compare and contrast the two different tracks (2008 Guidelines and New Guidelines) that are discussed in Chapters 3 and 8. Some of you may be on either one of these tracks. Do you think that people taking the old or new will differ in terms of their readiness to deal with the work?

Clubhouses

9

Attention

Fountain House

Fountain House is a professional self-help program, operated by men and women recovering from mental illness, in collaboration with a highly professional and caring staff. The emphasis at Fountain House is on relationships – member to member, and member to staff. Members engage with each other to regain their productivity and self-confidence, resume their lives, and re-enter society. They take part, as well, in promoting their rights, and in erasing the stigma that often separates them from their neighbors.

Since its founding in 1948, Fountain House has served a total of more than 16,000 men and women. Its innovative “clubhouse” model is today the basis for more than 400 similar programs in 32 countries around the world, assisting some 50,000 men and women. The Fountain House concept has been adopted in part by another 1,000 programs in the U.S. and abroad.

Fountain House is also a building — home base for the organization’s activities. A five-story mansion-like complex, it encompasses some 57,000 square feet, including four outdoor gardens. The building has been updated from time to time to meet the changing needs of Fountain House members and staff as

they create and operate Fountain House's diverse programs, administer the organization, tend to their lives, work and study, dine and relax, and make friends.

Fountain House's programs and partnerships originate in its units. Each unit is "home base" for a number of members and staff, who work together to develop and operate a particular activity. In each unit, as well, staff members provide community support for members, to ensure that they receive the benefits and services they need, from both Fountain House and beyond.

Members volunteer their work, to make Fountain House work. Together, members and staff are able to derive a sense of accomplishment, build skills, and establish relationships, helping everyone to know that they are needed and appreciated.

Fountain House

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Explore the history of the Clubhouse Model based on Fountain House
2. Identify typical daily skills that can be learned at a Clubhouse.
3. Design a flyer that advertises trainings on topics that might be used at a Clubhouse.

Teaching

Day Programming

Day programs operate on the assumption that an environment can be created that will contribute to the rehabilitation and recovery of a person with mental illness.

Clubhouse Model

Started with patients in NYC on the steps of the NYC Library. Developed into Fountain House.

Awareness of the advantages of this model spread and other programs began to appear.

Selected Standards for Clubhouses

- Membership - Voluntary, participation is individual
- Relationships - Meetings are open to members AND staff, staff members are generalist
- Space - There are no “staff only” spaces
- Work-Ordered Day - Work is engaged by staff and members, focus on strengths, talents, and abilities, help members to gain self-worth and purpose
- Employment - Does not provide employment to members

Clubhouses in Maine

Kennebec Behavioral Health is on the forefront of supporting Clubhouse Model facilities in Maine. They operate three of them right now.

Text Link

Text Link

Text Link

Penobscot Community Healthcare operates a Clubhouse in Bangor called Unlimited Solutions Clubhouse

Text Link

Click on the logos to visit each Clubhouse!

Each of these facilities is built around and promotes the Clubhouse Model that is delineated by Clubhouse International.

Visit Clubhouse International to learn about the expectations and structure of ALL Clubhouses around the world!

To learn a bit more about how these Clubhouses work, check out the video below from High Hopes!

VIDEO High Hopes Clubhouse

Text Link

Vocational Connection

It is probably clear to see that the Clubhouse Model centers around both a workday schedule and work itself.

It has long been the philosophy that helping people become employed is a key component of recovery and rehabilitation from mental illness.

Our next Chapter introduces you to the models associated with Vocational Rehabilitation. These models closely align with the Clubhouse model.

Chapter 9 Review

Question 1 of 5

According to the Clubhouse Model, membership is _____.

- **A.** mandatory
- **B.** fun
- **C.** the key to success
- ✓ **D.** voluntary

◀ Check Answer ▶

Assessment

Chapter 9 Discussion

Review the detailed explanation of the model on the Clubhouse International site and review the same information on the website of at least one of the Maine Clubhouses. Discuss the ways in which clients and staff interact in a club house. Is this a model that you would feel comfortable working with?

Chapter 9 Assignment

Clubhouse Teaching

Imagine that you were in charge of programming at the agency you are working at...keeping in line with the clubhouse philosophy, day programming, and milieu therapy models address the following tasks:

- **Teaching cooking skills at a clubhouse.**
- **Teaching about psychotropic medications.**

Using the app of your choice, you will design two flyers that you would post that would attract clients to your class. Be sure to be artistic and that you include essential elements of the outline of the teaching in your flyers. Keep in mind that your flyers have to reflect the prevailing philosophies and structures of the clubhouse (cooking skills) and group home (psychotropic medications).

Your posters should be attractive, detailed, inviting, and specific to the content of the content (cooking and medications)

Many of the word processing apps (Pages and Word) have built in templates that allow you to make very creative and engaging posters.

Post both documents into the assignment drop box.

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Grading Rubric for Chapter 9 Assignment

Vocational Rehabilitation

10

Attention

So, what do you do?

It is difficult to underestimate the importance of work in our lives. Social psychologist support that when we meet someone for the first time we are first interested in their name. We use names to determine familial status and note any additions to the name, such as “Doctor” or “Reverend” to establish status and hierarchy.

The next question, if it is not already clarified by title, is “What do you do?” This ALSO helps us to establish status and hierarchy and we use to modify how we communicate with the individual. This is not “being judgmental” it is one of the many tools we use to navigate a complex modern social world.

Imagine NOT being able to answer this second question! What does a disabled or unemployed person say? This is a major aspect of our identity, our sense of self-worth, and it establishes us in the hierarchy of the society we live in. In a sense, what we DO is who we ARE.

OpenLearn offers a free course titled “Work and Mental Health”

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Present the important characteristics of both formal and informal work culture
2. Discuss illness and financial barriers that make work a challenge for people with MI

Teaching

Employment is an essential adult activity

Work plays a major role in our lives. Work…

- Promotes self-confidence
- Income
- Identity
- Self-esteem
- Status
- Persons with severe mental illness rarely get to experience the positive results of having a regular job.

Stigma

Stigma (negative perceptions about someone related to a characteristic they have such as race, gender, or mental illness) can manifest in the environment in which a person exists and within the person as well. Major sources of bias, or stigma, against mental illness and work.

- Employer's personal understanding/experience with mental illness
- Beliefs about the abilities that persons with mental illness have
- Negative self-beliefs about a person's own ability

Misguided Service

Sometimes well-meaning individuals may wish to keep their clients from experiencing the pain of failure. While we understand that we don't necessarily want to "set up" our clients to fail, it is important that they be able to take risks. Trying to avoid failure for the sake of simply avoiding risk creates barriers. Barriers created by Misguided Service

- Overly concerned about stress, symptomology, medication and re-hospitalization

- Protection from failure
- Preparation in a non-competitive environment
- Formation of low self-expectations

Psychiatric Disability and Work

We must also keep in mind that some very real barriers to success in the workplace are created by the presence of mental illness. Our expectations of workers is that they are going to be present on the job and that they will follow the expectations of their job descriptions.

Some barriers created by Psychiatric Disability:

- Episodic and cyclical nature of disability
- Low self-esteem, lack of confidence, fear of failure, anxiety
- Lack of work experience
- Social skill deficits
- Medication effects
  - Side effects
  - Main effects
  - Stigma

Lack of Vocational Experience

One of the major barriers that persons with mental illness often face is the fact they they have a very limited or very poor work history. Because of this, clients who attempt to enter the workplace may have:

- Limited understanding and identity as a “worker”
- Lack of understanding of culture of the work place
- Poor vocational planning and decision making (what job roles have they experienced and thus imitate?)
- Less knowledge of skills, interests, and preferences
- Services may be measured by duration of job rather than a match

When I worked in rehabilitation services it was often observed that although a person with a disability may have had the skills to do the job, they did not have the skill, or were not invited, to join in the informal structure of the job. The informal structure is where a lot of "orientation" to "how things are done here" is done. It is the "hidden" culture of the organization and it is key to both doing the job well and to feeling comfortable and a part of the work place community.

Individuals unable to access the informal structure (hanging out after work, having lunch together, etc.) can become isolated, frustrated, and miss key aspects of job expectations that are communicated primarily through this structure.

Here is a little mini-lesson on Formal and Informal Work Culture.

Formal and Informal Work Culture

Work Culture is essentially the term we used to describe all of the beliefs, attitudes, policies, and principles of the workplace. However, there are usually two kinds of work cultures at every organization

Formal Work Culture

When you get a new job, or even when you became a student at KVCC, you were given an “orientation” as to “how things work” and what to expect.

This orientation is usually filled with a lot of information related to the roles of different people, how to accomplish certain tasks, and the “rules and policies” that are written in various manuals (such as an employee manual or even the Student Code of Conduct at KVCC.)

This “formal” set of expectations represents the Formal Work Culture of the organization. It is usually taught in the orientation and we sometimes receive written copies of it.

Informal Work Culture

In every organization there is also an “informal” work culture. This is the “insider” information as to how things “really work” at the job or in the company.

This information can be very important for someone to survive and thrive in the workplace, but it is hardly every included in the official orientation!

People learn the informal work culture through social connections in the workplace. These are the water cooler conversations where important information is passed on from employee to employee. When you make social connections at work, you open the opportunity to exposed and taught the informal work culture through an informal process!

Challenges to our Clients

The challenge that this presents to our clients is that they are not always invited into these social circles in which this kind of "education" is taking place. Being able to "make friends" and to have conversations with your colleagues is the only way to access some of this information. Someone has to see that it is important for you to know this information before they will tell you it. Having these social connections will make fellow employees more likely to help you.

Because of the stigma of mental illness and the relatively poor social skills of some of our clients, this can be a challenge.

It is important to help our clients understand that these two cultures co-exist in every workplace and that making "small talk" and making friends with coworkers is the doorway to access this information.

Possible Loss of Benefits

When someone has experienced a mental illness for a long period of time, they may (and in our work this is very common) receive financial and insurance benefits. A full analysis of the issues involved in these programs is beyond the scope of this particular lesson, but we certainly do encounter situations in which going back to work and beginning to earn pay may not only be challenging to the person but potentially harmful.

Barriers created by Possible Loss of Benefits

- SSI, SSDI, SS, and Medicaid are based on "poverty" and "employment status"
- Some programs have graded exit (SSI) others are "all or none" (SSDI)

In my own work this was probably the most significant barrier that I have ever come across. Many of the individuals that I had as clients would have gladly tried to work (they were bored!) but were very afraid of losing their benefits which were so important

in keeping them well (paid for doctors, medication, and sometimes their housing!)

As a person who will be working with others with disabilities it is vital that you understand how the Social Security Administration works. Visit the website by clicking the banner below and learn more about all their programs

Vocational Services

Vocational services provide a wide diversity of services to assist people in exploring career choices, preparing for the workplace, and finding work.

Features of Effective Vocational Services:

- Practitioner demonstrate respect to the client and his or her barriers.
- Process is comprehensive and responsive to changes in needs.
- Programs offer real pay for real work.

The principles of Vocational Services are very much akin to those in PSR. The Principles for effective Vocational Services include:

- Consumer choice
- Integrated services
- Natural supports
- Rapid placement
- Job accommodations
- Seamless services
- Employer education

Vocational Rehabilitation (The Federal Initiative)

Since the “Roaring Twenties” there have been services supported by the government to assist people in getting to work.

Text Link

Here is a very brief timeline depicting the changes in these services over the years:

- 1920-creation of Vocational Rehabilitation as a service
- 1943-expanded to include MR and MI
- 1960s-expanded to include SSDI recipients
- 1973-Rehabilitation Act (established Rehabilitation Services Administration)-prioritized “most severe”-funding to states-created the IWRP
- 1970s-access for MI improved with the establishment of Community Support Programs
- 1986-redefinition of the Rehab Act-defined supported employment and funds
- 1992-refinement of the Act-emphasis on consumer choice, and mandated a “presumption of employability” for all
- 1990 – Americans with Disabilities Act
- Protect from discrimination in five areas (employment, transportation, telecommunications, public accommodation, and the business of local and state government)
- The Act entered new terminology into the field:
  - “Qualified Applicant”
  - “Essential Functions”
  - “Reasonable Accommodation”

Making the distinction between an essential ad non-essential function of the job is the key to understanding the principles of the ADA. ADA protects individuals from being discriminated when it comes to non-essential aspects of the job. At KVCC some students have been sick and in the hospital and have missed class. While it may be up to the instructor on how to handle that situation, it is not a guarantee by the ADA that an accommodation must be made because "attending class" (at least in a live class setting) is an essential part of the "job" of being a "student".

Vocational Service Modalities

Here is a great article on Meaningful Work and Recovery that goes into a number of different ways in which these services are provided.

Here are some terms and options that you may come across in the field:

Transitional Employment

- Job Developers work with employers to create transitional jobs in the workplace.

- Support staff learn the job and are prepared to teach it and do it if the client does not show up.
- Staff help match clients with potential employers.
- This is a large part of the work that happens at Club House Model services.

Fairweather Lodges

- These programs are fairly rare, but exist to provide opportunities for persons with mental illness live and work together in member-run businesses.
- The Coalition for Community Living provides support and standards for the development of Fairweather Lodges nationwide.
- Website

Hospital Based Work Programs

- Some hospital day-programs incorporate work activities into their programs.

Job Clubs

- Job Clubs can exist within any agency that provides vocational services.
- The role of the Job Club is to bring individuals together who have not had a lot of work history, or face significant barriers to getting to work and discussion issues, resolving how to answer certain kinds of interview questions, resume writing, and other job landing skills.
- Job Clubs are offered at the Vocational Club Houses, Social Clubs, Employment Agencies, and even at State Vocational Rehabilitation Centers.

Sheltered Workshops

- While these are not very common for persons with mental illness, sheltered workshops are fairly common in the field of mental retardation or for persons with developmental disabilities.
- Sheltered workshops are businesses or workshops that have been developed to provide employment and activity for the clients.
- There is generally a high tolerance for various behaviors in these environments and the pressures of productivity and competitiveness are supposed to be significantly less than in the competitive workplace.

Affirmative Industries

- Affirmative Industries usually manifest as entire businesses or divisions of businesses being owned by a mental health agency for use as an employment avenue for their clients.
- Years ago when I first entered the mental health field, the agency Motivational Services owned an industrial and office cleaning company called “Clean Sweep.” For many individuals, working for Clean Sweep may have not been the most glorious and clean work but it was the first paying job they had ever had.

Supported Employment

- Supported employment may include other services such as Transitional Employment, Job Clubs, and Job Coaching.
- The focus is on finding a match between the client’s interests and a job and then place the client there and train them on the job. A place-train approach
- Individuals in supported employment programs often attend day programs or simulated work environments
- The overall goal is to help clients CHOOSE a job, GET the job, and then KEEP the job.

Job Coaching and Job Development

- These services are often a part of supported employment.
- These folks provide both career planning and career development services.
- Job Developers try to remain aware of potential jobs, careers and other market factors that may provide opportunities for their clients.
- When it comes to developing a transitional or supported employment job, the job developer will contact approximately 42 companies and/or individuals for every one job they successfully create.

Chapter 10 Review

Question 1 of 5

Stigma is a form of discrimination that includes all but which of the following:

- **A.** Employer's personal understanding/experience with mental illness.
- **B.** Beliefs about the abilities that persons with mental illness have.
- ✓ **C.** Symptoms that may interfere with work performance.
- **D.** Negative self-beliefs about a person's own ability.

◀ Check Answer ▶

Assessment

Chapter 10 Discussion

Discuss circumstances (illness and financial barriers) under which it would not be advisable to have someone go to work. What are some potential solutions to these problems? (This should reflect some research on the Social Security website.)

Chapter 10 Assignment

For this assignment you are going to design a brief training video on how clients understand and deal with the concepts of “formal” and “informal” culture in the workplace.

Keep in mind that BOTH formal and informal cultures exist in every workplace. You want to educate your viewer about each one, what each culture entails, and strategies for engaging in both cultures at the workplace.

The video will consist of you filming yourself conducting the presentation. You will edit the final video so that it is professional, and you will add explanatory text overlay in your video.

While this may seem to be a challenging task, it is profoundly instructional to watch how you present material and take note of your professionalism, delivery, and understanding of a topic.

Remember, the video is of you presenting this information to a CLIENT so that they understand what informal and formal culture is and what they can do to access both.

Suggested steps in the process:

1. Research the concepts of formal and informal culture and its impact on employees, particularly those with mental illness.
2. Write a script
3. Memorize the script (keep in mind you can do short segments of the video and then sequence them together in the software…I do not want you reading your presentation…eye contact is critical.)

4. Video record the presentation (or sequence of clips). Be sure to give yourself time to create multiple takes so that your presentation is "perfect." Do not submit substandard work when you have the opportunity to redo poorly performed aspects of your presentation.

5. Using video editing software, edit the video using cuts and pasts, sequence the shots logically, and add titles to your video that assist in your audience's understanding of the topic.

Once completed you will upload your video to YouTube or Vimeo and submit the **LINK** to your video in the drop box.

Grading Rubric for Chapter 10 Assignment

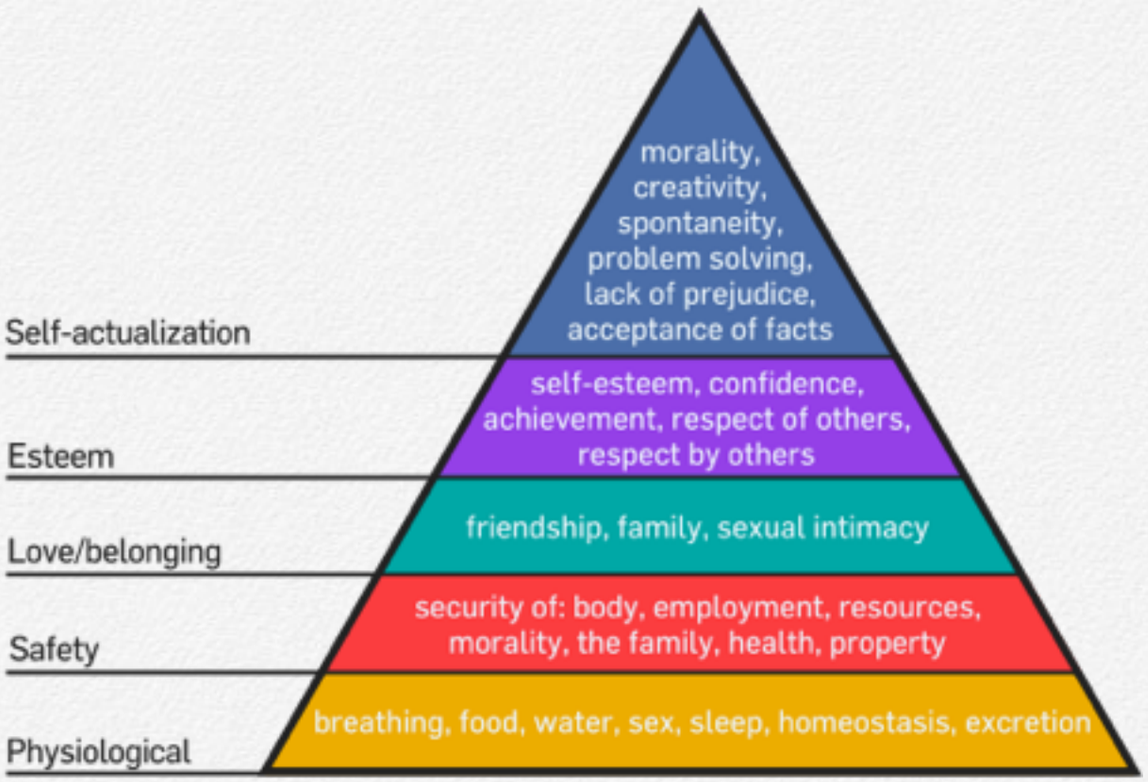
Learn more about recording yourself using your iPad in the Tutorial CourseBook.

Text Link

Residential Services and Housing

11

Attention



Needs

Consider this graphic...which depicts the hierarchy of needs as described by Maslow's theory...where does housing fit into this? How important is it to have a "place to lay your head"?

How many of these needs are fulfilled by having a stable home?

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Reflect on the importance of housing and home to mental health.
2. Identify web-based and peer reviewed resources on housing for persons with mental illness.

Teaching

Housing

For persons with mental illness there are two “financial” reasons why housing is difficult:

- Affordable housing is less available
- Cuts in funding for federal assisted low-income housing

Stigma

How do landlords, fellow tenants, neighbors, etc. feel about having persons with mental illness next door?

- Safety
- Property values
- Exclusion from “community”

Mental Health Systemic Issues

The field of mental health has long been in the business of providing housing. Certainly it is one of the defining characteristics of change within the history of mental health treatment: Where shall they live? In the institution, in the community, back home?

These questions have been a part of the discussion on the treatment of persons with mental illness all along:

- Residential treatment vs. permanent housing
- Extended hospital stays simply because of lack of housing
- “Burden” on families who are often ill-prepared

History

The history of housing for persons with mental illness is essentially the same as the history of mental health treatment itself.

- In old days we kept individuals at home. Later they were often located to boarding houses and other care facilities for the "feeble minded"
- As the local resources became overwhelmed and the state government began to become powerful the large institutions were built. Individuals were often very far from home

living in state run institutions such as Augusta Mental Health Institute (now called Riverview), Bangor Mental Health Institute, and Pineland Institute (now closed).

- With the advent of Supplemental Security Income, Medicaid, and the Mental Health Centers (all legislation under Kennedy), moving into the community began to be a viable option. (Medications are often credited with creating deinstitutionalization but far more it was the impact of SSI.)

Various services and housing options have been attempted over the years. Individuals options were often erratic and unstable.

- 1/4 way Houses
- Half-way Houses
- 3/4 way Houses
- Supported Apartments
- All of these continue to exist for some folks.

Group Homes and Halfway Houses

- Linear Continuum Paradigm (as you got better you can move to a place of more independence...not exactly the best motivator..."Go ahead, get better and we will kick you out!")
- This was later changed to Transitional Housing.

Supported Housing

Supported Housing makes the move to provide varied supports wherever the person lives. So, rather than the client moving when their needs change, the services provided for them changes.

- Avoids "placement" stigma since the housing is "normal"
- PSR oriented
- Family may be involved
- Normalization
- ADL focus (Activities of Daily Living)
- Formal and Informal Support
- Advocacy

Independent Living Movement

We have already looked a bit at the IL Movement. The IL Movement has its roots in the concept of deinstitutionalization and

the recognition that persons with disability can live in the community.

- Recognition that it is not something “internal” that makes someone disabled…it is based in the environment…the barrier to independence is “out there.”
- De-medicalizing of the issues
- Persons with disabilities have a right to self-determination
- Persons with disabilities can become experts in their own care

Independent Living Centers

- Grassroots
- Advocacy
- Support
- Training

For a few years I used to work for Maine Independent Living Services, one of the first Independent Living Centers in the US. Sadly, it is closed now.

My experience with IL was very positive. Individuals with disability helping others with disabilities. The services were particularly good when the worker could relate to what the individual was going through. Alpha-One, the remaining IL center in Maine, only hires individuals with a personal history of disability.

Chapter 11 Review

Question 1 of 5

Which of the following is NOT a factor that contributes to the shortage of housing for persons with mental illness?

- **A.** Affordable housing is less available.
- **B.** Cuts in funding for federal assisted low income housing.
- **C.** Poverty.
- ✓ **D.** A lack of public transportation.

◀ Check Answer ▶

Assessment

Chapter 11 Discussion

In this discussion I would like you to reflect on the importance you place on where you live. Is your home a haven, even more chaotic that work, an escape?

Having a home is a key need within any model of motivation, including Maslow's. We can see how our home may address a number of our needs in this hierarchy:

- Food and water
- Security, family, property, and safety
- Family and sexual intimacy
- Achievement and respect

Review what home means to you and reflect on how NOT having a permanent place to be could be a major factor in your mental health.

Chapter 11 Assignment

For this assignment I would like you to do some research on the Internet and in the professional literature. I want you to do research on the history and current status of housing for persons with mental illness. I want you to find web-based resources and create an annotated bibliography (AB) of these resources.

Remember, ALL papers have a title page.

Part I: Annotated Bibliography of Internet Resources

- Title page (standard elements)
- A list of the websites and web-based resources that you have found including the name and the URL (web address).
- Under each Name/URL I want you to write a 1-paragraph summary of the information found in the resources (in your own words.)
- You must have at least 5 web-based resources on this topic.

Part II: Research on Housing and Mental Illness

For this part of the assignment I want you to explore Google Scholar or our library services website and find a peer-reviewed article regarding housing for persons with mental illness. Write a 1 page summary and reflection of this article.

Be sure to include an APA formatted reference for the article.

Grading Rubric for Chapter 11 Assignment

Look up “Literature Reviews” and “APA Format” in the Mental Health Core Content CourseBook.

Text Link

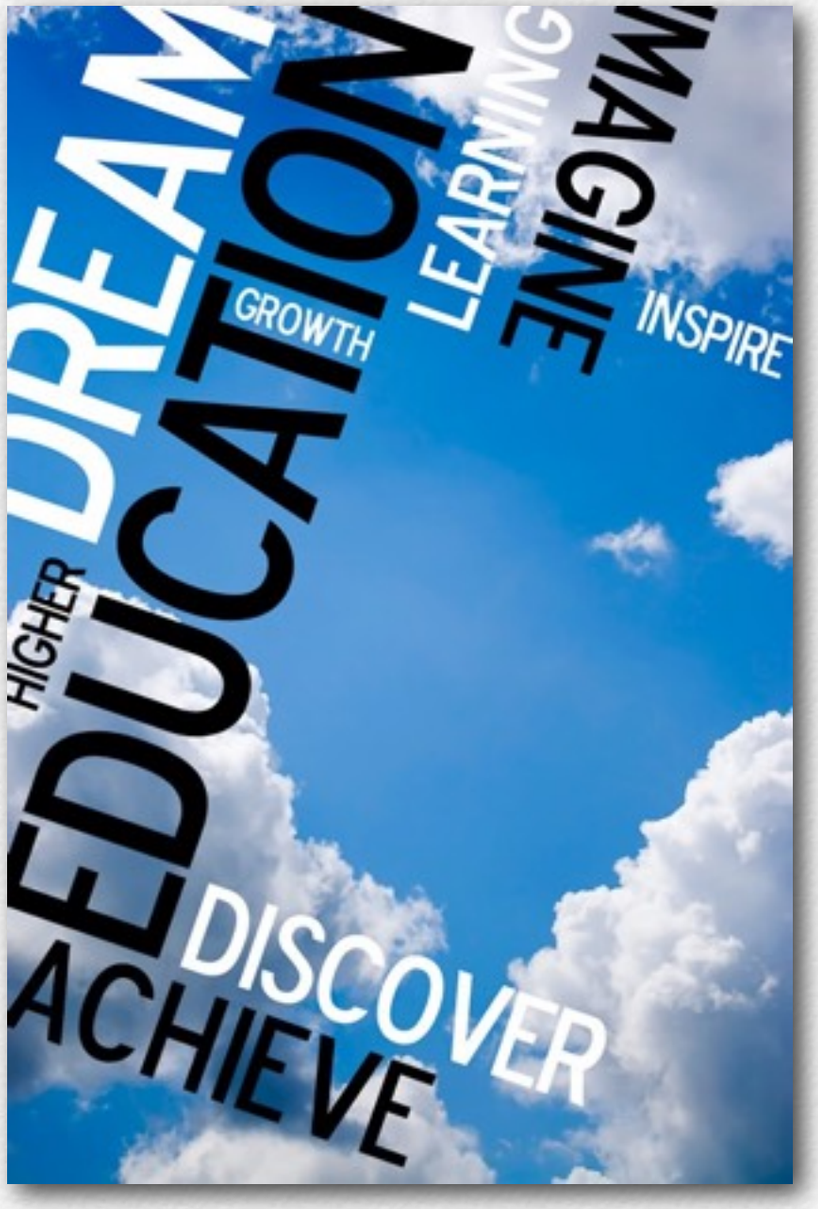
Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Educational Supports

12

Attention



Education Matters

As our economy becomes more technologically sophisticated and manufacturing jobs become replaced by service-oriented jobs, access to education has become an increasingly necessary gateway to work.

According to the publication Recovery: Job Growth and Education Requirements through 2020, published by the Georgetown Public Policy Institute at Georgetown University, by 2020 65% of all jobs will require post-secondary education and/or training. This is up from 28% in 1973 and up from 31% in 2010.

The file in the link above is rather large. If you take the time to download it be sure to add it to your iBooks app so you can read it offline.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss how students with disabilities may interpret their performance when they encounter challenges in their academic achievement.
2. Identify resources available to students with disabilities in a community college environment.

Teaching

Support at KVCC

This is a great topic to be discussing here at KVCC. It is, in fact, one of our specialties! Not only is KVCC cheaper than most colleges in Maine, the support services for individuals with disabilities (any kind of disability) are second to none...however, it is not without its challenges!

For this chapter I'm going to have you focus on the work that goes on at KVCC (and its associated organizations and programs). This is a great opportunity to develop an understanding of how this really works!

Learning Disabilities and KVCC

I'll relate to you my own experiences in this particular issue. Prior to coming to teach at Kennebec Valley Community College I was the director of a state-wide Independent Living program serving all manner of individuals with disabilities. My entire career, one can say, has been based in disability work.

When I was hired at KVCC I was well aware of the college's track record for exceptional services for persons with disabilities but I was in for some surprises. Once I was a teacher I become very committed to the idea of "integrity" and "consistency" in my classes. My class had to be "as good as" or better than the same classes taught at other colleges so that the credits would transfer. The battle was on, and remains to this day, of how do we balance the integrity and academic rigor of a college class AND best serve individuals with disabilities (particularly learning disabilities) who might be taking that class???

One thing that I began to observe was this...many individuals with learning disabilities maintained the belief that when they were having difficult learning something it was because of the disability. They also maintained that the concepts or skills would come easy to them if they did not have a disability (mostly by observing others more skilled than them). This is, in fact, very wrong. Much of what people learn in college is difficult because the concepts and skills are complex and difficult to master! Many people have trouble with them, disability or not. Some people are very good at college and they seemingly glide along, but most people struggle with one thing or another.

Making this distinction has been my quest in my various roles at KVCC. I advocate for a full understanding of the actual impact of a learning disability (many of which we don't really fully understand). I also advocate that we "push" our students to abandon a "helpless" approach to learning. Finally, I advocate for students to take risks and try new things and challenge the supposed limits of their abilities (by this I mean all of us, not just those with disabilities). All in all, my efforts have been very rewarding!

Supported Education

For all the reasons many people want to pursue higher education, persons with mental illness want to pursue higher education (better jobs, more satisfying jobs, better pay, prestige, accomplishment, etc.)

Barriers Considered in Supported Education

- Stigma
- Stress
- Symptoms and Side Effects
- Negative Expectations (from self and others)
- Financial Challenges
- Negative School Experiences

Programs at KVCC

As a Community College, KVCC is dedicated to providing the support and resources students need to be successful. While students have the responsibility to attend class, do their work, and ask questions, our Student Services provide both academic and social support for all of the students at KVCC.

To learn more about programs such as Counseling Services, Early College for ME, The Learning Commons, and Transportation Services...select the link below!

Kennebec Valley Community College
Student Services

TRiO

The principle program to assist individuals with disabilities at many colleges is the **TRiO program**.

Here is a link to the Federal TRiO Programs website

You can investigate services for persons with disability at your own college through your student services office.

The TRiO program targets individuals for support services who meet any of three criteria:

- Disability (any, not just learning disabilities)
- First generation College (they are the first generation in their family to pursue a college degree)
- Financial Barriers

If YOU experience any of these criteria you may be eligible for TRiO support services! Check it out!

TRiO is a tight-knit community of Staff, Faculty, and Students that works together to help students:

- Persist in college, following their chosen program of study from one semester to the next.
- Maintain good academic standing (Passing 66% of cumulative classes).
- Graduate and/or transfer to a 4-year college within three years.

KVCC TRiO Program Website

Note: When I was in high school I was considered a high-risk student (with lots of potential!) I grew up relatively poor and I had a hearing disability and some behavior disorders in school.

I was a candidate for a program called Upward Bound. This is ONE of the TRiO programs, so I'm a TRiO student! I attended Upward Bound at Bowdoin College for every summer after my Freshman year and I returned after my Senior year for my Bridge Summer Program prior to going to college.

I can attest that this program was life changing and deeply formative in regard to the person I am today.

I am an ardent supporter of the TRiO program at KVCC and the fantastic, and often, very fun, work they do with our students!

m-Learning and Learning Disabilities

When we initiated the m-Learning program we recognized that one of the many advantages of the use of the iPad are the many resources and apps available on the iPad to address issues related to learning and other disabilities.

Click HERE for a Complete Guide to Education and Special Needs Apps.

Click HERE for 40 Amazing Apps for persons with a Learning Disability.

The iPad (and all other Apple products) are designed specifically to be accessible to persons with disabilities. The concept of accessibility is considered right at the beginning of every design strategy.

Apple maintains a website that explores the accessibility features that are built into their hardware (Macs and iOS devices) and their software.

Click HERE to visit this page.

*Note: When you visit this page you can scroll down and introduce yourself to **Sady Paulson**. Sady has Cerebral Palsy and has managed to build a career as a video editor.*

Sady was the Special Guest speaker when I attended the Apple Distinguished Educator Academy 2017. Sady was also inducted into the ADE Class of 2017!

The picture below is a Meet and Greet I attended with Sady. While her CP causes her to have extremely spastic movements, her accomplishments, with the help of Apple products, was inspiring!

Click HERE to visit the page on accessibility specific to the iPad. The accessible features are so cool that persons who do not NEED them often use them!

Features outlined on this website specifically address vision, hearing, physical and motor skills, and learning and literacy.

You truly are holding an amazing device in your hands!

Chapter 12 Review

Question 1 of 5

According to Mark's experiences at KVCC, many students with learning disabilities perceive struggles with course material to be related to their _____.

- **A.** study skills
- **B.** support network
- **C.** literacy skills
- ✓ **D.** disability

◀ Check Answer ▶

Assessment

Chapter 12 Discussion

How do students with disabilities perceive the difficulty of class material? Is "difficulty" too often associated with disability instead of being attributed to the nature of the material?

Chapter 12 Assignment

Educational Resources Treatment Plan

For this assignment you are going to create another treatment plan. This treatment plan will be based on the case study below. The difference here is that this student is in the Mental Health program and currently has an iPad. Your plan will entail the research of both services at your college and apps to be used on the iPad to assist this person.

All of this needs to be written out in the format of a treatment plan.

Here is the case study:

Dan entered the Mental Health program at his local community college because having received mental health services as a teen, he felt that he wanted to be able to give back. Over the years Dan struggled in school. He struggled because of his depression but he also had been diagnosed with a number of learning disabilities. To top it all off, Dan is also legally blind. He can get around a space but reading course material, especially books, is very difficult for him without adaptive equipment.

As far as learning disabilities are concerned Dan struggles with paying attention in class. He can listen to a lecture and he can take notes, but he has never been able to figure out how to do both at the same time! Dan also has a diagnosis of dyscalculia. He recognizes that he needs to take a math class to graduate from the program, but he dreads this course.

The innovative program at Dan's school requires that all Mental Health students have their own iPad. Although Dan had used several electronic devices in high school, the Apple iPad was not the device he was most used to so he was not familiar with all of its features.

When Dan arrived at the college he was assigned a Peer Mentor in the program to assist him in developing a success plan for his completion of the Mental Health program. He is scheduled

to meet with is Mentor to establish a plan to address all these issues.

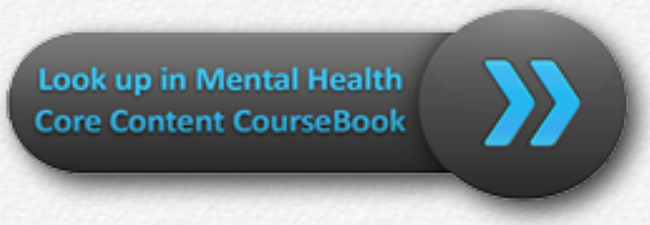
YOU are the Peer Mentor and have been charged with developing a plan to work with Dan in the context of the services provided at your college and the technologies associated with Dan's iPad.

This task will require that you investigate the process of accessing services at your college and different technological options for Dan's iPad. Your plan must be based upon real services and real apps…so names and contact information must be included.

Be sure to establish appropriate time lines and address each of Dan's challenges in your comprehensive plan. This plan should comply with the standard Treatment Plan format.

Grading Rubric for Chapter 12 Assignment

Check out the "Treatment Planning" section in the Mental Health Core Content CourseBook.



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Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

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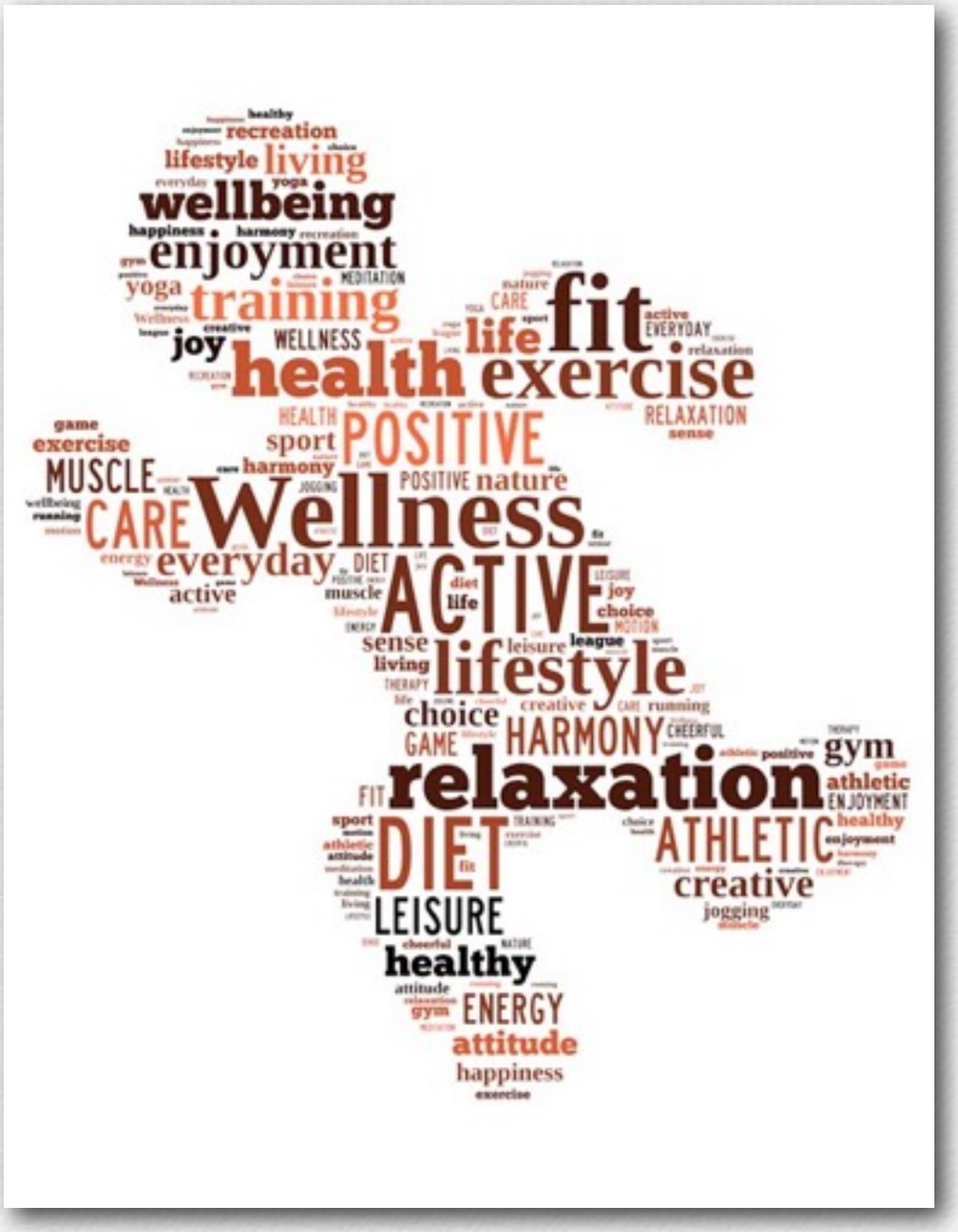
Health, Mental Illness and Medications

13

Attention



Let’s get physical!

What does it mean to live in a healthy way? What does health mean when you have a chronic illness? These are the questions that face many of our clients who are struggling with defining themselves in a world obsessed with healthy perfection.

Despite all this, there seems to be some truth to the notion that better diet and exercise not only create a stronger, healthier body, but impact our mental health as well.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss the social role of being "sick" in modern society
2. Describe alternative therapies for symptoms of mental illness with traditional medical approaches (medication and therapy)

Teaching

Being Sick in our World

Many aspects of our self-perception, and the perceptions of others of us, rely upon our "statuses". We each have multiple statuses and these include aspects of ourselves which are used to create our identity, much the same way a single piece of a jigsaw puzzle contributes to the overall picture.

For each Status that we have there is a "Role" that we need to play. These are the specific expectations for performance related to the status (this is a slight change in terminology from what you might usually associate with the term "role").

We can also think of Statuses as the "Job Title" and Role as the "Job Description"

Status and Role of being "Sick"

If someone is chronically sick it becomes a "status", and in Mental Illness, since the illness is "chronic, persistent, and pervasive" it becomes a "core status". So what is the Role of a "sick person"?

Well, think about it...what do sick people do?

- They have symptoms and they try to hide them
- They take medication
- They rest
- They don't go to work
- They take responsibility for their recovery
- They see their doctor and are compliant with doctor's orders
- We have less activity expectations
- They get better and return to "normal" life (or they die)

This is what we EXPECT sick people to do! But do persons with Mental Illness do a good job on fulfilling their roles as "sick people"?

These expectations as to what being "sick" means, and the failure of people with Mental Illness to abide by their ascribed status and role, is the PRIMARY source of STIGMA.

The ultimate message is that they can't even be "sick" right! This impacts:

- Society Perception
- Social Policy
- Health Care Policy
- Family Perceptions
- Self-Perceptions

There is another societal expectation related to being sick...you didn't "get it" on purpose. You "caught" it and otherwise you would choose to NOT be sick.

So, the "being sick" status/role is OK in the eyes of society as long as you are not doing anything to bring it on! Consider our perceptions of "fault" when it comes to the following situations:

- A small child has a cold and stays home from school
- A teenager gets the measles and goes in the hospital
- A young adult becomes depressed after his parents died
- An older gentleman begins to show signs of dementia
- A young woman gets breast cancer

Compare it to these situations:

- A gay man who has had multiple simultaneous partners contracts AIDS
- A young adult drinks heavily in college and becomes an alcoholic
- A young lady with Schizophrenia refuses her medications
- A depressed young man contemplates suicide
- A heavy smoker develops lung cancer

Do we think differently about these different sets of "sick" people? Whether we perceive that an individual brought on their problems themselves or if the problems were thrust upon them, we judge differently. This comparison is a key value within PSR.

Resources on Medications and Mental Illness

What role does Medication play in a person's recovery?

Today medications are the primary treatment modality for most symptoms of mental illness. They are portable, inexpensive (relative to some other treatments), and largely, very effective. We WANT medication because of the convenience.

However, being “stuck” on medications can feel life a life-sentence. Add to this the fact that many medications not only have primary, clinical effects (reducing depression) but additional “side effects” that can be very impactful on someone’s life.

The message that is often given to persons with MI is that they will be on some medication for the rest of their lives. How can we embody the values of PSR in discussions about medications? How can we approach a discussion about medications and still support:

- self determination
- optimism
- hope
- empowerment
- prevention

Mental Health Medications

Click HERE to download a guide published by the National Institute of Mental Health.

Alternative Approaches to Medication

While it is important to work with your physician on any aspect of your medical treatment, there is an increasing body of evidence that diet and exercise (among other interventions) can have a profound impact on your mental health

Articles on Diet and Mental Illness

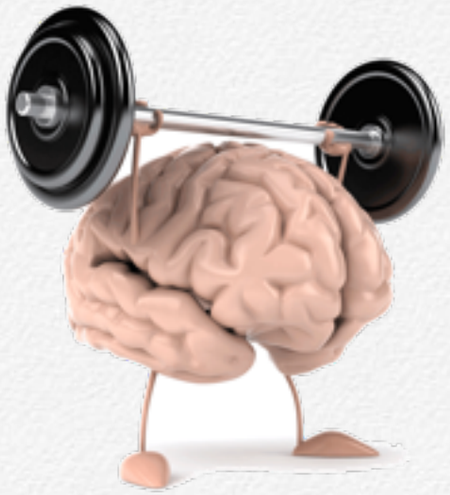
From as early as 1945 we have considered the connection between diet and mental health. Check out these article:

Thomas, W.R. (1945). Discussion on the importance of diet in mental illness. Proceedings from the Royal Society of Medicine.

Sathyanarayana, T.S., Asha, M.R., Ramesh, B.N., & Jagannatha, K.S. (2008). Understanding nutrition, depression and mental illness. Indiana Journal of Psychiatry. 50(2). 77-82.

Physical Activity and Mental Illness

What about physical activity and exercise?



Check out this article:

Richardson, C.R., Faulkner, G., McDevitt, J., Skrinar, G.S., Hutchinson, D.S., & Piette, J.D. (2005). Integrating physical activity into mental health services for persons with serious mental illness. Psychiatric Services. 56(3).

Diet and exercise are just a couple of the alternatives that are available to treat mental illness (remember, we are talking about treatment here...this is the actual reduction of symptoms.)

The Assessment section of this chapter will have you exploring some additional options.

Chapter 13 Review

Question 1 of 5

A person who has a “chronic, persistent, and pervasive” condition may establish this condition as their _____ status.

- **A.** secondary
- **B.** sick
- ✓ **C.** core
- **D.** alternative

◀ Check Answer ▶

Assessment

Chapter 13 Discussion

What barriers to PSR application lay within the medical culture? Describe how the "sick role" of our society creates stigma against individuals with mental illness.

Chapter 13 Assignment

Alternative Treatments

Research and discuss alternative treatments (exercise, diet, etc.) to treat symptoms of mental illness.

Find peer reviewed articles, web resources, or other sources, on alternative therapies in mental health and/or you can find resources on the web and/or through our library resources.

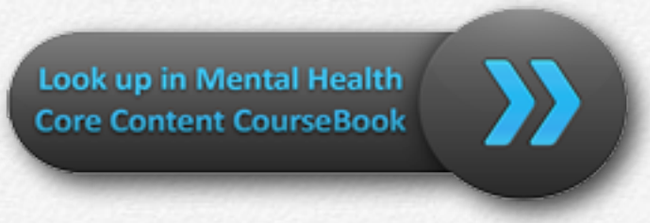
You need to cover at least **3 different alternatives** to medicine for the treatment of diverse mental illnesses.

Your paper will consist of the following elements:

- Title page
- 3 resources (one for each alternative you have found) - cited in APA style
- For each resource write summary of the information in that resource in your own words.
- A critical analysis (pros, cons, applications, risks) for each resource. (Also, include an analysis of the source...is it reliable, scientific, biased, etc.?)

Grading Rubric for Chapter 13 Assignment

Look up “Literature Reviews” and “APA Format” in the Mental Health Core Content CourseBook.



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Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

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Case Management and Community Integration

14

Attention

Case Management

Case Management is the highest form of service that can be provided for a person living in the community. Consider this, in order to demonstrate the need for case management services you need to have extreme difficulty managing the everyday decisions of regular life.

At the same time the focus of this work is transforming. The title “Community Integration Specialist” is beginning to float around. While this change may seem arbitrary, it does focus our attention on creating lasting connections between our clients and the communities in which they live.

This emerging title is not yet clearly defined so we will focus on Case Management for the time being.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Explore the definitions and job duties of a case manager.
2. Explore the availability and usability of digital device resources (apps) for persons with mental illness.

Teaching

Case Management

According to Wikipedia, Case Management is defined as:

the coordination of community services for mental health patients by allocating a professional to be responsible for the assessment of need and implementation of care plans. It is usually required for individuals who have a serious mental illness and need ongoing support in areas such as housing, employment, social relationships, and community participation. This level of support is also suitable for service users with a major psychotic disorder.

Basic Duties include:

- Assessment of need
- Care planning
- Implementation
- Regular review

Levels of Case Management

- **Level 1**
  - Relatively well controlled symptoms, family has self-management skills, relatively stable psychosocial status
- **Level 2**
  - Relatively poor symptom control, family or support system needs assistance in developing support resources, medical issues, and psychosocial resources
- **Level 3**
  - Poor symptom control, poor self-management skills in self, family, or support network, significant complications (psychosocial and otherwise)
- **Level 4**
  - Poor symptom control, severe lack of self-management, need for other services (social work, respite, crisis, hospitalization, health, etc.)

Mental Health System view of Case Management

- The term "Case Management" has been over used
- Different agencies will define it differently
- There is no "centralized" Case Management in Maine
- Intensive Case Management and the ACT Team Models are the closest
- Other "Departments" may have better facilitated Case Management

Case Management and PSR

- Core function of CM is to apply the PSR philosophy across the team
- Advocate
- Educator
- Motivational Counseling

Case Management Standards in Maine

Standard 1

The Case Manager shall meet the standard set forth in the job description of a Case Manager with the Department of Health and Human Services (DHHS) or the standards set forth in the certification for Community Case Management.

Standard 2

The Case Manager shall use his or her professional skills and competence to serve the consumer, whose interests are of primary concern.

Case Managers have two sorts of ethical obligations. The first is to resolve all scheduling and procedural conflicts by giving preeminent consideration to the concerns of consumers and their families. While the convenience of a Case Manager is a legitimate concern, during the workday it is secondary to the convenience of the consumer.

The second obligation is to be sensitive to the possibility that the Department or Agency may make a policy decision for its own convenience rather than for the direct interest of consumers. If a Case Manager strongly feels that the Department or Agency is doing so, then the Case Manager has an obligation to raise the issue, first to the immediate supervisor; if this action

does not provide resolution, the issue must be raised to successive levels of supervision and to the Office of Advocacy. As professionals, Case Managers are obligated to hold both themselves and the Department to the highest possible ethical standards.

Standard 3

The Case Manager shall ensure that consumers are involved in all phases of case management practice to the greatest extent possible.

The primary vehicle for assuring that consumers achieve this autonomy is the Person Centered Plan. However, some consumers elect not to have a Plan, and the Case Manager has the same obligations in these cases.

Standard 4

The Case Manager shall ensure the consumer's right to privacy and ensure appropriate confidentiality when information about the consumer is released to others. Case Managers are reminded that even in cases where a particular consumer appears to be unconcerned or uninterested in issues of privacy and confidentiality, Case Managers are still obligated to adhere to a high standard.

Standard 5

The Case Manager shall intervene at the consumer level to provide and/or coordinate the delivery of direct services to consumers and their families.

- Eligibility
- Referral and Intake
- Personal Planning Process
- Residential
- Developmental Disabilities Policies

Standard 6

The Case Manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services. Case Managers are expected to become progressively more knowledgeable about resources available to consumers throughout their service areas.

Standard 7

The Case Manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fis-

cally responsible in carrying out all case management functions and activities.

Standard 8

The Case Manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability.

Standard 9

The Case Manager shall carry a reasonable caseload that allows him to effectively plan, provide, and evaluate case management tasks related to consumer and system interventions.

Standard 10

The Case Manager shall treat colleagues with courtesy and respect, and strive to enhance inter-professional, intra-professional, and interagency cooperation on behalf of the consumer.

Resources

One of the most important roles that the mental health service provider plays is in the connection between clients and resources. As we will learn, the principle goal of PSR is to provide a bridge that spans the gap between what an individual can do on their own and what they cannot do on their own. We call this gap a “barrier” because without assistance or a strategy, the client will not be able to cross the gap between their current level of functioning and where they want to be.

Barriers take many forms and we will cover many of those through this course.

With near universal access to the web (and often, to mobile devices such as smart phones and tablets) digital, or virtual, tools aimed and educating and providing support (even some levels of treatment) are being rapidly developed.

Evaluating Resources

As with any resource, however, we need to be critical thinkers. We nee to evaluate these resources just as we would evaluate a service provider or a psycho-educational book that we may recommend a person to use.

The critical thinking process would progress in stages:

- Identify the resource

- Evaluate the resource (claims, evidence, access, cost, ease of use, etc.)
- Evaluate the creators of the resource (valid credentials, evidence based, etc.)
- Evaluate the specific client's ability to access the resource (access to technology, internet access, WIFI access, etc.)
- Evaluate the specific client's ability to utilize the resource (cognitive skills, reading levels, ability to apply abstract concepts to real-world problem solving.)

We can be quick to find a "neat" app that we think our clients (or ourselves) might benefit from but we need to be sure that we have gone through each of these steps to evaluate the app or other resource (website, eBook, etc.)

Chapter 14 Review

Question 1 of 5

Case Management duties generally include:

- **A.** Assessment of Needs
- **B.** Care Planning
- **C.** Implementation
- **D.** Regular Review
- ✓ **E.** All of the Above

Check Answer

Assessment

Chapter 14 Discussion

Essentially the role of the MHRT/C is the case manager/ community integration specialist. Use the app **Indeed Job Search** to review ads for these jobs and the duties and standards associated with this role. (Simply enter search terms such as Case Management and/or Community Integration).

Discuss if this is this the kind of work you envision doing?

Discuss the element of case management where you are not really providing specific services and help, but finding others to do it.

Click the app icon below to get this app!

Text Link

Use the link below to access the tutorial on how to use this app in the iOS and App Tutorial CourseBook.

Text Link

Chapter 14 Assignment

Digital Resources Evaluation

In this assignment I'm going to have each of you evaluate a single app that I came across. Based on the criteria that is outlined in this Chapter you will write a paper that is composed of the following sections:

1. Title page

2. Identify the resource (name the app and the developer)
3. Evaluate the resource (You will need to read the description for the app and then visit the website of the developer to explore the claims, evidence, access, cost, ease of use, etc.)
4. Evaluate the creators of the resource (Based on your investigation of the developer determine if the claims are valid, if the developers have valid credentials, evidence based, etc.)
5. Evaluate the specific client's ability to access the resource (For this part of the evaluation consider YOURSELF as the client and evaluate your access to technology, internet access, WIFI access, etc.)
6. Evaluate the specific client's ability to utilize the resource (Again, consider YOURSELF when evaluating the cognitive skills, reading levels, ability to apply abstract concepts to real-world problem solving associated with this app.)

Submit this paper to the appropriate drop box in Blackboard.

Your instructor will provide you with the name of the app you are to evaluate.

DO NOT EVALUATE THE "INDEED JOB SEARCH" APP...ONE WILL BE PROVIDED!

Grading Rubric for Chapter 14 Assignment

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Motivational Interviewing

15

Attention

Motivation is Key

In the course Interviewing and Counseling we focus our efforts on learning the basic skills associated with Motivational Interviewing.

Many times, as a rehabilitation provider, we are engaged with our clients in the process of helping them solve problems...this is not too different from much of what is "counseling" at the professional level.

However, our focus is to partner with the individual and assist them in taking charge of their own life plan and commit to a path of change.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

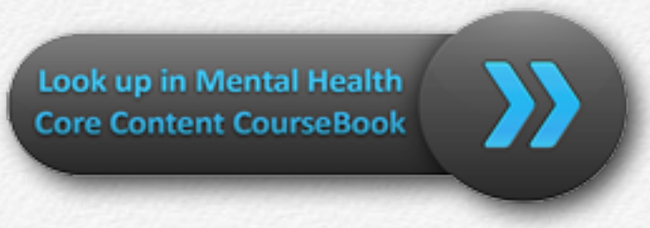
1. Identify the qualities of a good helper.
2. Identify the role that motivational interviewing plays in the psychosocial rehabilitation process

Teaching

Motivational Interviewing

"Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language go change. I tis designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the persons' own reasons for change within an atmosphere of acceptance and compassion." - Miller and Rollnick (2012)

Look up “Motivational Interviewing” in the Mental Health Core Content CourseBook.



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The "Spirit" of Motivational Interviewing

- Partnership
- Acceptance / Autonomy / Absolute Worth
- Compassion
- Evocation

Key Principles

- **Express Empathy**
  - Listening to the client without being judgmental, critical, or blaming. In the early stages a person may not be yet willing to give up their behaviors.
- **Develop Discrepancy**
  - Helping clients see a difference between what they are doing now and what they want to be in the future.
- **Roll with Resistance**
  - Resistance will happen. The key approach in MI is to "roll" with the resistance. Reflecting back to the client the

emotions that you sense and using the resistance to further explore their commitment to change.

- **Support Self-Efficacy**
  - Self-efficacy is the perception we have of our ability to do or accomplish something. We work to build our clients' confidence in their ability to bring about change...this ability can then be used to bring about other changes as well.

Consider how the "Spirit" and "Key Principles" that you have just read about match your own personal ways of communicating. How useful, based on your current understanding, are these skills in working with people with mental illness?

Working with Clients

When we are working with a client we engage in two simultaneous processes. They are completely compatible with one another or they can work independently. One is the Basic MI Process and the other is the Counseling Process. Explore these two models below and see how they work together.

Basic MI Process

The basic steps in the MI process are as follows:

- Engaging - Empathic Listening
- Focusing - Targeting Change
- Evoking - Client's Ideas
- Planning - Getting to Change

Counseling Process

Ultimately we often conclude that the best source of the "answer" to a problem lays within the individual themselves. We may need to simply create the opportunity for it to emerge. Sometimes this can happen fast while at other times it may take quite some time.

We can see this process develop over time and through different counseling processes. In each of these phases of the relationship you can see some of the counseling skills you would use.

Building the relationship

- Attending behavior that convinces the client they are important and that we are listening.
- Encouraging, paraphrasing, and summarizing as your clients tell their story.

Getting the story

- Open and closed questions.
- Client observation skills that seek to understand the emotional world of your client.

Re-storying

- Reflection an examination of feelings and motivations
- Focusing on the specifics of the plan.
- Reflection of meaning of these steps in an overall context of recovery.

Action planning

- Confrontation when we experience resistance or incongruent messages.
- Influencing your client through the use of self.

Chapter 15 Review

Question 1 of 5

"Developing Discrepancy" can be seen as somewhat equal to the Counseling Process of _____.

✅ **A.** Building the Relationship

B. Open and Closed Questions

C. Confrontation

D. Reflection

◀ Check Answer ▶

Assessment

Chapter 15 Discussion

What personality qualities make for an effective counselor/case manager?

OPTIONAL (This is NOT required) Discuss any personal counseling experiences you have had. What went well? What did not go well? What were the benefits of counseling for you?

Chapter 15 Assignment

Motivational Interviewing

Part I

Write a brief essay that describes how interviewing and counseling plays a role in the psychosocial rehabilitation process. Reflect on your own approach to the use of yourself (knowledge and experiences) in influencing others.

Part II

Find ONE peer-reviewed article related to Motivational Interviewing and Mental Illness and cite this article in your paper.

Grading Rubric for Chapter 15 Assignment

Look up “Literature Reviews” and “APA Format” in the Mental Health Core Content CourseBook.

Text Link

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Family Supports

16

Attention

We don’t get to pick ‘em...

Throughout this class we have focused much of our attention on the environment in which someone lives. We see the barriers to success often can be found in the stigma and challenges presented by our society.

The key component of a person’s environment, however, is often their family.

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Describe resources that may be helpful for families who are contending with mental illness

Teaching

Impact of Mental Illness on Family

Mental Illness does not only impact the individual, it impacts the whole family system...depends on how involved they are (to some degree)

- **Tier 1:** Life in the family is a stream of caregiving responsibilities
- **Tier 2:** Less exposed to the ups and downs
- **Tier 3:** Share an interest in the well-being but may not be directly involved

Families today are seen as resilient and resourceful, however, as with many individuals, having an adult living at home may cause stress to both the family and to the individual.

Consider that it was never the plan of the family to have this individual continue to live with them “forever”. No one really sets a date as to when they expect the kids to be gone, but it is an expectation in our society. While being a parent is a role that we probably never lose, we do intend to move on to a version of this role that does not imply primary care.

The family can sometimes feel burdened with an unexpected responsibility. There are also burdens of space, money, time, etc. The family can become stigmatized (consider that society still may associate mental illness with some specific dysfunction in the family)

Specific behaviors can contribute to the burden and struggle in a family:

- Hostile/abusive behaviors
- Mood swings
- Socially offensive or embarrassing behavior
- Poor motivation
- Self-destructive actions

In addition to all of this, the family, for a variety of reasons, may not have good coping or communication skills, may be unable or unwilling to take steps to make change, and may have its own degree of dysfunction/disease.

Family work is complex! It is complex because all the individual members of the family have complex psychological states and the family itself has complex social states.

Impact of Family

Family members can have a tremendous influence (positive and negative) on clients. Ways in which see family impact our clients include:

- Independence/Dependence
- Loneliness
- Unique burden of spouses
- Siblings and children
- Anguish of the individual (missing out)
- Family Dissatisfaction

Family Interventions

Working with families we can decide to introduce a number of interventions.

- Psycho-education
- Behavioral Problem Solving
- Family Support
- Crisis Management

Topics for Psychoeducation

One of the more powerful tools we can bring into families is education about mental health and mental illness. Possible topics for these kinds of sessions may include:

- Learning about feelings, learning about facts
- Introduction to Schizophrenia
- Introduction to Depression
- Basics about the brain
- Problem-solving Skills Workshop
- Medication Review
- What is it like to have a mental illness
- Relative Groups and Self-care
- Communication Skills
- Rehabilitation
- Advocacy

- Certification and Celebration

NAMI

The National Alliance on Mental Illness was started by family members of persons with mental illness in 1979 and has turned into a national movement and voice on mental health.

According to the NAME national website, NAMI states:

- we educate
- we advocate
- we listen
- we lead

This applies to all aspects of the experience of mental illness in all settings.

Families

The section specific to Families has information related to very critical topics that are more than familiar to families with a person with mental illness.

Visit THIS page and discover information on the following topics for caregivers and family members:

- Learning to help your child and your family
- Finding a missing loved one
- Supporting recovery
- Maintaining a healthy relationship
- Taking care of yourself
- Being prepared for a crisis
- Calling 911 and talking with the police
- Handling the arrest of a family member
- Preventing suicide

As you can see, NAMI provides a wealth of information to caregivers and clients alike.

NAMI Maine has its own website and provides a more localized set of resources. Tap the logo to visit the website.

Family Recovery

Families can learn to deal with and cope with the challenges of having a member with mental illness. Since having family involved is a great strength and asset, we want those families to be safe, effective helpers, and healthy.

Families can go through a variety of “stages” in the process of learning to live with mental illness.

1. Discover/Denial
2. Recognition/Acceptance
3. Coping/Competence
4. Personal/Political Advocacy

I think our goal would be to help families to get to the 3rd step (at least) and sometimes the 4th. Certainly families need the support they can get to help them discover the real cause of the situations they are dealing with and to remove the denial of mental illness. They can then move on to a recognition of the complexity of these circumstances and accept it as part of their lives.

Learning to cope with the cyclical challenges is facilitated by learning about strategies and becoming competent and implementing these strategies for the best outcomes for both the family and the member with mental illness. Finally, some family members may wish to become involved in the field, in helping other families, or even with the political and social policy aspects of mental health.

Family members have made significant societal change through the sharing of their personal stories with law makers and through direct involvement in politics and the creation of social policy.

Explore the NAMI websites, both national and state, and you find find inspiring stories.

Chapter 16 Review

Question 1 of 5

When families are embarrassed about the behavior of their member with mental illness, it shows that they don't care about the person.

- ✓ **A.** True
- **B.** False

◀ Check Answer ▶

Assessment

Chapter 16 Discussion

Visit the Maine branch of the National Alliance on Mental Illness. Describe at least two resources that might be useful for families from this organization. Discuss these resources with each other and describe ways in which you might use these sources in your practice.

Chapter 16 Assignment

For this Assignment you are going to write a training “Lesson Plan” for one of the topics listed in the Topics for Psychoeducation section of this Chapter.

You will be sending this all as a single document with the following components:

- Title Page - this will consist of the name of the training and list YOU as the name of the trainer.
- Training Lesson Plan - this will be based on the structure of the Chapters in this book. Review the content at the beginning of this book on the ALOTA structure of the Chapters. You will imitate this structure in your Lesson Plan by including all 4 parts.
    - Attention
    - Learning Outcomes
    - Teaching
    - Assessment
- Handouts - you will construct at least ONE handout that is on ONE page, graphic intensive, and aligned with the training.
- References - your last page should be a list of references outlining the sources of your information. This should be in APA format.

Grading Rubric for Chapter 16 Assignment

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Enlisted and Veteran Services

17

Attention

Those who serve...

The relationship between community mental health and military veterans has been a long and convoluted one, dating back to the First World War.

Some soldiers of WWI manifested symptoms of “shell shock” and displayed symptoms of perceptual loss or impairment (hearing or vision), tremors, confusion, and nightmares (very different from our modern view of Post Traumatic Stress Disorder - PTSD, but likely a physical manifestation of PTSD).

At first the military viewed these symptoms as a form of cowardice or malingering (faking symptoms). Advances in care, mostly through prompt treatment and reintegration, developed during this time are still in practice today.

Jones, E. (2012). Shell shocked. Monitor on Psychology. 43(6). 18

Learning Outcomes

Upon completion of this Chapter, students will be able to:

1. Discuss services for enlisted and veteran soldiers through the VA and Tricare.

Teaching

Veterans

According to the American War Library:

What is a Veteran?

A veteran is defined by federal law, moral code and military service as "Any, Any, Any"...A military veteran is ANY person who served ANY length of time in ANY military service branch.

What is a War Veteran?

A war veteran is any GI (Government Issue) ordered to foreign soil or waters to participate in direct or support activity against an enemy. The operant condition: Any GI sent in harms way.

What is a Combat Veteran?

A combat veteran is any GI who experiences any level of hostility for any duration resulting from offensive, defensive, or friendly fire military action involving a real or perceived enemy in any pre- or post-designated theater of combat (war) operations.

The VA

As you may have read in the "Detailed History of Mental Health" in Chapter 3, many pieces of legislation aimed at creating studies and services on mental health were geared toward assisting veterans that were coming back from war with signs and symptoms related to PTSD, substance abuse, and other illnesses.

The National Mental Health Act of 1946 funded psychiatric education and research that eventually led to the establishment of the National Institute of Mental Health (NIMH) in 1949. This was, in part a response to those Veterans returning from WWII.

In 1963, President Kennedy signed and enacted legislation that launched the Community Mental Health movement. This was, in part, a reaction to the needs of veterans returning from Korea and Vietnam.

However, the VA is the commonly known of service providers for Veterans.

History of the VA

Commonly referred to as the VA, the **U.S. Department of Veterans Affairs** represents the most comprehensive system of supporting veterans in the world. It, technically, can be traced back

to as early as 1636 when the Pilgrims at Plymouth Colony were at war with the Pequot Indians. A law was passed that disabled soldiers would be supported by the colony.

Click HERE to review a comprehensive history of the VA.

What does the VA do?

The VA provides a comprehensive set of services to all Veterans including those in three specific categories:

- Health Care
- Benefits
- Burials and Memorials

For many Veterans, the VA may be the only access to health care that they can have so it is important to familiarize yourself with their services.

Click HERE to visit the home page of the U.S. Department of Veterans Affairs.

The VA App Store!

Certainly keeping with the times, the VA has an app store! Many of these apps are specific for use by Veterans and their care providers.

Some of the apps you will find on this site include those that allow veterans to interact with their health care providers, explore different medications and communicate with pharmacies, engage in video conferences with their team, and learn more about PTSD and Mindfulness!

Click on the icon below to visit the VA App Store!

Specific Concerns

You are reading a special section in this book on Veterans because there are specific concerns and issues surrounding the mental health treatment of Veterans.

According to NAMI, both active and non-active duty veterans face similar challenges:

- Mental Health concerns (mainly PTSD, Depression, and Traumatic Brain Injury.)
- Reluctance to reach out for assistance because of the stigma.
- Reluctance to reach out to the VA because of a lack of trust in the VA.

- Making the transition to civilian life.

Here are some valuable websites that you may share with your clients:

Real Warriors

After Deployment

My Health eVet

US Department of Veterans Affairs - Mental Health

Guide to VA Mental Health Services for Veterans & Families

Working with Veterans

You may find yourself working with Veterans in the regular duties you engage in your community mental health job...or you may choose to work for the VA or another helping organization.

I believe the key to working with this population is to understand the unique quality of their experiences and their service. By this I mean that not only is there a difference between those with military experience and those without, there is also a great deal of difference among veterans.

For instance, some veterans have been in active combat while others have not, yet this will still not guarantee if one has a higher likelihood of having PTSD or not.

Another difference might manifest in the Veteran's perception of their own service. Some may be very proud and honored by their service, where others may feel ashamed and guilty.

As with any population, we need to meet Veterans "where they are" and not make any assumptions as to what they may be like or may be going through, simply because they are a Veteran.

Military Culture

One of the most important things that you can do to prepare yourself for working with this population is to become familiar with "Military Culture."

Once great resource for expanding your knowledge in this area is the **Center for Deployment Psychology**. Click the logo below to visit the Center's Military Culture Course Modules that you can take for free!

CDP Center for Deployment Psychology

Feel free to take these trainings and learn about:
Self-Assessment and Introduction to Military Ethos
Military Organization and Roles
Stressors and Resources
Treatment Resources and Tools

Community Providers

Even though Veterans often have access to comprehensive services through the VA, many may elect to use other resources. Your client may want to distance themselves from their service, may not trust the government or the VA, or may simply be unsatisfied with the quality of care they get at the VA.

The Community Provider Toolkit is a site that contains resources for community providers working with Veterans. The resources were gathered by the National Center for PTSD and the Office of Mental Health Services.

Click the logo below to visit this valuable resource!

COMMUNITY PROVIDER TOOLKIT
SERVING VETERANS THROUGH PARTNERSHIP

House in the Woods

House in the Woods is a unique Maine-based project in Lee, Maine. HITW has a mission to provide a therapeutic, recreational, and educational retreat for US armed forces and their families.

The facility provides housing for active military and veterans (and their families) to enjoy the great outdoors of Maine in activities such as hunting, fishing, canoeing, kayaking, hiking, nature tours, campfires, swimming, and wildlife identification and spotting.

Click on the logo below to visit the website for House in the Woods!

HOUSE IN THE WOODS

You can get involved in a number of ways:

- Donating
- Volunteering
- Shopping at Amazon
- Holding a Fundraiser
- Sponsoring a Veteran

More information can be found on the House in the Woods website.

Enlisted Military

Veterans services and benefits are for veterans alone. Individuals who are currently serving in the military, who may be on

leave, are NOT eligible for Veterans services because they are not Veterans!

You need to know about Tricare!

Welcome to Tricare

Text Link

Tricare is the medical coverage/insurance for active duty military and National Guard or Reserve Members and their families.

While individuals who are deployed will often receive care at military hospitals, access to healthcare outside of the military establishment can happen if the provider is either a “network provider” or a “participatory provider” in Tricare.

Providers need to sign a contact and agree to the terms and rates of service under Tricare.

Visit the Tricare website and click on

See What’s Covered > Mental Health Care

Explore the different areas in this website. Coverage appears to be comprehensive but not all providers participate in the Tricare system making it difficult for some persons to get care.

If you are working with someone who is eligible for Tricare, you may be in the position to help them ensure that their providers can provide services under Tricare. Providers can even sign up on a case-by-case basis.

Chapter 17 Review

Question 1 of 5

Service in some branches of the military do not qualify for VA benefits.

- ✓ **A.** True
- **B.** False

◀ Check Answer ▶

Assessment

Chapter 17 Discussion

Review the resources for both Veterans and Enlisted persons.
This is an open discussion, bring up any topic you wish.

Signature Assignments

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Signature Assignments

Signature Assignments and General Education Learning Outcomes

This section of the CourseBook provides guides and instructions for the completion of a set of assignments referred to collectively as “Signature Assignments.”

According to the Association of American Colleges and Universities:

Signature assignments require students to demonstrate and apply their proficiency in one or more key learning outcomes. This often means synthesizing, analyzing, and applying cumulative knowledge and skills through problem- or inquiry-based assignments or projects. Signature assignments may also follow a theme across curricular and co-curricular experiences tied to the institutional mission or features of the surrounding community, allowing students to apply their growing knowledge and abilities to meaningful questions over time. At some institutions, all signature assignments must include specific components, such as a “real-world” application, reflective writing, or collaborative work.

The most distinctive feature of signature assignments is the way programs integrate them across the educational pathway to help students demonstrate their growth, make connections across the curriculum and co-curriculum, and apply their knowledge to real world problems.

AAC&U, Retrieved June 14, 2017

Association of American Colleges and Universities

The AAC&U has defined what it feels is essential knowledge and skills for undergraduate education and defines them through their VALUE Rubrics (Value Added Learning in Undergraduate Education.)

These outcomes outline important expectations for higher education.

Click HERE to visit the AAC&U website that outlines each of these areas.

KVCC and the Educated Person (Essential Learning Outcomes)

Kennebec Valley Community College has adopted a number of recognized general education learning outcomes (aligned closely with the VALUE Rubrics) to provide an operational definition of the outcomes we ensure all students have upon graduation from any program.

Here is a summary of the KVCC Essential Learning Outcomes

Critical Thinking is a habit of mind characterized by the comprehensive exploration of issues, ideas, artifacts, and events before accepting or formulating an opinion or conclusion. (AAC&U)

Problem Solving is the process of defining the problem, designing, evaluating and implementing a strategy to answer a question, achieve a desired goal, or reach a solution. (AAC&U modified)

Quantitative Reasoning also known as Numeracy or Quantitative Literacy (QL) - is a habit of mind characterized as competency in working with numerical data. Individuals with QR skills possess the ability to reason and solve quantitative problems from a wide array of contexts. They understand and can create reasonable sophisticated arguments supported by quantitative evidence and they can clearly communicate those arguments in a variety of formats (using words, tables, graphs, mathematical equations, etc., as appropriate). (AAC&U modified)

Effective Communication is the transactional process of sending and receiving verbal, nonverbal, and visual symbols to create and share meanings based on form and purpose.

Students will demonstrate effective communication in written communication.

Written Communication is the development and expression of ideas and information in writing. Written communication involves learning to work in many genres and styles. Written communication abilities develop through iterative experiences across the curriculum. (AAC&U modified)

And students will demonstrate effective communication in one or more of the following ways:

- **Oral Communication** is a prepared and delivered purposeful presentation designed to increase knowledge, to foster understanding, or to promote change in the listeners' attitudes, emotions, values, beliefs, or behaviors. (AAC&U modified)

- **Interpersonal Communication** is the process of message transaction between two or more people for developing and maintaining professional and personal relationships. (West & Turner; University Nebraska Lincoln)
- **Teamwork** consists of the behaviors under the control of individual team members (effort they put into team tasks, their manner of interacting with others on team, and the quantity and quality of contributions they make to team process) to achieve mutual goals. (AAC&U modified)

What you will see...

To address this aspect of your education, we have designed a variety of assignments that engage students in higher-order thinking targeting a number of specific learning outcomes and contextualized within the course material.

You will find assignments throughout this program (in the CourseBooks) that align with teaching and learning of EVERY one of the VALUE Rubrics and the KVCC ELOs. We feel it is essential that we address each of these across the curriculum to ensure that all of our graduates not only leave KVCC with the skills specific to their field, but the general abilities and knowledge that they need to be successful at anything they want to do.

It is hoped that most of these assignments could be categorized as “high-impact” activities. “High impact” activities may be defined as those that require a higher degree of creativity, engagement, attention, and an ability to integrate information and skills.

In addition...

You might, on occasion, see other types of assignments in this section. Assignments that are important to the course but are not necessarily identified as “Signature Assignments” or aligned with a specific general education learning outcome.

These assignment will still be high impact and engaging.

Lifelong Learning

Program Review

Learning Outcomes

- Describe the course requirements for the Associates in Applied Science in Mental Health
- Relate each course description to fundamental components of the PSR philosophy
- Identify short- and long-term career goals and plans

Reviewing the Program

There are two major tracks of study in Mental Health at KVCC. One is the **Mental Health Certificate Program** and the other is the **Associates of Applied Science in Mental Health**.

Click HERE to visit the KVCC Mental Health website that describes these two programs.

The Certificate Program is made up of the 10 Core Curriculum mental health classes and the 1-credit Mental Health Seminar class.

The Degree program has additional requirements in general education classes including writing, communication, math, and science.

Each degree leads to the MHRT/C certification.

Throughout each of these classes there is a running connection and that connection is Psychosocial Rehabilitation. The concepts developed and explored in this class relate to every single class in the Core Curriculum.

The point of this assignment is to have you review the content of each of the classes in the Core Curriculum and reflect on how each one relates to the goals, values, and principles of PSR.

Here is what you are going to do:

Steps

Review the Program Requirements

For the purpose of this assignment, we are going to focus on the 2008 Guidelines. Those on the New Guidelines track should select 2 of the 4 2008 classes that are identified as similar to the new classes we will be creating.

Review the MHT designated courses in the Mental Health Program. Select TWO of these courses (any two with the exception of MHT 124).

Write the course number, name, and course description. You will find this course description in each individual syllabus that you may have or you can refer to the course descriptions in the KVCC Course Catalog. (Click HERE to visit the KVCC website to access digital copies of the Course Catalog. Remember that these are large PDF files so it might take a while to download it.)

Part I - Reflect on the PSR Goals

For EACH of the courses you have selected, reflect on how the following two GOALS of PSR are supported in the class content. If you have not already taken the class, you will need to speculate as to how you think the class would address the two goals.

The two goals of PSR are:

Goal #1: The goal of all PSR is to restore each person's ability for independent living, socialization, and effective life management. It is a holistic approach that places the person at the center of all interventions.

Goal #2: Effective rehabilitation builds on a person's strengths and helps the individual to compensate for the negative effects of the psychiatric disability.

Part II - Reflect on your own Career Plan and Goals

Based on what you know about the field, potential jobs in mental health, your interests, etc., reflect on your own career plan. Specifically answer the following questions:

- What is your current degree of progress toward your goals in the Mental Health program (how many classes have you got done? When do you expect to graduate, etc.)
- Do you want to continue your education? If so, where do you want to go? If not, reflect on what job or jobs you wish to explore.
- What are your ultimate career goals?
- What do you need to do that job? (This may require some research.)
- What do you need to do (education, training, etc.) to achieve your ultimate career goals (be very specific...if you are going to get additional college degrees, research where you might complete your education and be specific.)

In this section of your paper, write the question in bold and then your answer in regular type underneath. Do this for each question.

Put all this reflection into a single paper and submit it to the appropriate drop box in Blackboard.

Grading Rubric for Lifelong Learning - Program Review

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Written Communication

Feature Article

Learning Outcomes

- Interview and/or job shadow a person who holds a position in the mental health field
- Contrast the content of the interview or job shadow with descriptions of the position available through the Department of Labor
- Demonstrate competency in writing

You have been hired!

You are a feature reporter for the Morning Sentinel newspaper. You have been tasked with writing a feature article about jobs in the mental health field. Your audience is the general population of Waterville, ME so you cannot assume that this population understands mental health jargon and terms.

The purpose of the feature article is to educate the public as to what these jobs entail, their working conditions, and what makes the jobs different from "official" sources of job descriptions (Occupational Outlook Handbook).

Write a compelling, entertaining, descriptive, and educational article reflecting your interview and/or job shadow experience.

You should include information about the individual you are interviewing, their educational/career path, challenges and joys in their current work, advice to those who may want to do the same kind of work, etc.

You should also do research in the Occupational Outlook Handbook to see how the person's description of the work compares to "official" statistics.

Here are some examples of articles in the magazine SCIENCE...this is SORT of what I'm looking for...the personal story...but I'm also asking for you to go into details about the career from a research standpoint as well. So you are providing both the data about the work from your research and a specific example from the person you interview.

Grading Rubric for Written Communication - Feature Article

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link

Information Literacy

Sources of Information

Picture yourself as this tree. The branches are your sense taking in information all around you. All the icons represent different sources of information (I like that it includes a “little bird”, because sometimes “a little bird told me” is all I have to go on!)

The problem with this picture is that some sources are better than others. This is particularly challenging in a world where there is so much information readily available on the Internet and where even the large network news programs have instances of “Fake News”.

We should all venture to be sure we are critical about the sources we turn to for information. We always “evaluate our sources” particularly when the information seems to be wild and abnormal!

However, when we are making important decisions about work and our professional practice, it is particularly important to make an effort to get the very best information we can get from the very best source.

In this assignment you are going to explore some of the methods used to evaluate sources to compare different kinds of information.

Learning Outcomes

- Thoroughly analyze your own and others' assumptions.
- Evaluate the type of information needed to explore a question.
- Evaluate the reliability of sources of information.
- Synthesize a conclusion based upon reliable sources of information.

Assumptions about the World

Through our own personal history and experiences, we formulate what Sociologists call our "Sociological Imagination". This is the sum total of how we view the world and our place in it.

We can also assume that this imagined world is full of errors, biases, and prejudices of all kinds! None of us escape out of childhood without a good deal of untrue ideas and notions of the world.

While we may be able to survive and thrive with some of these false assumptions, we also can be hampered by them. They may skew our perceptions in our professional lives and cause us to make costly mistakes, both to our career and to others.

Education is the weapon against these kinds of errors in our thinking. Through education we are exposed to multiple perspectives of reality and, if we are open to it, we have the opportunity to to modify our own perceptions in kind.

Truthfully, all our talk about prejudice, discrimination, and stigma arise from faulty assumptions regarding the reality of race, gender, and disability.

Knowing Your Sources

For this assignment we are going to use the following resource regarding different sources of information:

Know Your Sources
A Guide to Understanding Sources

Reviewing this document you can see that there are many different “channels” that can deliver information to you. Everything from a blog to a scholarly resource.

In all cases it is important for us to evaluate if the source of information is “reliable” (meaning, you can trust the information to be true) and “relevant” (the information helps you answer the question or solve the problem.)

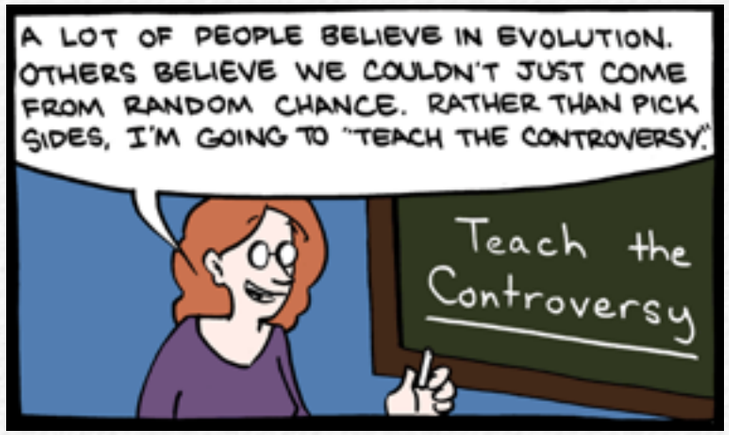
Facing your Bias

To start off this process we are going to engage in a discussion regarding bias. There are any number of different topics that we can have strong opinions on...and, of course, they do not have to be about Mental Health.

Below is a link to an MS Word file...It contains a list of 70 controversial topics. In addition, many of the terms are hyperlinks to we resources on these questions.

Controversial Topics (MS Word)

Controversial Topics (PDF)



Select one of these questions as the ones you are going to focus on in this assignment. Select one that you feel you already hold some strong opinions on.

At this point you are ready to engage this assignment!

Expectations

Part 1 - Reflect on your Bias

Prior to looking up any information outline your own thoughts on this topic. Include, if you can, any sources of this opinion that you have (however, don’t do any research to FIND sources yet...just off the top of your head.)

Part 2 - Evaluating Sources

For this assignment you are going to look up three resources for each of your questions. Based on the “Knowing your Sources” resource, you understand that some sources are more reliable than others.

In order to get a good feel of different sources of information, you will need to find the following in regard to your topic:

- One source must be a Twitter, Blog, or YouTube Video
- One source must be a Newspaper or Magazine Article
- One source must be an Academic Journal or Scholarly Textbook source

You are going to evaluate each of these sources by answering the following questions. Answer the questions in detail by providing information about what you found:

Questions about Reliability

- Is the author qualified to write about the topic? (Look at his or her credential or organizational affiliations.)
- Does the URL or Publisher reveal anything about the author or source?
- Is the author trying to sell something?
- Does the source reveal a bias?
- Is the information factual?
- Are there spelling, grammar, or other typographical errors?
- Is the information current?

Questions about Relevance

- Does the information relate to your topic or answer your question?
- Does the source meet the requirements of this assignment?
- Is the information at an appropriate level (not too elementary or advanced) for your needs?

Part 3 - Conclusions

Write a one-page essay reflecting on this process and on how encountering different points of view based on differently reliable/relevant resources can shape your thoughts on a topic.

Grading Rubric for Information Literacy - Sources of Information

Use the icon below to review resources on writing papers in the iOS and App Tutorial CourseBook.

Text Link