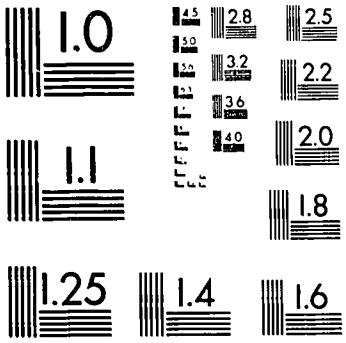

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ABSTRACT

A study examined the statewide mental health agency training programs for paraprofessional mental health workers that exist throughout the United States. During the study, researchers contacted all 50 state mental health manpower development offices and requested copies of statewide training programs, instructional materials, training needs assessment studies, and descriptions of unique training developments. Although there was little consensus about training priorities for paraprofessionals in community mental health agency positions, many states indicated that few new staff, whether professional or paraprofessional, had adequate skills for working with severely disturbed, chronically mentally ill clients. In addition, most respondents believed that two broad subject areas were important: case management skills necessary for developing linkages with community supportive services and skills in developing treatment plans. The ways in which different states have approached the problem of training mental health workers varied considerably. Included among the training strategies adapted by different states were the following: the development of statewide agreements with colleges or universities to define the conditions for training agency workers, the use of training materials for specialized subjects geared to several levels of staff, and the establishment of decentralized responsibility for developing training programs and materials. (This publication analyzes the findings of the survey in detail and provides examples of training materials.) (MN)

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MENTAL HEALTH WORKER TRAINING

A STATE-OF-THE-ART REFERENCE ON STATEWIDE MENTAL HEALTH AGENCY TRAINING PROGRAMS

This report was prepared under the auspices of the Paraprofessional Training Program of the Southern Regional Education Board funded by National Institute of Mental Health Grant No. 5 T15-MH16510. Jack B. Schmitt, Project Director, Harold L. McPheeters, Program Director.

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PREFACE

Mental health worker (paraprofessional) training in state mental health agencies poses a unique problem. Unlike professional staff, who enter the system with fairly extensive training in their field, most mental health workers* begin their employment with little or no training in the skills and knowledge needed to function competently in their jobs. Yet, in most mental health systems these are the workers who carry a major share of the contact with patients and clients.

States have responded in a variety of ways to this training need. Some have extensive and highly organized mental health worker training programs. Others fit the description written by one state official who answered "no" to all questions about mental health worker training, "Paraprofessional training is a real need in our state mental health program. I would like to see a copy of your survey findings."

This monograph reports the results of a survey that grew out of a larger NIMH-funded project to provide technical assistance to the faculty and staff of para-professional training and education programs. During the course of that project, staff were in contact with manpower and training personnnel from state mental health agencies and learned that few of them were aware of the many exemplary training programs and different approaches to training used in other states.

The goal was to find out what state agencies were doing in statewide mental health worker training and let all state mental health agencies know about current developments in training programs, instructional materials, and different approaches in this training area.

The report is written both as an overview of different approaches state mental health agencies have taken to training of paraprofessional workers and as a practical reference for those agency personnel that are concerned about training for mental health workers.

Jack B. Schmitt
Project Director

*Exceptions are graduates of human service worker or mental health technician programs which offer practitioner-oriented training at associate and bacca-laureate degree levels.

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MENTAL HEALTH WORKER TRAINING

A STATE-OF-THE-ART-REFERENCE ON STATEWIDE MENTAL HEALTH AGENCY TRAINING PROGRAMS

SUMMARY

The Mental Health Program of the Southern Regional Education Board (SREB) has been conducting a project to provide technical assistance to staff and faculty of college-based mental health worker education and training programs. In the course of this project it was discovered that many manpower development staff in state mental health agencies were not aware of the many excellent training programs and unique approaches to training that had been developed in other states. Because of this, many states have duplicated efforts and others have never developed training programs for mental health workers when, in fact, ideas and material could have been borrowed.

The project staff prepared this reference publication to acquaint state mental health agencies with the ways in which other states are training their mental health workers. The report is based on a survey, conducted in the early summer of 1983 of all 50 state mental health manpower development offices. The survey requested copies of statewide training programs, instructional materials, training needs assessment studies, and descriptions of unique training developments. The focus was on statewide training for mental health workers--defined as "employees providing direct services to patients or clients, who require training to provide those services competently, but whose education when hired is typically not more than a baccalaureate degree and is not in one of the traditional professions such as nursing." Responses were received from half of the states.

An analysis of the needs assessment studies and the content of basic training programs both indicate the following priorities for training mental health workers in institutions:

Communication and basic interviewing skills
Knowledge of treatment interventions
Control and prevention of assaultive behavior
Observation and recording skills
Emergency medical skills
Techniques of training patients in independent living skills
Patient rights
Psychopathology, theory and classification

Although there was less consensus about training priorities for paraprofessionals in community mental health, many states indicated that few new staff, whether professional or paraprofessional, had adequate skills for working with severely disturbed, chronically mentally ill clients. In addition most respondents believed that two broad subjects were important: case management skills necessary for developing and linking with community support services and skills in developing treatment plans.

The ways in which different states have approached the problem of training mental health workers varied considerably. The following list summarizes the major approaches:

I. Materials that govern or support the basic training of mental health workers:

   Materials limited to training objectives, instructional outlines, and suggested texts.

   Materials that include instructional materials, lesson plans, work sheets, and other assists to help the instructor.

II. Materials that are designed for successively higher levels of employment and are usually linked to opportunities for advancement to these higher positions or grades.

III. Statewide agreements with colleges or universities to define the conditions for training agency workers and offering a degree or certificate which the state assists its employees in obtaining.

IV. Training materials for specialized subjects, often available to several levels of staff.

V. Decentralized responsibility for developing training programs and materials, with varying degrees of assistance in coordination and arrangements from central manpower staff.

Obviously, these are not mutually exclusive and many states combined several approaches in training mental health workers. For most subjects, the different training programs exhibited wide variations in depth of training, organization of material, and even underlying theory.

The publication analyzes the findings from the survey in considerable detail and provides examples of the training materials and names of contact persons from the states that are mentioned so that staff development officers will have a ready reference guide to where they can obtain the materials they need.

BACKGROUND AND METHODS

The latest in a series of National Institute of Mental Health (NIMH)-funded projects at the Southern Regional Education Board on mental health worker training provides technical assistance to staff and faculty of mental health worker education and training programs. One of the project goals was to identify the current state of the art in statewide paraprofessional training that is conducted or supported by state mental health agencies and to distribute this information.

A letter and survey form were mailed to the persons listed as state mental health manpower development contacts by the NIMH Center for State Mental Health Manpower Development in all 50 states. The main thrust of the survey was to obtain training materials, training program descriptions, and training needs assessments. For the purposes of the survey, a paraprofessional was defined as "an employee providing direct services to patients or clients who requires training to provide those services competently but whose education when hired is typically not more than a baccalaureate degree and is not in one of the traditional professions such as nursing." Training was defined as "classroom or experiential education provided to employees for the purpose of improving their skills, knowledge, and especially competence in providing effective service to patients or clients." Responses, received from 25 states, were from a representative cross-section of all states with no apparent bias in size or section of the country.

No attempt was made to conduct statistical analysis of responses to questions, since the questions were designed primarily to facilitate more accurate content analysis of the training materials and to identify those states where follow-up telephone contact was needed for additional information. The method of analysis involved two stages. First, a preliminary review of the training materials and needs

assessments was used to identify the major approaches being used in training paraprofessionals and the major subjects included in training programs. Second, a more detailed analysis was made of those states using each approach and of the specific topics and training design used for each of the major subjects. The results of the analysis are reported by these categories.

The survey permitted two means of determining priorities for the content of training programs for mental health workers (paraprofessionals). One was to do a content analysis of the training programs themselves and identify the subjects that are most commonly included by those states with statewide training programs. The other was to review the training needs assessments that were conducted by the state central manpower offices and identify the subjects most commonly mentioned in those reports. While half of the states responding to the survey said that they had conducted needs assessments that identified the training needs of mental health workers, only some of them sent copies of their studies. Nevertheless, enough needs assessment studies were obtained to include them as a basis for identifying priorities both in institutions and in community mental health.

In order to analyze the content of training programs, it was necessary to develop a set of categories for the variety of terms used to label a training subject. (A detailed list of these categories can be found in Appendix H.) Some guesswork and compromise was involved in this process since complete descriptions of the training were not always included. For example, "communication skills" is listed under "treatment skills" because it was most commonly described as skill training for the purpose of working with patients in their treatment program. In some cases, however, training in communication skills appeared to have the primary function of preparing workers to make observations in order to keep more accurate case records.

Another aspect of these categories to keep in mind is the great variation among the different states in the extent of the training for a particular subject. Thus, the category "behavior modification" (variously called behavior therapy, behavior modification, or a series of discrete topics normally included under one of those titles) was

recorded as being included in a training program if only an hour was spent describing the principles and use of behavior modification so that the mental health worker could assist others in the process. It was similarly recorded for programs that had several days of training and skill practice.

TRAINING PRIORITIES IN INSTITUTIONS

Training priorities in institutions can be assessed in two different ways: a) the most common subjects actually incorporated into training programs and b) the subjects that workers in institutions indicate should be of high priority. Four states sent needs assessments that involved surveys or nominal group process techniques to determine priorities and eight states returned information on the training actually provided at state institutions.

There were some significant differences between these two measures of high priority training subjects, but there also were some basic agreements. Eight subjects were a priority for institutional training, based on both needs assessments and training program content (see Table 1).

These subjects exhausted the topics found in two or more of the training needs assessment studies. In the actual training programs some other subjects were common to a large number of the states. In the area of physical care were training objectives like taking vital signs, infection control, and body mechanics for lifting and transferring patients. Also recording skills, behavior modification skills, treatment planning, and team management were usually covered in the training programs. Table 2 lists all the subjects covered by more than 25 percent of the training programs for mental health workers in institutions.

TABLE 1

High Priority Training Subjects For Institutional Staff

In 50% of the Training Programs and 75% of the Needs Assessments:

1. Communication skills, basic interviewing and counseling skills, relating on a personal caring basis, etc.
2. Clinical understanding of psychopathology, theory of mental health treatment, dealing with variations in mental illness, etc.

In 25% of the Training Programs and 50% of the Needs Assessments:

3. Controlling and preventing agressive or assaultive behavior
4. Observation and assessment techniques
5. Emergency medical skills (CPR, first aid, etc.)
6. Teaching skills, independent living training, skill training, etc.
7. Patient rights, legal issues, confidentiality, etc.
8. Basic psychology, theories of psychopathology, human development, classification of mental illness, etc.

TABLE 2

Most Frequent Subjects In Mental Health Worker (Institution) Training Programs
(All Training Stages)

Health &Personal Care	Observation & Recording	Treatm't Plan. & Management	Treatment Theory	Treatment Skills	Other
Over 50% of the Programs:					
*Vital signs	*Observation techniques	Problem solving/ treat. planning	Classification of mental illness	Interviewing & counseling	
*Infection control	*Recording skills/policy	Team roles & policy	Human development	Behavior modification	
*Body mechan.- transf.		Monitor & evaluate treatment	Intro to mental health	Communication skills	
			*Psychotherapy theory & method		
25% to 50% of the Programs:					
Emergency skills - CPR, first aid, etc.		Problem identification	Psychotropic drugs	Independent living training	Prevention & control assaultive behavior
Personal care		Team - group skills	Sexuality	Crisis intervention-- suicide, etc.	Patient rights
				Substance abuse counseling	Patient safety-- fire, etc.
				Activity therapy	
				Teaching skills	

*Also included in over half of the entry-level training programs.

TRAINING PRIORITIES IN COMMUNITY MENTAL HEALTH

Three state-sponsored surveys that measured opinions about training needs in community mental health were obtained during the SREB survey. Because they were conducted using quite different approaches, the results were difficult to compare. They illustrated how much the manner in which a question is asked influences the results. For example, in one state, the survey of community mental health agency directors was open ended, leaving it to the respondents to identify the categories that best expressed their concerns. The general area most frequently identified as a training need by these directors was expressed in the following different ways:

Community support
Case management*
Tapping community resources
Linking to agencies
Networking with the community

In another state, mental health workers were asked to identify the relative importance of 65 different categories of training subjects. Only two of the 65 seemed clearly to match the "case management/developing community resources" concept. They were "advocacy" and "human service programs (eligibility/regulations)." Both were rated among the top 50 percent in importance. The categories used in the survey from a third state did not lend themselves to identifying the need for training in the "case management/developing community resources" area.

*The term case management was commonly used in two quite different ways, depending on whether the reference was to institutional or community mental health services. In institutional service it generally referred to the mental health worker's interdisciplinary team role of observing, recording, and reporting the patient's progress. In community mental health the term applied to a wide range of activities including assessment, treatment planning, arranging community support services, coordination of therapy and support services, advocacy, and monitoring progress. This report used both these definitions and relies on the context of community mental health or institutional services to provide clarification.

These problems of relatively poor comparability were dealt with in Table 3 by grouping those words and phrases from the different reports that seemed to be related. Only one of these groupings was identified as a priority for community-based mental health workers in all three states; others were identified by two of the three states.

TABLE 3

High Priority Training Subjects in Community Mental Health
(Consensus of Needs Assessments)

Three States

1. Acute and chronic care, services for severely disturbed, chronic clients.

Two States

2. Crisis intervention, emergency services, emergency group skills.
3. Case management, advocacy techniques, human service programs (eligibility/regulations), tapping community resources, linking to agencies.
4. Psychotropic drugs, medications for mental illness.
5. Psychosocial assessment, interviewing techniques, diagnostic interviewing, evaluation, what to look for in clients, classifying/gathering client information.
6. Writing/developing treatment plans, planning mental health services.

Training material relating to community mental health was received from four different states. Taken together, the four different community mental health training programs identified four major services:

1. Counseling, providing emotional support, reinforcing reality orientation, reinforcing independence.

2. Skill training necessary for clients to manage as independently as possible.

3. Developing and linking with community resources necessary to support the clients in areas where clients are not able to function independently (this often involves advocating for clients).

4. Coordinating of all therapy and resources.

The process of providing these services requires four stages which often must be recycled several times during the course of working with clients in community support programs. These are:

1. Assessment

2. Treatment planning

3. Provision of service

4. Monitoring and re-assessment if necessary

All of the training programs included educational objectives related to this comprehensive view of community mental health. They also covered the values of promoting and supporting independent functioning and normalization, and they used these values as an underlying theme in teaching treatment and treatment planning skills.

Beyond that general consensus about what community mental health should encompass, the training programs varied greatly. Two were really specialized and designed for all levels of staff. One of these was developed to teach mental health personnel in institutions those patient training skills necessary to prepare patients for living independently after discharge into the community. The other was designed to teach case management skills and the integration of case management and therapy to personnel who already had clinical or counseling skills. Despite these variations there were four training subjects included in at least three of the four training programs (see Table 4).

TABLE 4

Most Frequent Subjects in Community Mental Health Training
(Included in Three Out of Four Programs)

Functional assessment skills oriented toward identifying services needed for achieving maximum independent living
Treatment planning skills
Service mobilization, linkage, case management, advocacy
Counseling, interviewing, clinical skills

It should be noted that the only good matches in community mental health priorities as determined by both needs assessments and training programs were case management/resource development and treatment planning skills. Taking both sources of information from all states that provided data on community mental health training, it was apparent that some states stressed crisis intervention, clinical assessments, and medications, while other states stressed functional assessment, support services, and skill training. Still other states seemed to emphasize a mix of subjects drawn partially from each of the first two trends. The great variation, when compared with training in institutions, probably derives partly from the relative newness of community mental health, partly from different approaches to treatment, and partly from chance variations in training opportunities and personnel.

TRAINING MENTAL HEALTH WORKERS

This chapter describes what state mental health agencies are doing in mental health worker training.* The first section looks at the different approaches states have taken. They range from decentralized training with some coordination and support from the central manpower office to statewide specifications for training that must be successfully completed before an employee can be promoted to a higher grade or position. The degree of specification in some statewide training programs was limited to an outline of objectives; other states provided detailed material including lesson plans, worksheets, and audio-visual materials. The guiding philosophy, whether expressed or not, determines what technical support local-level staff can expect from the state agency in training of paraprofessional staff. That support, in turn, probably determines what the agency can expect from its mental health workers.

The second section reviews the details and variations in training materials for specific training subjects that were given a high priority by the state agencies. Trainers and supervisors in mental health agencies will be able to identify a specific training subject, such as interviewing, communication skills, or behavior modification, and review the various approaches and specific contents that have been used to train entry and middle-level staff. With this information on the range of options, trainers will be better able to decide which approach best suits the needs of their agency, contact those states that have used those approaches, and build on the work of others rather than duplicating efforts that already have been made.

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*In this publication the past tense is used to describe the materials reported by the states. However, this does not imply that these materials or the policies have terminated, for, in fact, they are current materials and ongoing policies in the states.

APPROACHES TO STATE MENTAL HEALTH TRAINING

The state mental health agency approaches to training are divided into five broad categories; they are not mutually exclusive (see Table 5).

TABLE 5
Approaches to State Mental Health Agency Training

I. Statewide materials that govern or support the basic training of mental health workers.

   Materials limited to training objectives, instructional outlines, and suggested texts.

   Materials that include instructional materials, lesson plans, work sheets, and other assists to help the instructor.

II. Statewide materials organized into training stages that are designed for successively higher levels of employment and are usually linked to opportunities for advancement to these higher positions or grades.

III. Statewide agreements with colleges or universities to define the requirements for a particular degree or certificate which the state assists its employees in obtaining.

IV. Specialized statewide training materials for particular subjects, often available to several levels of staff.

V. Decentralized responsibility for developing training objectives, training programs, and training materials, with varying degrees of assistance in coordination and arrangements from central manpower staff.

Statewide Materials for Basic Training: Objectives and Outlines

One of the longest basic training programs identified through the survey was in Connecticut where persons seeking employment as a Psychiatric Aide I had two options. One, geared to the college-level learner, consisted of four weeks of classroom and clinical experience, followed by two weeks of supervised clinical

experience. The second option was a Psychiatric Aide Trainee program--a six month pre-entry Affirmative Action program that did not require high school graduation. This option included 410.5 hours of clinically supervised experience, 354.5 hours of theory, and 19 hours of group experience. During the six-month training period the Psychiatric Aide Trainees were employed in one of several training institutions, but their status was defined as learners, not employees. Successful completion earned the trainees nine external college semester credits.

More typical of the basic training programs was Tennessee's Basic Psychiatric Technician Training Course. It consisted of 130 classroom hours and 130 hours of supervised training experience within the work setting. Thirty of the 130 classroom hours were not specified by the state standards and were reserved for material directly related to specific duties to which the employee would be assigned. It was expected that the employees would complete the course within six months of employment.

The Texas training program was also more typical, but had its own variation. Like Connecticut it had a preservice training period, although for considerably fewer hours and limited to principles and fundamentals. This was followed by a second training program designed to be taken prior to promotion beyond entry-level employment. This program was designed to meet basic competencies that were identified through a needs assessment study. Unlike Tennessee, a separately identified period of supervised training experience was not included in the core curriculum.

Of those states that provided information on the length of their basic training programs, slightly more than half had over 200 hours. These same programs were the ones that included structured, supervised training experience as part of the training. Counting only classroom hours, half of the programs had between 100 and 200 hours; the rest had less than 100 hours.

The written training material developed by the central agency staff using this approach typically included training objectives; some had instructional guidelines. The objectives to guide the training were usually phrased in terms of what the trainee would be able to do, that is, they were behavioral objectives:

...the participant will demonstrate how to deflect blows
...the participant will demonstrate ability to plan and organize client activities
...the participant will identify policies and procedures that relate to personnel and patient safety
...the participant will present reality in response to delusional and/or hallucinatory material
...the participant will distinguish between continuous reinforcement and intermittent reinforcement
...the participant will discuss process of cognitive dissonance reduction.

Among those programs that used behavioral objectives, there was considerable variation, even within the same program, in the extent to which the required expectations demonstrated performance, as opposed to being able to describe what should be done. Without instructional materials, it was difficult to determine whether this reflected an actual difference in the training that took place, that is, practice and skill training as opposed to gaining only knowledge about what should be done.

In some of the states there were also brief instructional outlines. These outlines seemed to provide greater consistency among institutions and centers in how mental health workers were to be trained. See Table 6 for an example of an additional guide to the decentralized training staff. It should be noted that the example is taken out of context; the full guide includes related subjects, such as the assessment, planning, implementation, and evaluation stages of treatment.

The preceding description of statewide training material using the behavioral training objectives approach illustrates the most common format; there are others. Some states used very broad objectives and provided greater detail with a content outline. Others used only a subject outline for describing the statewide standard for training. One state, whose training for employees desiring placement in community settings was established through court action, had descriptions of five core curriculum

TABLE 6

An Example of Instructional Outline Supplements to Training Objectives
(Subject: Case Management; Source: Tennessee)

Objective	Content	Activities
Participant will:		
--define the role of the Case Manager	A. General Responsibilities	
--develop a format for writing progress summaries/case review	B. Progress Summaries/Case Reviews 1. frequency 2. guidelines on writing	
--discuss formulation of treatment plans	C. Team Treatment Plans 1. developing goals 2. describing problems in behavioral terms 3. determining measurable objectives 4. developing interventions 5. sharing with the patient	--practice developing a treatment plan ASSIGNMENT: Complete "Nursing Care" for case study.
--outline guidelines to be used when recording date	D. Documentation 1. procedure 2. legalities involved 3. terminology to use and avoid 4. psychiatric symptomatology and vocabulary	--group discussion on psychiatric terms and symptomatology
--discuss some legal factors to consider when charting		--bring examples of charting to class for critique and discussion
--interpret commonly accepted terms, symbols, and abbreviations used in charting		LAB ASSIGNMENT:
--demonstrate accurate, concise documentation		1. Arrange with head nurse to be case manager for one patient. 2. Each student will write and present a. a complete treatment plan b. at least two progress summaries case reviews c. results of sharing an approved treatment plan with the patient

areas in which applicants must demonstrate minimum competence. These descriptions were in sentence and paragraph form similar to the course descriptions found in college catalogs.

The subjects included in the different training programs varied greatly: Table 2 shows the most common subjects for institutional staff training; Table 4 shows the most common subjects in community mental health training. In order to illustrate the composition of an entire training program, the training outline for two different states is provided in Appendix A. It should be noted that there was no typical pattern in the order of subjects, the depth to which any one subject was covered, or even what subjects were included.

Statewide Materials for Basic Training: Instructional Materials

Some states went far beyond identifying training objectives and content outlines. Some of the examples of more extensive approaches were for special subjects; they will be described later.

The two examples described here are from Florida and Indiana. Florida's program consisted of a four-volume participant's workbook and a four-volume facilitator's manual. A unique element is the fourth volume which provided guidelines for a structured practicum to integrate and practice the skills learned in the first three courses. The program was designed for 180 hours of training and included videotape and slidetape presentations to support the courses.

Indiana's Mental Health Technician Training Program covered 15 broad areas of training in three notebooks. It additionally made use of a wide variety of other texts, training materials, and manuals, and incorporated the instructions for the use of these other materials into the training procedures. It required appoximately 200 hours to complete the program.

The two state-level training programs were initially designed to meet somewhat different needs. Indiana's goals were to prepare participants in those common core competencies needed for service in both institutions and community agencies. It was intended to cover the training needs in mental health and developmental disabilities. The Florida program was initially designed to meet the training needs of staff in mental health institutions, but its generic nature has resulted in its being used for community mental health as well. Thus, both programs probably could be considered appropriate for the training of generalists for the field of mental health.

There were many subjects common to both training programs, but there also were many differences. Subjects covered by both programs included individual treatment planning, working with treatment teams, psychodynamic treatment, behavior modification, instructional methods, and classification of mental illness. Training time allotted to these different subjects varied considerably between the two programs. Only the Indiana program included health care skills, dealing with assualtive behavior, client rights, advocacy, developing commuity resources, and human development. Only Florida included psychotropic medication.

Both training programs were divided into modules--60 in the Florida material and over 100 in Indiana's. The length of time required to complete each module varied from one to twenty hours in the Indiana program; Florida's modules were more consistent in length. Appendix B contains a list of all modules in each program.

In Indiana, the instructional material for each module was organized into seven sections following the title and time estimate:

Summary description
Goals and objectives
Equipment and materials
Suggested procedures
Training aids
Evaluation
Bibliography (of other resources)

The suggested procedures were divided into individual and group procedures to allow for variations in training approaches in individual institutions and agencies. Not all

modules had training aids, since the Staff Developer Manual was meant to be supplemented extensively with other texts and manuals. In all cases, the training material, whether suppplemental or contained in the manual, was clearly linked to specific training objectives. Indiana's basic training program was designed to be used flexibly and as a resource; it was not considered a set of statewide standards for training. Staff developers were encouraged to modify objectives, substitute other material, and change procedures.

The Florida training material was far more self-contained and was designed to be used as it was developed. With the Participant's Workbook, the Facilitator's Manual, and the tapes, the trainer had all the material needed to conduct the training program. Each module in the Participant's Workbook contained 1) participant outcomes (training objectives), 2) a paragraph summary of the subject, 3) a longer description of the main points, 4) a list of definitions, and 5) training materials. The Facilitator's Handbook contained a duplicate of the first four items in the Participant's Workbook and was followed by the following sections:

Preparation
Implementation
- Orientation
- Practice
- Review

At the end of each of the four courses (notebooks, each containing 15 of the modules) was a set of tests, one for each module, and a gradebook to record whether a participant had mastered each module. The section on implementation was, in fact, a detailed lesson plan indicating the number of minutes to spend on each section, when to take breaks, how to introduce subjects and use the worksheets (training materials in workbook), and details of class exercises.

Appendix B provides for comparison a complete copy of the second module (of three) on behavioral techniques from the Participant's Workbook in the Florida training material, along with the preparation and implementation sections of the Facilitator's Handbook; and two complete modules from the Indiana training material--Interdisciplinary Team Skills and Client Advocacy Skills.

Statewide Training Materials Linked to Several Staff Levels and Advancement

Some states went beyond basic comprehensive training and identified the core training needs of several positions or grades. Comprehensive (as opposed to special subject) training programs were then developed to meet needs for different levels of employment. In most cases, these states required successful completion of the training programs as a prerequisite for promotion to a higher employment level.

Texas provided the most extensive example of this approach to training. The mental health agency developed five different comprehensive training programs designed to meet the gradually increased skill and knowledge needs at successively higher levels of employment. The first training program was preservice and was required before the MHMR Aide Trainee (entry-level) could report to the work station for duty. When the Aide Trainee had successfully completed the second training program and had sufficient experience, he/she was eligible for promotion to MHMR Services Assistant. Similar combinations of successful completion of the next training program and additional experience provided an effective career ladder for para-professionals, allowing them to rise to supervisor positions. At the same time, the agency ensured that its paraprofessional staff had the core competencies necessary to function effectively on the job.

In addition to the core curriculum, the agency established statewide continuing education modules. All employees above the Service Assistant were required to complete at least three of these modules annually. Completion of the core curriculum for advancement to the next level was an alternative to meeting this requirement. Those employees who had completed the core curriculum series and advanced to a Supervisor I position were required to use these continuing education modules (the choice being made in consultation with their supervisor) in order to continue their career advancement. Appendix C contains an outline of the subjects included in each of the core curricula and the continuing education modules.

Other states developed similar but less extensive systems. Nevada, for example, had a 75-hour basic training program for their Mental Health Technician I (MHT I) employees that was required for advancement to the MHT II position. A second 75-hour training program for MHT IIs was required for advancement to the MHT III position. The state agency also had a similar training series for Mental Retardation Technicians and the child and adolescent services.

There seemed to be considerable variation in the subjects that were included at different levels in these staged training programs. Whether this was the result of differences in other orientation courses or differences in the job responsibilities was not determined. Table 7 provides a comparison of the comprehensive training program for the first training level in the series for two different states. Both states used the training as a requirement for promotion to the next level, and both training programs had between 70 and 80 classroom or lab hours. The information in the Appendix on Texas (preservice and the next program combined) provides a third comparison.

TABLE 7

A Comparison of the Content in the First Level of Staged Training
(Both Programs Between 70 and 80 Hours)

Subject	Percent of Total Hours Spent on Each Subject	
	State A	State B
General roles and responsibilities	9	8
Health and personal care skills	50	--
Management of assaultive behavior	--	17
Observation and recording skills	6	11
Problem identification/treatment plans	--	8
Human development	3	--
Psychotherapy theory, methods, skills	32	39
Crisis intervention--suicide	--	17
TOTAL	100	100

Statewide Agreements Between Colleges and the State Mental Health Agency

Several states approached mental health worker training by developing agreements with colleges and universities for degree oriented training of their employees. All such programs identified through the survey resulted in associate degrees. As with almost every other approach, the diversity among the states was great, and in this approach, where negotiation between two major state systems was involved, almost every issue seems to have been resolved in a different way.

Analysis of training program content offered comparison with the previously described agency-based approaches to mental health worker training. The range of options is illustrated in Table 8 which compares the courses agreed upon in Maine and Alabama. Maine's core curriculum tended to put more emphasis on general knowledge and liberal arts courses, such as developmental psychology, oral communication, social problems, and biology. Alabama's course listing included more skill development courses, such as behavior modification, activity therapy, and a second course in group dynamics. Both states left to inservice training in the state agency some of the high priority subjects, such as health and personal care skills, prevention and control of assaultive behavior, and psychotropic drugs.

Although both states began their development of a college-MH agency agreement with needs assessment, a systematic review of worker activities, and an exploration of a wide range of options for implementation, the results of their efforts were different in many other ways besides the curriculum content. A description of these differences illustrates the many approaches available to state agencies interested in using this means of developing a trained staff.

In specifying what would be taught, Maine used the fairly standard course syllabus and schedule format common to colleges and universities. It contained a description, a brief list of very broad objectives, evaluation criteria, textbooks, and list of topics by week. Alabama prepared a very detailed list of instructional

TABLE 8

Comparison of Course Requirements for Two Associate Degree Programs Agreed Upon by the State Mental Health Agency as Appropriate for Statewide Mental Health Worker Training

General Category	Course Listings	
	Maine	Alabama
Basic Psych/Soc Knowledge	Intro to Psychology Intro to Sociology Develop Psychology	General Psychology Sociology
Biology/Physical Illness	Biology	
Introduction to Profession	Intro to Human Service	Orientation to MHT
Particular Problems/Conditions	Abnormal Psychology Contemp Social Problems	Abnormal Psychology (Mental Retardation)
Therapy for Particular Problems	Intro to Mental Health Principles of Rehab.	Family Dynamics* Special Problems
Research	Behav. Research Methods	
Observation/Testing/Recording	Psych-Soc Evaluation	(Clinical Observation)
Interview/Counseling/Commun.	Interview/Counseling	Techniques of Counsel*
Groups: Process & Counseling	Group Process	Group Dynamics I Group Dynamics II*
Behavior Modification		Behavior Modifica. I (Behavior Modifica. II) Learning Theory & Behavior Change
Activity Therapy		Activity Therapy
Human Service System/Referral		Prin. of Clinical Agencie
Other	Human Serv. Practicum Written Expression Oral Communication	Field Experience English

Note: Both states had provision for electives: Maine, 3 semester hours; Alabama, 25 quarter hours. In Alabama's core course listing there were two options, one for mental health and one for mental retardation. Those taking the mental health sequence were not required to take those courses in parentheses. Those taking the mental retardation sequence substitute the courses in parentheses for courses with an asterisk.

objectives (defining what the instructor would do rather than what the student would be able to do) and an instructional outline that was linked to the objectives. Appendix D includes the syllabus and course schedule for "Introduction to Supervision," developed by Bangor Community College as an elective course to meet one of the training needs identified by the Maine Department of Mental Health and Mental Retardation. Appendix D also includes the instructional objectives and outline for the "Behavior Modification II" course contained in the Alabama Department of Mental Health's curriculum guide for work-education linkage programs.

Both states considered using practitioners employed by the state mental health agency as faculty for the program. They arrived at quite different conclusions. In Maine, the resolution was that faculty should be from the education system and not from the mental health agency because 1) it would not be cost effective to provide sufficient release time for the state agency staff, 2) the faculty of the college were screened to include persons with past clinical experience, 3) mental health workers should be exposed to practitioners not employed in the same facility or agency, and 4) generally, clinical services are provided most effectively by clinicians and educational services are provided most effectively by educators.

In Alabama, selected mental health professionals were released by the Department of Mental Health to teach, under the supervision of the community colleges, academically accredited courses in the degree program. The courses were taught on the grounds of the mental health facilities, and enrolled employees had full student status. The state mental health agency paid the college for student tuition, and the college paid the agency for faculty salaries and use of facilities; the checks had a tendency to be for identical amounts. The college gained increased enrollment and successfully met an educational need; the agency gained college accredited training for its employees.

Naturally, not all mental health workers will be interested in obtaining college degrees, but for those who are, this approach serves to improve the quality of staff, build morale, and help employees move one step toward obtaining professional degrees so that their potential career ladder is open-ended. The responses indicated that this approach takes a great deal of time and energy, and it requires considerable cooperation between the two state systems.

While the type of college-agency agreements just described were the most comprehensive, there were other options. One, mentioned in connection with Connecticut's program, was an agreement with the higher education authorities in the state to grant college credit for training programs conducted by the state agency. Another option was to develop brief curricula linked to certificates for specific job classifications. Washington provided an example at the other end of the continuum from the associate degree programs described above. The mental health agency there defined a core curriulum required for a job classification of institution attendant. Completion of specific courses totaling 28-30 quarter hours enabled employees to increase their salary. Statewide, only three courses were a required part of the total quarter hours: English composition, introduction to psychology, and abnormal psychology or human growth and development. The remaining 16-18 quarter hours were determined by the local facility in conjunction with the local community college. Other examples of college-agency agreements were found in the many programs (both degree and non-degree granting) that were developed between colleges and individual institutions or agencies within a state.

Statewide Training for Specific Subjects

A number of states developed programs for training in specific topics. Some of these topical programs related to specific new departmental policies or procedures. Others, however, were programs for developing skills needed to provide competent

service to major groups of patients or clients of mental health agencies. The following programs are used to describe this approach:

Maryland: A complete training package for teaching workers how to train residents of chronic units in the independent living skills necessary for functioning in less restrictive environments after discharge.

Colorado: A one-day training program for community mental health workers with clinical skills to teach the additional skills needed for case management and for integrating therapy with case management.

Florida: A program to train workers in skills necessary for management and supervision in the mental health setting.

It should be noted that, because of the nature of the training topics, most of these programs were designed for several levels of staff: professionals, paraprofessionals and aides. Maryland's program to teach functional assessment, task analysis, and skill training needed to prepare chronically ill patients for independent functioning in the community was a complete training package. The instructional materials were comparable to those described for basic training in Indiana and Florida. The program was divided into 11 units. Each unit began with an introduction describing the purpose and rationale, followed by behavioral training objectives, an overview outlining the instructional/experiential formats that would be used to achieve the different objectives, an instructional outline or lesson plan, and homework assignments. The units also included training materials--handouts, pages for making transparencies, worksheets, etc. Throughout the program there was considerable emphasis on practicing skills with patients slated for return to the community.

The first unit was an introduction to community mental health using the Fountain House model and included visitations to a number of community programs. The next section taught the basic skills of performance training using task analysis, stimulus control, and reinforcement. It was followed by a unit on functional skills

assessment and a unit providing an overview of different pre-entry needs. The remaining units were on skill training in specific functional areas including:

Housing
Transportation
Food
Possessions
Crisis management
Intermediate needs
...psychosocial linkage
...self-help group linkage
...psychiatric care
...physical medical care
Employment

Appendix E contains the Introduction, Objectives, Formats for Experience, and Instructional Process sections of the unit on Performance Training; the entire unit on Crisis Managment is also included.

The Colorado material on integration of case management and therapy functions in community mental health used quite different teaching materials. It contained a series of verbatim short lectures that were integrated into the Trainer's Guide and supplemented by exercises, charts and tables, and a series of vignettes, both summarized and verbatim, on different client/counselor interviews. While the lectures were written out, it was suggested that trainers adapt the material to their own style. The vignettes were used for discussion and critique by trainees. The program was designed to be conducted from 9:00 to 5:00 in a single day.

Seventeen phases were built around seven major subjects, preceded by a warm-up phase and ending with a participant critique of vignettes of counselor-client interaction that deliberately lacked different case management or therapeutic interventions. The major subjects were:

1. The problem of the chronically mentally ill adult in modern society: needs, resources, and barriers.
2. Comprehensive clinical service: integration of therapy and case management.
3. Framework for clinical behavior: decision points, factors in decisions, and four steps in comprehensive service.

4. Assessment.
5. Goal setting.
6. Intervention planning and monitoring.
7. Interdependence of therapy and case management.

Appendix E contains the lecturette and exercise phases for the second subject, "Comprehensive Clinical Service."

Florida's training program on management and supervision in the mental health setting was a paperback book of nearly 700 pages containing 19 chapters divided among five sections: management foundations, applied personnel management, management in specialized settings, personal competence, and interpersonal competence. Appendix E includes the complete table of contents.

Each chapter began with text material describing the subject and ending with a reading list. This was followed by a participant's summary that included participant outcomes (training objectives), main points, and definitions. Finally, each chapter had a set of learning activities, a self-quiz, and an application section. Most of the learning activities were similar to workbook exercises, requiring the participants to list points or think about and describe personal experiences that illustrated some aspect of management and supervision described in the text. Some of the activities required the participant to listen to a vignette and answer questions on the text material. The application section was similarly structured but emphasized exercises involving personal experiences or previous workplace situations of the participants.

There was a more common method of developing special subject statewide training than those three programs. In most states, there was a central training committee that identified priorities for training. Those priorities were then used as a basis for preparing contracts with consultants to develop and provide specific training courses. The availability of these courses was announced to the different institutions and centers, and they determined, using their own criteria, who should attend which courses. In some states these courses were provided from the central training office

budget, and in others the institutions training budgets paid for the costs of employee training. Many states used a combination of these two financing methods, depending on the priority given to a particular course. The staff obtained a few lists and bulletins announcing these courses. The range of subjects included was extensive; in most cases, each course listing included a description or a rationale for the course and a list of training objectives, in addition to the time, place, date, trainers, and maximum number of participants.

Decentralized Development of Human Service Worker Training

Most state agencies delegated the development of training standards, objectives, instructional outlines, and materials for some of the mental health worker training to individual institutions and centers. The extent of this delegation varied greatly. In some states, almost all training needs assessment and training program development were decentralized. In other states, where there was greater desire for minimum training standards to ensure basic statewide competencies among mental health workers, the delegation of training responsibilities was much more limited.

CONTENT AND ORGANIZATION OF TRAINING ON SPECIFIC SUBJECTS

This part of the report is intended as a reference for state mental health agency personnel and state manpower personnel who are in the process of developing a specialized training program. States that provided these specialized curriculum designs are identified. Readers wishing more detailed information on a particular issue may contact the states directly (see Appendix I).

Training programs organized specialized topics in quite different ways. Skill training in therapeutic interventions, for example, was sometimes combined with the study of categories of mental illness, sometimes included with communication skills, and sometimes integrated into a survey of therapeutic methods. To avoid unnecessary duplication, the following sections on different training areas are organized so that the overlapping areas appear next to each other and some topics are covered over the course of several sections.

Health and Personal Care Skills

This broad area of training received greatly varied emphasis in statewide training programs among the different state mental health agencies (see Table 7). The range of specific topics in four different states can be seen in the appendices: Appendix A, Connecticut and Tennessee; Appendix B, Part 1, Indiana; and Appendix C, Texas.

As indicated in Table 2, the most common subjects were vital signs, infection control, and body mechanics for lifting and transferring patients. For those who included the subject, the vital signs taught were usually pulse, respiration, temperature, and blood pressure; trainees were expected to be able to take these measurements. Infection control was most often limited to teaching proper cleanliness habits

for employees. A few states, Indiana for example, also included sterile techniques, isolation procedures, and how to change sterile dressings. As with many subjects in this content area, the training objectives for body mechanics were general and seldom provided additional detail, perhaps due to the implicit assumption that these nursing subjects have fairly standard curricula at the basic level.

Observation, Monitoring Treatment, and Recording

Most of the statewide training programs that included subjects in this area spent a fair portion of the training time teaching the use of specific state forms. The Problem Oriented Record System (PORS) and the training objectives defined for it by the Texas program provide a typical example of the depth of training.

TABLE 9

Typical Training Objectives for the Problem-Oriented Record System
(Example from Texas Training Program)

The participant will identify:
The two major goals of PORS and will state five benefits of using PORS,
The five major sections of PORS,
15 common forms utilized by the PORS, and
The four "I's" to be charted in the Progress notes.
Utilizing a simulation package, the participant will complete the appropriate PORS forms.

Observation and monitoring skills are needed by mental health workers to varying degrees, depending on specific job responsibilities. The description of Indiana's module on program evaluation explained fairly well the monitoring functions, and the related training objectives that were typically found at some stage in a mental health worker's progression through the different levels in the state's job classification series. In some states these were entry-level responsibilities, but more often they were tasks required at a higher level.

> The purpose of this module is to build the MHT's practical skills for evaluating the success or failure of the objectives and strategies used to help clients reach specific goals. This module will define two types of evaluation: process and product, and explain how they are used to provide feedback to the client, interdisciplinary team and agency. In addition, the module will provide a background in the release/discharge planning process so as to make MHTs aware of client's goal to function in the community in as smooth a manner as possible. With this knowledge secured, the MHT will have acquired an understanding of what is considered the complete cycle of the IPP process. This will enable MHTs, as advocates, to contribute substantially to the team's formal staffing skills by treating clients in accordance with the principles of current laws and legislation for the rights of mental health clients. (Description of Program Evaluation module in Indiana's MHT training program.)

Some states included observation and recording skill training as part of the role of the case manager (see next section). In other states these subjects were linked to training in admission interviewing, behavior modification, and/or communication skills. The linkage with admission interviewing can be seen in the following partial list of objectives from the module on assessment in Connecticut's Psychiatric Aide Trainee Program:

...Discuss utilization of the admission data base to record client behaviors and recommendations for nursing care.

...Demonstrate an assessment interview through role playing.

...Record client's presenting behaviors in behavioral terms.

The observation skill training related to behavior modification and communication skill training will be covered in later sections under those topics.

One final note on observation and recording--almost all states included training in the legal aspects of medical records. Some include this training objective under recording skills; others included it as part of their training in the client's legal rights.

Problem Solving and Treatment Planning

Those states that included problem solving and treatment planning in their human service worker training programs usually incorporated assessment and recording skills in that section of the training. Tennessee's case management training was a good example (see Table 6). Another example was from the Assessment and Intervention Process section in Nevada's first stage of training (see Table 10). The modules listed under Individual Program Planning Skills in Indiana's training program and in Florida's Course 3 (Appendix B, Parts 1 and 2) demonstrated other handling of these topics.

TABLE 10

Subjects and Methods Included in Assessment and Intervention Process Training
(Example from Nevada's Training Program)

Problem solving techniques	Self-study workbook
Collecting baseline information	Seminar on use of Behavioral Observation Inventory
Indentifying problems	Inservice: charting and therapeutic interventions
Selecting solutions	
Evaluating results	

Preparation of behavioral treatment plan and supervised one-to-one therapy

Team Roles, Policies, and Skills

One role of the human service worker in an institution's interdisciplinary treatment team is that of the case manager, with responsibilities for observing, recording, and reporting information about the client's progress. The objectives for this subject from the third stage of training in Texas were typical:

1. Identify three reasons why involvment in client staffing is important.
2. Identify three benefits of involvement as a paraprofessional case manager.
3. Identify four major tasks he/she can perform as a paraprofessional case manager in staffings.
4. Demonstrate ability to participate in a simulated client staffing.

Tennessee's case management module was a more extensive treatment of the case manager role (see Table 6).

Some states included group dynamics and communication skills as part of their interdisciplinary team training. Indiana allotted more than 12 hours to team skills using the following six modules:

The importance of teaming
Interdisciplinary teaming
The importance of the Mental Health Technician
Assertive team communication skills
Team support skills
Burnout management skills

The entire second module is included in Appendix B.

Human Development

In their human development training objectives most state programs included physical, cognitive, and personality development from infancy to senescence, although some states limited their efforts to personality development. Prenatal development was included in the training programs for persons who would be working with expectant mothers in prevention of mental retardation.

The most common approach was to acquaint trainees with the work of Freud, Erikson, and Piaget on child development and then continue with later stages of life. The heredity, environment, and ego determinants of personality were typically covered.

Introduction to Mental Health/Illness

Those training programs that contained a unit on introduction to mental health/illness used that section to promote the development of appropriate attitudes concerning mental illness. Listed below are some typical training objectives from several programs:

...Will describe how the client is more like them than unlike them.

...Will define mental illness and list two misunderstandings concerning mental illness.

...Will be able to refute the misconception that mental illness is a disgrace.

The units also were used to acquaint participants with common terms and classifications in the field. Training objectives included:

...Will identify four major classifications of mental illness and give one example for each.

...Will understand the terms used in referring to abnormal behavior in order to use them appropriately in communicating with others.

...Will describe the potential harm from the use of common terms and labels.

Classification of Mental Illness

Some of the programs that included the classification of mental illness based training on Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) and expected the trainees to acquire a general understanding of the classification system, its merits, and its drawbacks. Others organized their training around a study of traditional categories with the expectation that participants would be able to list the common characteristics of each. The categories of mental illness typically included were:

Organic brain syndromes	Affective disorders
Schizophrenic disorders	Psychosexual disorders
Paranoid disorders	Substance use disorders

A few of the training programs combined the teaching of the classification of mental illness with training in methods of therapeutic intervention. The classification used in this approach was quite different, as can be seen in the lesson plan titles from the first of two training stages in Missouri's Psychiatric Aide I training program (see Table 11).

TABLE 11

List of Lesson Plans Combining the Study of Classification and Therapeutic Intervention (Example from Missouri's Psychiatric Aide I Training)

Therapies used in treating the mentally ill
The patient who is anxious
The patient who is assaultive
The substance abuser
The patient who is depressed
The patient who is elated
The patient who is suicidal
The patient with organic brain syndrome
The patient who is anti-social

Connecticut's training modules (Appendix A) followed a similar training plan. The specific training objectives for one of these modules, Clients Whose Behavior is Characterized by Depression, are listed in Table 12.

TABLE 12

Specific Objectives for Training Module: Clients Whose Behavior is Characterized by Depression

(Example from Connecticut's Psychiatric Aid Trainee Program)

1. State the difference between withdrawn behavior and depressive behavior.
2. Contrast grief (bereavement) and depression.
3. Discuss the relationship between feelings of loss and depressive behavior.
4. List at least five nursing needs of the depressed patient.
5. List at least two medications frequently used in the treatment of depression.
6. Discuss the use of electro-convulsive therapy in the treatment of depression.
7. Define Involutional Melancholia.
8. List nursing approaches utilized with the depressed person and the rationale for each.
9. Write a progress note after observing a role play using descriptive (behavioral) terms.

Personal Interventions: Theory and Methods

Many mental health worker training programs included a survey of the interventions used in treating mental illness. One common approach to this subject was just described--a combination of teaching the categories of syndromes and the interventions that are used with each.

Another, equally extensive, but quite different approach was to organize the training according to categories of therapeutic methods and combine the intervention skill training with a review of these. Naturally, the degree of skill training included varied, depending on the expectations for the mental health worker's use of a

particular type of intervention. For example, the Indiana and Florida training programs included modules covering transactional analysis, rational-emotive therapy, Gestalt therapy, client-centered therapy, independent living skill training, and behavioral techniques. Each added other types of interventions (see Appendix B, Parts 1 and 2). The training objectives ranged from the mental health worker being able to communicate with therapists who use these interventions, through having better insight into the nature of the patients' problems, to personal participation in the therapeutic intervention. Behavior modification and independent living skill training were on the latter end of the continuum.

Communication Skills, Interviewing, and Crisis Intervention

Many training programs began their therapeutic intervention skill training with one or more modules on communication skills. These tended to flow from identifying barriers to communication and developing listening skills to beginning intervention skills and interviewing techniques. The training programs in Florida and Missouri offered two examples: Missouri included a module in each of two training programs, with emphasis on the therapeutic aspects of communication in the second program; Florida's first course (15 modules) was devoted to communication skill training, with two modules at the end covering interviewing skills (see Table 13).

TABLE 13

Illustrations of Communication Skill Training Content

List of Handouts from Missouri's Module on Communication Skills in the First Training Program	List of Modules in Florida's First Course: Communication, Influencing and Interviewing
Barriers and roadblocks to listening	Attending skills
The listening techniques	Paraphrasing
Ten commandments for good listening	Open and closed questions
Listen	Reflecting feelings
The questioning techniques	Genuineness, warmth, and respect
Interpersonal techniques	Expressing yourself
Intervention through conversation	Focusing
Communication for specific behavior patterns	Giving directions
	Interpreting
	Integrating your skills
	Using three types of interviews
	Steps in interviewing

Crisis intervention was identified as a training need in both institutions and community mental health. One of Nevada's training modules in the first training stage was devoted to this subject; training content was followed by three 1-hour practicum sessions (see Table 14).

TABLE 14

Content of Crisis Intervention Training
(Example for Nevada's First Training Stage)

Behaviors indicative of crisis
Theory
Interventions
Suicide prevention
Stalling techniques
Factors affecting the lethality of suicide attempts

Behavior Modification

One of the most common therapeutic interventions used by mental health workers is behavior modification, and in many training programs it received considerable emphasis. In Texas, before entry-level workers could be promoted to the next level, they were required to take a training program that was designed for them to learn enough about behavior therapy to begin training clients. Within six months following appointment to that classification, employees must have successfully completed three additional training modules in behavior therapy. These modules were in observing and measuring behavior, learning how to increase appropriate behavior, and learning how to decrease inappropriate behavior. Appendix F contains the objectives for each of these modules.

Nevada also had a training program that included behavior therapy training in two stages. The first stage of training was integrated into a survey of therapy models but included inservice supervised practice in behavior therapy. The second stage emphasized the following subjects:

...Application of the principles of behavior modification
...Assessment of problem behaviors
...Establishing baselines
...Devising and implementing a behavior change program
...Evaluating the outcome of interventions

Florida included three modules on behavior modification in its single stage 180-hour program; the second module is in Appendix B, Part 4. Indiana included three modules on learning theory techniques--behavior modification, cognitive, and assertion--in its 200-hour basic training program. The cognitive module included modeling and relaxation techniques for use in anxiety-provoking situations. The first module had objectives similar to Florida's behavior modification training, and the third module was designed to teach assertiveness training skills. Appendix D contains the

instructional objectives and outline for the college-level course, Behavior Modification II, used in Alabama's work-education linkage program.

Skill Training, Independent Living, and Functional Assessments

Training for independent living becomes the link that facilitates the successful transition from institution to community life. Maryland designed a training program with this specifically in mind. A description of the program was presented in a previous section and two modules are reproduced in Appendix E.

Indiana's basic training program had 18 modules on different aspects of teaching independent living and skill training. They included academic instruction, such as math and writing skills, various facets of employment and job skills, self-care instruction, and a series on socialization skill training that covered the principles of normalization, methods of instruction for basic social skills, such as shopping and eating out, sexuality, and structured learning therapy for teaching advanced social skills.

On a less ambitious level, many training programs included a section on organizing activity groups that often include independent living skill training.

Controlling and Preventing Assaultive Behavior

Controlling assaultive behavior was frequently part of the basic training program; in some states there were special training programs on this topic. The special training manual developed by South Carolina contained 60 pages filled with photographs illustrating step-by-step methods of protection against blows, breaking away from various grips, and physically restraining patients. There were also sections on preventing aggressive behavior and non-physical management of aggression. The

content and objective of training modules in basic training programs were organized in similar fashion and typically included objectives like the following:

...Will identify appropriate outlets for combative behavior.
...Will state five changes in client behavior which could indicate signs of stress.
...Will participate in role play, reducing client stress through verbal intervention techniques.
...Will demonstrate ready posture.
...Will demonstrate two defense techniques for assisting their team members under attack.
...Will practice self-defense and take-down techniques.

Psychotropic Medication

Knowledge of the major types of psychotropic medications and their side effects was identified as a training need in both institutional and community mental health. The subject was found in a number of the one-stage basic training programs. Those that had training programs for each of several staff levels differed in when the subject was covered. In Texas, it was the first module in the preservice training program. The objectives included in the Texas program are typical:

TABLE 15

Training Objectives for Psychotropic Medication
(Example from the Texas Preservice Training Program)

1. The participant will demonstrate knowledge of basic terms used in pharmacology by correctly matching eight terms with their respective definitions.
2. The participant will demonstrate beginning knowledge of drug classifications by correctly matching four classifications with their respective use and actions.
3. The participant will demonstrate an understanding of the actions of selected drugs by matching correctly two drugs from each of the four drug classifications with the proper drug classification.
4. The participant will demonstrate knowledge of possible drug side effects by correctly identifying eight symptoms from a list of twelve observations.
5. The participant will demonstrate an understanding of the departmental policy on administration of medication by correctly choosing from a list of possible answers those persons who can give medication.
6. The participant will demonstrate knowledge of the reporting procedures used to communicate a client's response to medication by identifying and documenting correct reporting procedures used at the work area.

Case Management in Community Mental Health

In community mental health, case management generally referred to a wide range of activities including assessment, treatment planning, arranging community support services, coordination of therapy and support services, advocacy, and monitoring of progress. Despite the general consensus that this was a high priority training subject, the project received relatively few examples of training programs to meet this need. Colorado's training program on integration of case management and therapy has been discussed and part of the instructional material is included in Appendix E. Indiana's basic training program included several modules under the general heading of Client Advocacy Skills. Two of these--Using and Improving Community Resources and Taking Action--dealt with the topic of assessing the need for and arranging community support services. Appendix G contains the description, objectives, and list of materials used in these two modules. Maryland's program, designed to teach workers how to train residents of chronic units the independent living skills necessary for living in less restrictive environments after discharge, has been described. One of the training units was on assessing functional skills of mentally ill persons; other units provided excellent training in identifying community resources.

APPENDIX A

STATEWIDE BASIC TRAINING PROGRAMS: OBJECTIVES AND OUTLINES

Part 1 Connecticut: Training Program for Psychiatric Aide Trainees
Outline of Training Modules

Part 2 Tennessee: Basic Psychiatric Technician Training Course
Outline of Subjects

Part I

Connecticut: Training Program For Psychiatric Aide Trainees

Outline of Training Modules

This pre-entry program is geared to the employee who is not a college-level learner. It is a six-month Affirmative Action Program including 410.5 hours of clinically supervised experience, 354.5 hours of theory, and 19 hours of group experience.

Understanding the Organization: Your Roles and Responsibilities

- Orientation to Rules and Regulations Related to Nursing Service
- The Person in a Learning Role
- The Organization
- Roles and Responsibilities of the Mental Health Worker
- Legal Rights of Hospital Patients
- The Interdisciplinary Team

The Need to Understand Yourself and Others

- Human Behavior and Mental Health
- Personality, Growth and Development
- The Therapeutic Relationship
- Task Oriented Groups
- Therapeutic Use of Self in One-to-One Relationship
- Communication Skills

Nursing Procedures

- The Admission Process
- Psychosocial Nursing Assessment
- The Problem-Oriented Record
- Nursing Care Plans
- Meeting the Hygienic; Comfort and Safety Needs of Clients
- Hygiene and Comfort Needs
- Safety Needs
- Lifting Objects and Positioning Patients
- Restraints, Seclusion and Searching a Patient
- Monitoring Vital Signs
- Blood Pressure
- Temperature, Pulse and Respiration
- Dealing with Medical Emergencies
- Respiratory Emergencies
- Foreign Body Obstruction of the Airway

Therapeutic Interventions and Treatment Modalities In Current Use

History of Psychosocial Health Care
The Client and the Community
Introduction to Mental Illness
The Person Who is Experiencing Anxiety
Anti-social Behavior
The Person Whose Behavior is Characterized by Depression
The Person Who is Suicidal
The Person Whose Behavior is Characterized by Extreme and Inappropriate Emotional Responses
Alcohol/Drug Abuse
The Person Whose Behavior is Characterized by Withdrawal
The Person Whose Behavior is Characterized as Suspicious
The Person With Organic Conditions
Introduction
Convulsive Seizures
Urine Testing of Glucose and Acetones
Aggressive/Assaultive Behavior
Therapeutic Community
Client Centered Care
Behavioral Approaches
Cognitive Approaches to Working with Clients
The Aged Person
Introduction
Physical Needs of the Aged
Psycho-social Needs of the Aged
Death and Dying
The Use of Psychiatric Drugs
Sexuality
Crisis Intervention
Counseling the Client Who Has Been Sexually Assaulted
The Client and His Family
Patient Education

Part 2

Tennessee: Basic Psychiatric Technician Training Course

Outline of Subjects

I. Core: 100 Classroom Hours
   A. Basic Nursing Skills--60 Classroom Hours
      1. Orientation
         a. Policy and Procedures
            1) Institute
            2) Nursing
            3) Interdisciplinary Relationships
         b. Legal Issues/Confidentiality
         c. Ethical Standards/Professional Behavior
      2. Signs and Symptoms of Physical Illness
         a. Body Systems and Related Diseases
         b. Diagnostic Examination
         c. Personal Care of Patient and Environment
         d. Observation and Documentation
         e. Infection Control
         f. Care of Equipment
      3. Emergency Care
         a. First Aid
         b. Cardio-Pulmonary Resuscitation and Hiemlich Maneuver
         c. Seizures
         d. Hot and Cold Compress
      4. Body Mechanics and Transportation
      5. Care of the Dead
   B. Mental Health Principles--40 Classroom Hours
      1. Overview and Trends in Mental Health
      2. Communication Skills
      3. Overview of Diagnosis, Assessments and Terminology

4. Personality, Growth, and Development
5. Treatment Plans/Treatment Teams
   a. The Helping Relationship and Therapeutic Interaction
   b. Accountability
      1) Charting
      2) Utilization Review
      3) Professional Standards Review
      4) Medical Audit

II. Specialty Training--30 hours

To be used to prepare individuals for their specific duty assignment

III. Supervised Practical Experience--130 Hours

To be used to provide experience and on-the-job training to supplement classroom instructions.

APPENDIX B

STATEWIDE BASIC TRAINING PROGRAMS: INSTRUCTIONAL MATERIALS

Part 1 Indiana: Mental Health Technician Training
Outline of Training Modules

Part 2 Florida: Training for Human Service Workers
Outline of Training Modules

Part 3 Indiana: Mental Health Technician Training
Module on Interdisciplinary Teaming
Module on Client Advocacy Skills

Part 4 Florida: Training for Human Service Workers
Module on Behavioral Techniques
Related Sections from Facilitators' Manual

Part I

Indiana: Mental Health Technician Training

Outline of Training Modules

Interdisciplinary Teaming Skills

- Importance of Teaming
- Interdisciplinary Teaming
- Importance of the Mental Health Technician
- Assertive Team Communication Skills
- Team Support Skills
- Burnout Management Skills

Client Advocacy Skills

- Defining Advocacy
- Combating Prejudice
- Defending Client Rights
- Using and Improving Community Resources
- Taking Action

Human Development

- Introduction to Human Development, Prenatal and Infancy Stages
- Childhood
- Adolescence and Young Adulthood
- The Mature Adult and Old Age

Developmental Disabilities

- Different Views of Developmental Disabilities
- Mental Retardation
- Epilepsy
- Cerebral Palsy
- Autism
- Prevention

Mental Illness

- Introduction to Mental Illness
- Different Views of Mental Illness
- Classification of Problems and Systems
- Anxiety Disorders
- Affective Disorders
- Schizophrenia and Paranoia
- Addictive Disorders

Individual Program Planning Skills

- Introduction to IPP
- Overview to the Data Base
- Progress Assessment Chart: Behavioral Assessment
- Mental Status Assessment
- Charting
- Goal Planning
- Implementation
- Evaluation
- Review and Application of Skills

Health Care Skills

- Anatomy and Physiology
- Cleanliness
- Isolation
- Sterile Technique
- Sterile Dressings
- Lifting and Carrying
- Moving and Positioning Clients
- Transferring Clients
- Range of Motion
- Hygiene and Skin Care
- Elimination and Perineal Care
- Bed Making
- Taking and Recording: Temperature, Pulse, Respiration
- Taking and Recording Blood Pressure
- Neurological Assessment
- Irrigations
- Application of Heat and Cold
- Intake and Output
- Tube Feedings
- Enemas
- Bladder Catherization
- First Aid
- Cardio-Pulmonary Resuscitation
- Medications

Therapeutic Communication

- Understanding Self
- Understanding Client
- Understanding Relationship
- Psychodynamic Perspective
- Psychodynamic Technique--TA
- Psychodynamic Technique--RET
- Experiential Perspective
- Experiential Technique--Person Centered
- Experiential Technique--Gestalt

Therapeutic Communication (continued)

- Learning Theory Perspective
- Learning Theory Technique--Behavior Modification
- Learning Theory Technique--Cognitive
- Learning Theory Technique--Assertive
- Community Perspective
- Family Therapy Techniques
- Crisis Therapy Techniques

Residential Administration Skills

- Leadership Style
- Helping New Clients Adjust
- Scheduling for the Client
- Scheduling with the Team
- Maintaining a Home Environment
- Managing Combative Behavior

Academic Instruction

- Basic Functional Academics
- Functional Language Arts
- Temporal Relations
- Functional Writing Skills
- Working with Higher Functioning Clients

Self-Care Skill Instruction

- Programming for Nutrition Skills
- Programming for Dressing Skills
- Programming for Toileting Skills
- Programming for Hygiene Skills

Employment

- Vocational Rehabilitation Act of 1973
- The Right to Employment
- Employment Resources
- Teaching Job Skills

Creative Therapy

- Music Therapy
- Art Therapy
- Drama Therapy
- Dance Therapy

Socialization Skill Instruction

- Different Views of Socialization
- Programming for Basic Social Skills
- Sexuality Education
- Programming for Advanced Social Skills

Therapeutic Recreation Techniques

- The Importance of Recreational Activity--A Self Examination
- An Introduction to Therapeutic Recreation
- Programming in Therapeutic Recreation
- Therapeutic Recreation Activity Leadership
- Therapeutic Recreation Facilitation Skills

Part 2

Florida: Training for Human Service Workers

Outline of Training Modules

Course 1

Overview of Course 1

Communication Skills

- Attending Skills
- Paraphrasing
- Open and Closed Questions
- Reflecting Feelings
- Genuineness, Warmth, and Respect
- Summarizing

Influencing Skills

- Expressing Yourself
- Focusing
- Giving Directions
- Interpreting
- Integrating Your Skills

Interviewing Skills

- Using Three Types of Interviews
- Steps in Interviewing

Review and Future Directions

Course 2

Overview of Course 2

Orienting Skills

- Orienting Patients to the Hospital

Psychodynamic Therapies

- Psychoanalytic, Client-Centered and Gestalt Therapies
- Transactional Analysis, Rational-Emotive and Reality Therapies

Behavioral Techniques

- Behavioral Techniques - Part 1
- Behavioral Techniques - Part 2
- Behavioral Techniques - Part 3
- Peer Management
- Patient Self-Reliance

Patient Groups

- Working with Patient Groups
- Resources for Skill Groups
- Communication and Assertion Skills
- Assertion and Problem-Solving Skills
- Activities of Daily Living Skills

Review and Future Directions

Course 3

- Overview of Course 3

Team Treatment

- Treatment Team Responsibility
- Consultation and Supervision

Patient Diagnosis and Medications

- Mental Status Examination
- Diagnostic Categories - Part 1
- Diagnostic Categories - Part 2
- Patient Medications

Record Keeping

- Clinical Record Keeping
- Intake: Data Base and Asset List
- Individual Treatment Planning
- Progress Notes - Part 1
- Progress Notes - Part 2
- Discharge Planning

Continuing Education and Self-Development

Review and Future Directions

Course 4

Structured Practicum

Introduction to Human Services Practicum
Orienting Patients to the Hospital
Observation of Unit Patients
Case Record Study of Clients
Client Interview Case Study
Case Presentation to the Treatment Team
Unit Treatment Group Case Study
Planning Group Activities
Carrying Out Client Groups
Case Study of Individual Therapies
Participation in Behavioral Techniques with Clients
Participation in Continuing Education and Staff Development
Practicum Wrap-Up

Part 3

Indiana: Mental Health Technician Training

Module on Interdisciplinary Teaming

Module on Client Advocacy Skill

The entire series of modules on teaming skills is listed below. The second module is reproduced in this Appendix.

Importance of teaming
Interdisciplinary teaming
Importance of the Mental Health Technician
Assertive Team Communication
Team support skills
Burnout management skills

The entire series of modules on client advocacy is listed below. The last module is reproduced in this Appendix.

Defining advocacy
Combatting prejudice
Defending client rights
Using and improving community resources
Taking action

Area: Interdisciplinary Team Skills

Module: Interdisciplinary Teaming

Time Estimate: 2 hours, 15 minutes

Description: The purpose of this module is to introduce the MHT to the practice of interdisciplinary team (IDT) service. MHTs will learn what interdisciplinary service is and how such teaming leads to better service for clients. MHTs will also learn how interdisciplinary service enhances the status and importance of the MHT contribution more than other types of service. MHTs will have an opportunity to examine how their agency teams. The following module will then investigate their particular team responsibilities in greater detail.

I. Goal: MHTs will understand the issues of interdisciplinary teamwork so that they may responsibly advocate for and follow interdisciplinary procedures in formal and informal team communications.

Objectives:
1. MHTs will define interdisciplinary service.
2. MHTs will describe how interdisciplinary service differs from other types of service.
3. MHTs will discuss why interdisciplinary teamwork helps clients more than other types of service and therefore why interdisciplinary service is preferred by accrediting commissions.
4. MHTs will describe basic service directions or team goals for clients.
5. MHTs will describe how membership on the team is determined.
6. MHTs will describe how decisions are made.
7. MHTs will discuss benefits of interdisciplinary teaming for staff morale.
8. MHTs will describe why the MHT contribution gains greater respect on interdisciplinary teams compared to other types of teaming.
9. MHTs will discuss common problems which hamper team communication.
10. MHTs will describe how common communication problems are overcome.
11. MHTs will describe general professional responsibilities of all team members which contribute to more effective teaming.

II. Goal: MHTs will understand the extent to which their agency practices interdisciplinary service in order to responsibly advocate for any necessary changes while tolerating the realities of their workplace.

Objectives:
1. MHTs will be able to describe any discrepancies between interdisciplinary teaming and teaming at their workplace (if any exist).
2. MHTs will be able to discriminate teaming relations and communications from administrative relations and communications.

III. Goal: MHTs will experience a formal IDT Process

Objectives:
1. MHTs will simulate a formal IDT staffing.
2. MHTs will attend and be able to analyze patterns of communication at an actual IDT meeting using knowledge learned in Module 1.1 (The Importance of Teamwork) and using knowledge of appropriate interdisciplinary teamwork.

Equipment: Slide projector and cassette
Overhead projector

Materials: 1. Stanley, Ruth R.N., Director Psychiatric Nursing, IDMH "The Interdisciplinary Process," slide/tape, Indiana University Developmental Training Center, Bloomington, Indiana, 1980.

This slide/tape provides an overview to issues of interdisciplinary teamwork fulfilling Goal I. Indiana MHTs and their team members are actually portrayed. A discussion guide is provided with the carousel.

2. Byers, K. and Pappas, V. "Interdisciplinary Planning: A Simulation," Indiana University Developmental Training Center, Bloomington, Indiana, 1979.

This simulation engages trainees in a role play of an IDT staffing. Each trainee plays a different professional on the team. The simulation meets Goal III, Objective 1.

3. Pfeiffer, J. and Jones, J. "Process Observation: A Guide" in Handbook of Structured Experiences for Human Relations Training, Vol. 1. LaJolla: University Associates, 1974.

The observation form used in Module 1.1 can be used to rate patterns of communication at an actual staffing. The material is intended to meet Goal III, Objective 2.

4. ASPIRE TRAINING AIDS

a. How Teamwork Helps (1.2 - No. 1)
This handout encourages trainees to discuss the benefits of teaming for clients and staff.(Goal I, Objectives 3, 7)

b. Basic Service Goals for Clients (1.2 - No. 1)
This information sheet portrays the basic direction of service for all clients for all team members to follow. (Goal I, Objective 4)

c. Professional Development Responsibilities (1.2 - No. 3)
This graphic illustrates professional responsilities of all team members that encourage better service. (Goal I, Objective 10)

d. Teaming Relations Versus Administrative Relations (1.2 - No. 4)
This aid attempts to help trainees begin to discriminate between their service or team relations and administrative relations. (Goal II, Objective 2)

Suggested Procedures

1. Group Procedures

   A. Preliminary Planning

      1. Make a copy of the Discussion Guide for the "Interdisciplinary Process" slide/tape and a copy of each ASPIRE TRAINING AID for each trainee.
      2. Invite a knowledgeable team member or agency official to discuss the agency's position on interdisciplinary teaming and the status of the agency in meeting IDT accreditation requirements.

   B. Goal I

      1. Pass out the Discussion Guide for the slide/tape. Paraphrase the Module Description or accent the importance of IDT teaming to the MHT to motivate attention. Preview the Discussion Guideline questions.
      2. Show the "Interdisciplinary Process" slide/tape.
      3. Discuss the side/tape using the Discussion Guideline.
      4. Pass out TRAINING AID 1.2 - No. 1. Discuss the benefits of teaming for clients and staff.
      5. Pass out TRAINING AID 1.2 - No. 2. Discuss basic service directions for all clients by all team members. Ask trainees to apply each general service goal to a client they serve (publicly if the situation does not violate client confidentiality: private if the situation would).
      6. Pass out TRAINING AID 1.2 - No. 3. Preview the graphic. Discuss consequences of failure to meet these responsibilities.

   C. Goal II

      1. Have the agency team member discuss the agency's type of teaming to meet Goal II, Objective 1. Attempt to honestly pinpoint discrepancies in the discussion.
      2. Discuss the lines of authority and supervisory relationships of the agency. Use TRAINING AID 1.2 - No. 4 to help trainees discriminate between IDT communications concerning client programming and communications which are administrative in nature.(Goal II, Objective 2.)

   D. Goal III

      1. Pass out the Interdisciplinary Planning Simulation Players Books and follow the Instructions Sheets for the Simulation. Play the simulation. (Goal III, Objective 1)
      2. Have MHTs attend a formal IDT meeting. Encourage trainees to analyze the staffing using the Process Observation Report Form (Module 1.1) and their knowledge of IDT. Have trainees discuss observation results after the meeting.

   E. Evaluation

      1. Conduct the Evaluation.

II. Individual Procedures

A. Goal I

1. Read the Module descriptions, goals and objectives.
2. Read the discussion guideline questions for the Interdisciplinary Process slide/tape. Attempt to answer the questions as you view the slide/tape.
3. View the slide/tape.
4. Review TRAINING AID 1.2 - No. 1 to clarify teaming benefits for clients and staff.
5. Review TRAINING AID 1.2 - No. 2. How do the stated service directions or client goals relate to the clients you work with?
6. Review TRAINING AID 1.2 - No. 3. What would be the consequences if team members did not work at these responsibilities?

B. Goal II

1. Seek out your supervisor, staff developer and/or responsible coworker. Discuss the status of interdisciplinary teaming at your agency. Use TRAINING AID 1.2-No. 4 to clarify team relations and communications from administrative relations and communications.

C. Goal III

1. In cooperation with your supervisor, make time in your schedule to attend and observe a formal IDT staffing. Use your knowledge of IDT procedures and group process communications to analyze the meeting.
2. Discuss your impressions and observations with your supervisor, staff developer and/or coworker.

D. Evaluation

1. Take the Evaluation. Role play the Performance Evaluation section with other coworkers if possible. If not possible, give answers in writing.

ASPIRE TRAINING AID 1.2 - No. 1

How Teamwork Helps

1.	Since clients have more staff to relate to	Clients have a better chance of finding a team member they like and trust.
2.	Since staff from different professions serve	More varied programs are likely.
3.	Since the team makes program decisions	Client rights are more likely to be protected.
4.	Since a team is implementing programs	Programming is more consistent; people are not working at cross purposes leading to client confusion.
5.	Since all team members must reach consensus regarding a client's program ..	Accuracy and effectiveness increase because there is more input.
6.	Since there is greater communication in a team and since the team has reached consensus regarding each member's responsibilities.	Staff morale is higher. No one works in isolation.

Think of Other Benefits

for Clients and Staff!!

ASPIRE TRAINING AID 1.2 - No. 2

Basic Service Goals for Clients

FROM	-	TO
CHILD	-	ADULT
DEPENDENT	-	INDEPENDENT
IGNORANT	-	INFORMED
IMPULSIVE	-	IN CONTROL
NEEDS MUCH SUPERVISION	-	NEEDS NO SUPERVISION
IRRESPONSIBLE	-	RESPONSIBLE
INCAPABLE	-	CAPABLE
DECISIONS MADE FOR PERSON	-	INDEPENDENT DECISION-MAKER
SUBJECTED TO RULES OF OTHERS	-	PARTICIPATES IN RULE-MAKING
RECEIVES CARE	-	OFFERS CARE
HAS RESTRICTIONS OF MOVEMENT	-	HAS FREEDOM OF MOVEMENT
FOLLOWS	-	INITIATES
NEW RIGHTS	-	EQUAL RIGHTS
NONPRODUCTIVE	-	PRODUCTIVE

ASPIRE TRAINING AID 1.2 - No. 3

Professional Development Responsibilities

To work positively, respectfully, openly, confidently, and thus effectively with other team members

To advocate for clients

Prepare for formal Interdisciplinary team meetings

To diligently plan with other team members for client growth

To maintain a positive work attitude

To increase one's professional knowledge and skill in order to serve more effectively

Add Others to this Collage that

You Think are Important!

ASPIRE TRAINING AID 1.2 - No. 4

Teaming Relations Versus Administrative Relations

Teaming Relations and Communications	Administrative Relations and Communications
1. Concerned with Client Education.	1. Concerned with Agency Operations.
2. All team members encouraged to provide direct, open, honest input. Disagreement is welcomed.	2. Input is often regulated.
3. Team decisions are reached by consensus.	3. Administrative decisions are made according to lines of authority.
4. Membership on service teams are a function of client needs.	4. Authority decides. Assignments are made.
5. "Turf" is not recognized.	5. "Turf" is recognized.

IN YOUR AGENCY, WHAT DO THESE

TERMS MEAN?!!?

EVALUATION

In your own words. answer the following in discussion in writing.

I. 1. In a formal staffing, the social worker, the psychiatrist and the teacher gave a report on Client Joe. No one asked any questions of anyone else. (It would have been quite improper!) They left and went back to do their own programming in their own area. Since MHTs do not represent one particular field they never are invited to attend these meetings. Discuss this type of "teaming."

2. In Ken Kesey's One Flew Over the Cuckoo's Nest, Nurse Ratchett ran the ward at the Hospital - completely. Nothing happened without a decision from her. Discuss this type of service (service ?!?). What role do you suppose that the technical staff had?

3. John was overweight. John, a physician, MHT, speech therapist and recreation therapist initially composed the IDT. Was anyone there who perhaps should not have been and who was not there who perhaps should be?

4. Jane, a New MHT, was asked by her supervisor to transport a client. Jane said she would bring the request up for discussion with her coworkers to see if there is consensus on the need to transport the client. Discuss.

5. Jean has been described as too dependent on others, lacking self-control and irresponsible. What team goals does this description suggest?

6. How interdisciplinary is your agency? What difficulties do you have personally advocating for interdisciplinary teaming?

II. Performance Simulation

Staff developers are encouraged to role play the following situation so that the MHT must demonstrate acquired skills. If such a role play is unfeasible, MHTs can respond to the Scene and Role Play script in writing. Staff developers are encouraged to revise this or substitute another situation to better reflect their workplace conditions and to better meet the evaluation dimensions.

A. Scene:

You are sitting in a lounge with a psychiatrist, recreation therapist, and vocational educator. They are informally discussing goals and strategies for Sam. Sam has been described as lethargic (slow moving) or not very energetic.

B. Role Play:

Psychiatrist: "I think a drug therapy program for Sam to get him stimulated is what I want to do."

Recreation Therapist: "I think I'll get Sam started on a leisure skill program to get him active. I'll start slow asking little and then ask for more gradually."

Vocational Educator: "I think Sam needs to feel productive. I want him to get going now, doing something productive - something he can see results in immediately. I want to get him up and going and the sooner the better."

Psychiatrist: "Well let's all do our own thing. The tech can help us implement the programs we devise. (To tech) How's that sound to you?"

MHT Response No. 1:

Psychiatrist: Well you are probably right. We are supposed to be interdisciplinary.

Vocational Educator: "I have to admit that I am a little concerned about teaming this way, too. I get the feeling that this interdisciplinary teaming stuff, at bottom, questions and insults our competence. I mean when I write up a vocational assessment, I am not sure I want it questioned by other team members. I am not too sure that it won't cause more problems than it solves."

MHT Response No. 2:

Evaluation Sample Answers:

I. 1. The teaming used here is multidisciplinary. There is no push to share, no consensus. Each discipline goes its own way. Since MHTs do not represent a single discipline, our input is not as respected in this situation. MHTs "fall through the cracks" on multidisciplinary teams.

2. Undisciplinary. As for techs, what can we say lackeys; gophers (go for), slaves!

3. Since team membership is based on client need, maybe the speech therapist is not necessary for John's team. A nutritionist ought to be included.

4. The new MHT has confused teaming and administrative relations. The request seems to be a legitimate administrative request.

5. a. to be independent
   b. to be in self-control
   c. to be responsible

6. Answer specific to situation.

II. Criteria and Sample Resources:

1. Criterion: Does the MHT define his/her appropriate role?

   Sample Response: As a member of the ID team, I too, should take part in making decisions about treatment, not just implement recommendations from others.

   Criterion: Does the MHT point out the multidisciplinary approach being used and responsibly advocate for an interdisciplinary approach?

   Sample Response: We are tending to approach this client's treatment from a multidisciplinary rather than interdisciplinary approach which accreditation standards require. We are carving the client up into problems, taking responsibility for that problem closest to our discipline, and going our own way. By doing so, we lose the benefits of interdisciplinary teaming, input from others, unified approaches, shared data and so on.

   I think it is necessary for us to keep communicating and to try to reach consensus. I know it is not easy sharing our ideas and listening to and respecting different perspectives but in the long run the effort we make at communication now should help our treatment efforts later. We will understand each others concerns, we will be more consistent in serving Jack and we will all be working in a unified committed manner in the same direction.

2. Criterion: Does the MHT responsibly advocate for interdisciplinary approach while lessening unfounded fears of ID teaming?

Sample Response: "ID teaming should never insult our competence if we do it right. When we question reports, it should be done respectfully with the purpose of clarifying issues, assumptions or whatever, never to put someone down. ID teaming should recognize and respect the worth of the input of all disciplines in serving clients."

"There are problems. Most of us are not used to teaming and it takes effort and practice before we feel comfortable. It does take extra effort at communication, especially if there are differing view points."

Additional Sources

Holm, V. and McCartin, R. "Interdisciplinary Child Development Team: Team Issues and Training in Interdisciplinariness" In Early Intervention: A Team Approach. Allen, V. Holm, R. Schiefulbush (Eds.). Baltimore: University Park Press, 1978.

Parham, J., Rude, C. Bernanke [illegible]ual [illegible]am Planning with Developmentally Disabled Persons. Lubbock, Texas: [illegible]ch and [illegible]aining Center in Mental Retardation. Texas Tech University, 1977. pp. 14-23. Reprinted in Ryan, F. Manual Uniform Client Information, Indiana Department of Mental Health, 1979.

Area: Client Advocacy Skills

Module: Taking Action

Time Estimate: 3 hours

Description: This module presents a systematic method for advocating. This approach includes: needs assessment, identification of resources, strategy, and follow-up. This method will enable the MHT to advocate effectively and efficiently in many different problem situations. This material is presented in context of promoting self-advocacy, the ultimate goal of all advocacy activities.

I. Goal: The MHT will be familiar with a basic method of advocacy which will enable him/her to work effectively in problem situations.

Objectives:
1. The MHT will describe the components of an advocacy action plan.
2. The MHT will apply the basic components of needs assessment.
3. The MHT will demonstrate an ability to gain client commitment to an action plan.
4. The MHT will explain the importance of resources and indicate their general use.
5. The MHT will describe the process of preparing a plan for action.
6. The MHT will discuss the importance of follow-up.

II. Goal: MHTs will be able to use their advocacy skills in practical situations and in context of self-advocacy.

Objectives:
1. MHTs will evaluate client advocacy situations in terms of the components of an action plan.
2. MHTs will demonstrate their advocacy skills by identifying and acting upon a real need situation in their facility.

Equipment: Large, paper pads and felt-tip markets (optional)

Material:

1. Sturgeon, Suzanne, et al., Advocate! A Manual on the Rights of the Developmentally Disabled. The Indiana Protection and Advocacy Service Commission for the Developmentally Disabled, Indianapolis, Indiana, 1980.

   This booklet includes a basic guide for planning for action. It partially fulfills Goal I.

2. Way To Go, University Park Press, Baltimore, Maryland, 1978.

   This book includes information concerning preliminary planning for advocacy activities as well as an approach to action. This partially fulfills Goal I.

3. Rude, C.D. (ed.), Action Through Advocacy, A Manual for Training Volunteers, Research and Training Center for Mental Retardation, Texas Tech University, Box 4510, Lubbock, Texas 79409, 1980.

   This book includes an exercise in resource identification. It partially fulfills Goal I.

4. ASPIRE TRAINING AIDS

a. Identifying Needs (2.5 - No. 1)
This handout presents a discussion of needs assessment in terms of both the advocate and the client. It partially fulfills Goal I. Objective 1.

b. Gaining Commitment (2.5 - No. 2)
This handout presents a discussion of the importance of commitment in self, the client and/or others involved in the action. This partially fulfills Goal I. Objective 1.

c. Plan For Action (2.5 - No. 3)
This handout provides a discussion of the basic components (and their interrelationships) of an action plan. This partially fulfills Goal I. Objective 3.

d. Trouble Shooting (2.5 - No. 4)
This handout/exercise provides the MHT practice in the application of advocacy skills. A Trainer's Response Guide is included. This fulfills Goal II. Objective 1.

e. Taking Action (2.5 - No. 5)
This handout/exercise provides MHTs practice in applying their advocacy skills to a real situation. This fulfills Goal II. Objective 2.

Suggested Procedures:

I. Group Procedures

A. Preliminary Planning

1. Review the "Advocacy Folio," in Way To Go, pp. 4-14. This partially fulfills Goal I.
2. Review, Action Through Advocacy, a Manual for Training Volunteers, pp. 205-207. This partially fulfills Goal I.
3. Review the ASPIRE TRAINING AIDS. Make copies for each MHT. Distribute Nos. 1, 2, and 3 prior to group meeting. These partially fulfill Goals I and II.
4. Review, Advocate! A Manual on the Rights of the Developmentally Disabled, pp. 104-107. Make copies for each MHT. This partially fulfills Goal I.

B. Goal I

1. Discuss, Advocate! A Manual on the Rights of the Developmentally Disabled, pp. 104-107. This presents the basic components of planning for action. This fulfills Objective 1.

2. Discuss needs assessment, including the information in ASPIRE TRAINING AIDS 2.5 - Nos. 1 and 2. Further information on this subject may be found in the "Advocacy Folio," in Way To Go, p. 8. This fulfills Objectives 2 and 3.
3. Conduct the "Identifying Community Resources" activity in Action Through Advocacy, a Manual for Training Volunteers, pp. 205-207. Expand the exercise to include your agency's resources. Invite an experienced advocate, from your area, to discuss the identified resources in context of accessibility and usability. This fulfills Objective 4.
4. Discuss ASPIRE TRAINING AID 2.5 - No. 3. This fulfills Objective 4.
5. Discuss the TRACK method as presented in the "Advocacy Folio," in Way To Go, pp. 12 and 13. Emphasize follow-up. This fulfills Objective 6.

C. Goal II

1. Distribute ASPIRE TRAINING AID 2.5 - No. 4. Upon the MHTs completion of the exercise, discuss their results using the accompanying Trainer's Response Guide. This exercise may be done individually or in a group discussion. This fulfills Objective 1.
2. Distribute ASPIRE TRAINING AID 2.5 - No. 5. At a later time, when all MHTs have completed their assignment, have the group analyze their results in a group discussion. Instruct the group to save their handouts for use during the evaluation. This fulfills Objective 2.

D. Evaluation

1. Conduct the evaluation.

II. Individual Procedures

A. Goal I

1. Read, Advocate! A Manual on the Rights of the Developmentally Disabled, pp. 104-107.
2. Read the "Advocacy Folio," in Way To Go, p. 8, and ASPIRE TRAINING AID 2.5 - Nos. 1 and 2.
3. Read and complete the "Identifying Community Resources" activity in Action Through Advocacy, a Manual for Training Volunteers, pp. 205-207. Expand the exercise to include your agency's resources. Speak to someone in your area who is familiar with resources. Ask them for insight into gaining access to and in using them. Discuss your results with your trainer or coworker.
4. Read ASPIRE TRAINING AID 2.5 - No. 3.
5. Read the "Advocacy Folio," in Way To Go, pp. 12 and 13. Pay particular attention to the last step.
6. Discuss any questions you may have about your readings with your trainer or coworker.

B. Goal II

1. Complete the exercise in ASPIRE TRAINING AID 2.5 - No. 4. Upon completion of the exercise, compare your answers with the Trainer's Response Guide.
2. Read ASPIRE TRAINING AID 2.5 - No. 5. Following completion of the activity, discuss your results with your trainer or coworker. Be sure to save the handout for use during the evaluation.

C. Evaluation

1. Take the Evaluation. At some point, discuss the results with your trainer or coworker.

ASPIRE TRAINING AID 2.5 - No. 1

Identifying Needs

The purpose of needs assessment is to find out the real needs of the client. The first step in this process is to sort out your needs from those of the client. This assures that your activities will truly be those of an advocate, rather than those of an enabler.

The advocate strives to assist the client in meeting his/her own needs as independently as possible. An enabler does for the client. An enabler sees the client as helpless and, no matter how well meaning, ends up causing the client to be more dependent upon the "advocate" and the system.

RULE 1: Check out your own feelings, be sure you're advocating for the client, not your own need.

Once your own needs are clarified, assist the client in defining his/her own needs. This is done by creating an arena in which the client is able to state his/her needs. This means gaining his/her trust in you and your abilities. It means listening and understanding. Often, the client presents several needs and, together, you must prioritize them in terms of what is most important in getting the client into as normal a life-style as possible.

RULE 2: Be sure to separate the client's real needs from his/her stated needs. Sometimes the two get mixed up - and that's where active listening helps.

Finally, you must set limits. How much are you willing to do? How much time can you spend? Is the client asking you to do things which may be ethically, legally or personally impossible for you to do? What risks are you willing to take? What are the client's limits?

RULE 3: Know your limits and be sure to share them with the client - before you begin acting.

Remember, setting limits is not a cop-out, they are based on your legitimate feelings and abilities.

ASPIRE TRAINING AID 2.5 - No. 2

Gaining Commitment

An important part of the needs assessment is the client's (as well as yours and others'you're working with) commitment to action. The client must not only see the need to solve a problem on a thinking level, but he/she should "feel" the need on a gut level. "Feeling" the need to act will make success more likely. The following are stages by which you may gain the client's commitment:

STAGE 1: Discuss the problem. Once the client's need has been identified, review the problem with him/her, on both a thinking and feeling level.

STAGE 2: Demonstrate the relevance of solving the problem. Discuss, with the client, how his/her life would be better if the problem were removed. Emphasize positive results.

STAGE 3: Develop goals. Begin to develop general goals - end results of the proposed activities. Make sure the client is active in this process and that the goals are his/hers, not yours. Review the goals in terms of their side effects - the pros and cons. Make sure the goals are obtainable. Several small, successful steps are far better than one, large failure.

STAGE 4: Demonstrate the relevance of the goals to the needs. Restate the need and make sure the client understands the connection between it and the goals.

STAGE 5: Promote the belief in the possibility of change. Discuss past successes in terms of both your and the client's abilities. You do not want the client to completely depend upon you for leadership, but he/she must believe that your belief in him/her is trustworthy.

STAGE 6: Develop contingencies. Set yourself up for success. Don't do more than is realistic. Break your goals down into small steps, making sure that the first actions you (or the client) take are successful. Develop a support group - get others involved to "cheer you on." Remember: Commitment creates more commitment.

ASPIRE TRAINING AID 2.5 - No. 3

Plan For Action

Preparing an action plan simply means taking the results and information obtained in needs assessment and resource identification and organizing them in a way that gets results. The following chart shows the proper stages for this procedure. It is important to write down or document your activities during this procedure for future reference during evaluation and other, future advocacy activities:

IDENTIFY NEEDS
↓
STATE PROBLEM
↓
PROPOSE CHANGE
(Develop Goals)
↓
IDENTIFY RESOURCES
(Legislation, Agencies, People)
↓
STATE STRATEGY
(Match Resources with Goals)
↓
IMPLEMENT
↓
FOLLOW-UP
AND EVALUATE

Problems in any one part of the process may require re-thinking the previous part. For instance, if you can't find resources to match goals, you may have to reconsider the goals. If, during follow-up and evaluation, you find your action was not effective, needs may not have been accurately identified, goals inappropriate, resources inadequate or strategy and action poorly planned and executed. Because of these possibilities, documentation is very important in correcting the procedure. On the other hand, everything may go as planned and you will then have a ready reference for future work.

Finally, during your evaluation, you should ask: How did the procedure improve the client's ability to advocate for him/herself? If the answer is positive - even in small but useful ways - your activities were well done!

ASPIRE TRAINING AID 2.5 - No. 4

Trouble Shooting

Read the following problem situations and suggest what action(s) might be taken (or should have been taken) to eliminate the trouble:

1. A client is "profoundly retarded." He indicates a need to interact with people - he especially enjoys participating in activities provided by a local service organization, but these volunteers often avoid him as he is incontenant. John, an MHT, tries to keep the client "clean," but wishes the IDT would recommend a toilet training program.

2. An advocate is working with a client in needs assessment. The client isn't sure what he wants.

3. A client cons an advocate into taking actions he, the advocate, later regrets.

4. A client and advocate have developed goals, but can find no resources.

5. A client and advocate have designed a plan for action, but the client (or the advocate) bolts before action can be taken.

6. A client has determined that he would gain from the services of a particular resource agency. When he contacts the agency, they give him the run-around.

7. An advocate is working with a client. The problem reminds her of a very similar situation she dealt with a few months earlier, but she can't remember the details of the action.

ASPIRE TRAINING AID 2.5 - No. 4

Trainer's Response Guide

1. John's efforts are "enabling" rather than advocating. The problem is lack of toilet training. The client is advocating for himself in trying to interact with others, but he needs assistance. John should assist him by advocating for a training program during IDT.

2. The advocate must be careful to not project his own needs into this situation. The best action would be to be patient and assist the client in sorting-out his own needs.

3. The advocate should have set his limits and explained them to the client before he took action.

4. The client and advocate may need to redefine the goals in terms of available resources or advocate for getting the resources.

5. There is an apparent lack of commitment. The advocate and/or client should reassess their needs and commitment.

6. The client should talk to someone who has dealt with the agency before and learn how to get what he needs from it.

7. The advocate should have documented the earlier activity for present reference.

ASPIRE TRAINING AID 2.5 - No. 5

Taking Action

The following exercise provides you the opportunity to apply your new skills in advocacy. Identify a need in your facility (preferably working with a client) and proceed as suggested in this module. Briefly document your activities below.

I. Needs Assessment

A. Statement of Needs:

B. Method of Gaining Commitment:

II. Identify Resources

A. What are they?

B. How will you use them?

III. Strategy

How did you match resources with needs/goals?

IV. Implementation

What really happened?

V. Follow-up

A. Justify your action in terms of promoting self-advocacy.

B. Did it work?

(Use additional sheets as necessary)

EVALUATION

In your own words, answer the following in discussion or writing:

I. 1. Discuss the basic steps in needs assessment.

2. Discuss the need for resource identification.

3. Discuss the components of an action plan.

4. Discuss the usefulness of follow-up.

II. 1. Briefly discuss actions you might take or the problems involved in the following situations:

a. A new volunteer to your agency wishes to become more involved with clients. He isn't sure what to do.

b. You and a client have developed a plan for action in cooperation with another agency. At the last minute, the agency representative says he doesn't have time to follow through with the plans.

c. A fellow staff member has been having problems at home and he seems to be pushing himself too hard. He tends to be an "enabler" and his activities usually fall through because of his inappropriate expectations for the clients.

2. What is the relationship between your work as an advocate and the client's self-advocacy?

III. 1. If you were working with a client who has identified some real needs, but has worried about taking action, how would you help him commit himself to act?

2. Review your own advocacy activity (ASPIRE TRAINING AID 2.5 - No. 5) and make suggestions on how you might improve or revise it. Place your suggestions below. (Return the TRAINING AID with the evaluation.)

Evaluation Sample Answers:

I. 1. There are two basic steps in needs assessment. First is identifying needs. Here you must make sure that the needs are the client's and not your own. Secondly, you must get a commitment to make sure the plan works.

2. If you know what kinds of services are available, you have more options for your plan of action.

3. You state the problem and proposed changes, find the resources, set a strategy, implement the plan, and follow-up and evaluate the results.

4. It is important to follow-up your activities to make sure things went according to plan. You may need to make corrections to make it better. The feedback will also help you as a reference during later activities.

II. 1. a. I would introduce him to needs assessment and develop a plan for action. In short, I would advocate.

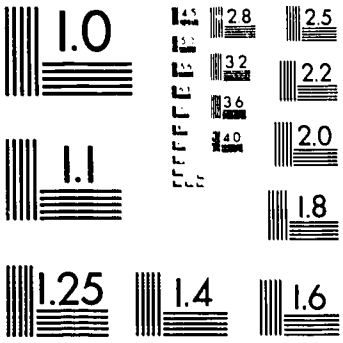
b. One of two things (or both) could be wrong here. First, the representative lacked commitment. Secondly, he may have needed to define and communicate his own limits.

c. The staff member needs to separate his needs from those of the clients.

2. All advocacy should promote the client's self-advocacy.

III. 1. I would discuss the problem in terms of what solving it would do for him. We would develop goals and make sure they would solve the problem. I would get him/her to believe change was possible and then make sure our plan would be set-up to succeed, especially at first.

2. The revision should indicate a definite refinement in, and increased awareness of, effective advocacy procedure.



MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

Part 4

Florida: Training for Human Service Workers

Module on Behavioral Techniques

Related sections from Facilitator's Manual

The module reproduced in this appendix is preceded in the training program by a module that describes terms common to behavior modification and demonstrates targeting skills, use of positive reinforcement, and the use of contingencies.

It is followed by a third module in the series that focuses on how to use the behavioral techniques when making a behavior contract with a client and how to reinforce desirable behaviors that are not in the contract.

MODULE 6
BEHAVIORAL TECHNIQUES—PART 2

Participant Outcomes

As a result of your participation in this training, you will be able to:

1. CLASSIFY a behavioral contract, problem, target, contingency, "Did Do", and "Didn't Do", by explaining each;

2. DEMONSTRATE the use of the problem, target, and contingency sections of the Behavior Contract by writing examples that draw upon actual hospital experiences;

3. DEMONSTRATE the use of the problem, target, and contingency sections of the Behavior Contract by conducting simulated hospital interviews with patients, while having an observer give feedback;

4. CHOOSE to refer to patients in behavioral terms rather than in generalities; and

5. CHOOSE to systematically reinforce 4 healthy behaviors to each disapproval used as a consequence for inappropriate behavior.

Overview

BEHAVIORAL TECHNIQUES—PART

Summary

In this module you will begin to learn how to use positive behavioral techniques with the clients on your ward. You will use a specific therapeuti tool, the Behavior Contract. In this contract you will learn how to choose target behaviors for treatment. You will learn how to set up contingenci s (relationships between behaviors and consequences) by using positive reinforcement to strengthen healthy behaviors. You will do this systematically as you chart what you do in the contract. It is very important to set up the contract with the patient. Begin by setting up reasonable behavioral goals that the client can achieve. It is also important to fill out the chart correctly.

Main Points

1. The Behavior Contract is an agreement between a UTR Specialist (or a professional) and a client. Clients agree to change specific behavior and the UTR Specialist agrees to reinforce the new behaviors.

2. Together, target areas are established. That means that specific behaviors are selected to help the client act in more healthy ways.

3. A UTR Specialist and a client establish contingencies together. The client agrees to work for particular positive reinforcers (rewards which the client likes). The UTR Specialist makes certain that the reinforcers are available to the client.

4. The UTR Specialist learns to correctly chart the "target" section of the Behavior Contract. This includes writing in the problem (usually shown by inappropriate behavior) and the target behavior (or appropriate behavi) that the client has contracted to do.

5. When using reinforcement, the UTR Specialist should always remember:

   a. Reinforce immediately! Be sure the positive consequence happens immediately after the target behavior, not two hours later.

   b. Reinforce as often as possible. This will help to strengthen the healthy behaviors. Each time the healthy behavior occurs, reinforce it.

   c. Be sure that the reinforcers used are positive for the client. Free time or UTR Specialist time may reinforce some clients but not others. Be sure to choose reinforcers your client <u>really</u> likes.

6. If you use disapproval or ignoring to weaken a behavior, remember these important points:

   a. Disapprove immediately so your clients connect the disapproval with their behavior and make the association that their behavior was wrong.

   b. Disapproval should not last long, but should be clearly negative. For example: "No!" That is a sufficient disapproval. Keep it short. It is more effective than if you nag on and on.

   c. Never threaten. If the behavior is inappropriate, disapprove quickly and continue what you were doing. Threats are useless in changing behavior.

   d. <u>NEVER</u> use disapproval unless you have reinforced four times recently. If you haven't used reinforcement, simply ignore.

   e. Ignoring will help to weaken inappropriate behavior. Try not to rely on ignoring. It will weaken behaviors, but you should concentrate on using positive techniques.

   f. <u>ALWAYS</u> use positive reinforcement for appropriate behaviors which occur along with inappropriate ones. This is essential so patients learn not only which behaviors are inappropriate, but also which behaviors are appropriate.

itions

vior Contract. This is an agreement between a UTR Specialist and a patient. This contract states the changes that are expected of the client and the reinforcements that will be provided when the client does the behavior.

Target Behavior. This is the desired behavior you are focusing on in the Behavior Contract. For a withdrawn client, the target behavior might be "starting a conversation".

Supplementary Reading

What's the Big Idea Behind Behavior Therapy?

The whole point of UTR is helping the patient. Every change is directed toward helping paitents get better and get out of the hospital and into the community. Often this means that if patients can stop their inappropriate ways of behaving which makes others think of them as sick, and learn new, healthy behaviors, they can live as part of the community.

We have talked in the past about how skills training groups help people learn new ways of acting. Another powerful way of helping people do this is behavior therapy. It has proved to be one of the simplest and most effective ways of doing treatment that is available in hospitals like those in the Florida system. It works very well. It helps people lose behaviors that separate them from other people and develop new, useful ways of acting. It can go on continuously during the ordinary activities of the day and is not limited to sessions with a professional therapist, and parts of it can be done expertly by trained paraprofessionals. (A side benefit for the paraprofessional is the chance to do real therapy and see its effectiveness.)

What's the big idea behind behavior therapy, and how does it work? Behavior therapy concentrates on how people act in the here-and-now instead of focusing on the things in their past lives that cause them to act in a particular way. It assumes that all behavior is learned, unless it is caused by a physical problem (like an epileptic seizure) or illness (like senile psychosis). The reason that people learn to repeat any behavior is that the world around them gives them a pay-off, a reward, for that behavior. (Example: A baby learns to talk because people respond to it when it makes language sounds.) This is true of both healthy and unhealthy ways of behaving.

When there is no pay-off, or when something unpleasant happens as a result of a behavior, it probably won't happen often again. (Example: All babies make spluttering noises, but since they are not answered with spluttering noises very often, they soon stop and learn to make the sounds that their families repeat. And very few babies touch a hot stove twice!)

People can stop acting in inappropriate ways and learn new, healthier behaviors if their environments begin to teach them something new. This means that:

- UTR Specialists can change my environment so that my inappropriate behaviors get no pay-off (are ignored) or so that something that I don't want will happen to me when I behave that way.

- My environment can be changed so that when I act healthy, there are pay-offs. When I do healthy things, good things happen to me.

This works if it is done systematically, the same way every time, over and over again, by all treatment staff. The patient (wherever possible) is involved in the treatment by making a contract with his Treatment Coordinator. In time, many patients can learn to use the system on themselves.

There are several important "big ideas" behind the use of behavior therapy. First, this therapy separates the person from his or her behavior and labels the behavior as good or bad, desirable or undesirable, but not the person. To take a trivial example from ordinary life, there are many nice children who sa "ma'am" and "sir" to grownups and other very nice children who don't. Both may be equally moral, well brought-up and polite children, but one child's environment has rewarded saying "ma'am" and "sir" and the other's has not.

In much the same way, a person who has never learned to understand and feel the difference between what others mean by "decent" and "indecent" behavior can nevertheless be taught to stop the particular behaviors which seem indecent to others and make them not want to associate with him or her. This learning depends on how the environment reacts to the person's behavior.

Second: All behaviors follow a pattern:

(A) Something happens to a person - either an event or some other person's behavior. Example: A mother calls her little boy to come to her. (This is called an antecedent.)

(B) The person does something or says something in response to what happens. Example: The boy runs to her and throws his arms around her legs. (This is called a behavior.)

(C) The behavior is followed by something positive and rewarding or something negative and punishing. Example: The boy's mother picks him up and hugs him, or she slaps him away and tells him to get down. (This is called a consequence.)

The rule, then, is that an antecedent causes a person to perform (do) a behavior which is followed by a consequence. If the consequence is good, the behavior is more likely to happen again. If it is bad, the behavior will be less likely to happen again. All behavior can be understood according to this pattern.

Third: Behavior therapy looks at the patient's behavior here and now, not in the past. Take the little boy in our example. Suppose that experiences of being slapped and pushed away over and over again have taught him not to respond at all when he is called. Instead of trying to deal with his past experiences to make today's behaviors change, a behavior therapist would change the boy's environment so that good things happen when he responds to others.

Fourth: People (and not just people in hospitals, either) learn faster from being rewarded than being "punished." In fact, it is suggested that therapists use four positive, approving responses for every one that is disapproving or punishing - something to experiment with with your own children!

Behavior therapy can work for patients of all kinds, patients like yours, because it is based on general, basic psychological principles that apply to sick people and well people alike.

■ by Millicent Shargel

Supplementary Reading

What's the Big Idea Behind Token Economy?

In Miami, Gus picked up his pay envelope at the end of the work week. On the way home, he opened it and used the loose change to buy a pack of cigarettes. "Boy," he said to the clerk. "You work hard for a living these days. I had to work 15 minutes to earn these Salems."

We live much of our lives in what is called a "token economy". If I pick your peaches and you pay me in peaches, we are not using tokens. But if you pay me money, then you are giving me coins or pieces of paper tokens that stand for my time and my work. And the store will trade me groceries for those tokens.

Our most important tokens are money. When we are paid, it is a sign that we have done something that somebody else valued. When we pay out money, we are getting what we want (a reward) in exchange for what we have done. The token is an object which connects what we do with the reward it brings us, like three links of a chain: behavior - token - reward.

In Tampa, the second grade teacher put another gold star on Lawanda's chart. "You completed another set of exercises today, Lawanda, and you earn another gold star. Look! When you earn just one more gold star you will have collected enough stars to pick out another new book to keep."

Tokens do not have to be valuable the way gold or uranium or even silver dimes are valuable. They can be valuable just because everybody agrees that they are -- like gold stars, or Green Stamps or those pieces of paper we call money.

Also tokens can be saved up to earn things we want. They can be saved until we have enough tokens (enough "buying power") for things we can't afford to earn all at once. Try saving for a new car if you are getting paid for your work in bushels of peaches and see where it gets you!)

In Cleveland, Mrs. Franklin put down the grocery bags from Fisher's. Even before she put away the milk and eggs, she pasted her Green Stamps in the book. She had shopped at Fisher's for ages (even though they were a little more expensive for some things) to get enough Green Stamps for a set of china. Now she had enough. Well, Fisher's was a pretty nice store. She guessed she'd keep on shopping there anyhow, even after she got the china. She liked it now.

Tokens can act as pay-offs or reinforcers. These are small, immediate awards that strengthen our motives for doing something. Mrs. Franklin only gets a few Green Stamps every time she goes to Fisher's. But she gets them every time and gets them right away. These tokens (the Green Stamps) are pay-offs that are connected for her with going to that store. They strengthen (reinforce) her feelings that Fisher's is a good place to shop. Even though the tokens are not so important to her now that she has enough stamps for the china (her "reward"), she will keep up her old behavior of shopping at Fisher's because she has learned to like the store, not just to get the reinforcers.

What have pay envelopes, gold stars and Green Stamps got to do with UTR? A hospital can use a token economy to help change clients in ways that will help them live more successfully with other people.

Token economies are often used to teach new behaviors to people who find it hard or even impossible to choose new behaviors for the usual rewards. For example, the reward for a smile is usually that somebody smiles back. But getting a smile back may not be a reward to a psychotic person. So in the token economy there is another reward set up, a reward which is valuable to the patient. This means finding a reward that the patient is willing to work toward (like Mrs. Franklin saving for her china). The reward may be something that he or she has to wait for, like an extra hour of TV tonight, a game of checkers with a favorite UTR Specialist on evening shift, or a walk on the grounds the next sunny day. So the patient who does the desired behavior now gets a token right away and then can trade it later for the thing that is valuable. The token becomes a way to connect doing the desired behavior with getting the reward.

In the long run, the idea is for people to grow out of token economies. Mrs. Franklin will go to Fisher's in the future because she has learned to like shopping there, not because they pay her off in Green Stamps. In the same way, hospital treatment in a token economy is meant to teach people to do appropriate new behaviors for appropriate rewards, rewards that fit with the behavior. If they get better, people learn not to need rewards like movies and ball games and leave time to do things like dress properly and talk to each other. Instead they learn to like the rewards of being accepted by others, making friends, and so forth. These are the rewards that are the natural result of the new behaviors.

Token economies in hospitals are used only as a limited part of behavior therapy. For example, they are being used with children and with people who have become "institutionalized" and just allow themselves to be taken care of.

This kind of carefully designed set of outside controls is sometimes called behavior management. It is important to remember that, like all active treatment programs, its goal is to help people reach a point where they can manage themselves more effectively and hopefully take control of their own lives again.

■ Millicent Shargel

Using the Behavior Contract

These instructions and the sample contract below will show you how to fill out the Behavior Contract. Before using the Behavior Contract it is important to remember: 1) that the contract must be agreed upon and signed by both the UTR Specialist and the client; and 2) that after the contract is set up, any acting UTR Specialist may use the contract with the client. (In other words, more than one UTR Specialist can use the "Did Do" and "Didn't Do" sections.)

How to set it up:

1 Write in the client's problem area.

2 Write in the target behavior (the desired behavior) you and the client agree to work toward.

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem: WITHDRAWN		
		Target Behavior: TALK TO OTHER PATIENTS ON THE WARD FOR AT LEAST 2 MINUTES.		
		Contingency: If YOU TALK TO ANOTHER PATIENT FOR 2 MINUTES,		
		Then: I WILL TAKE A COFFEE BREAK WITH YOU.		

3 Write in a contingency by identifying the "if" (the desired behavior) and the "then" (the positive reinforcer for the behavior).

How to use it:

4 Every time the client performs the desired behavior, the UTR Specialist puts a check beside "Target Behavior" in the "Did Do" column and writes his/her initials in the "Initial" column.

5 Every time the desired behavior is performed, the UTP Specialist should give the reinforcer in the "Contingency" section. Then the UTR Specialist places a check in the "Did Do" column beside "contingency" and writes his/her initials.

6 Every time the client refuses to perform the desired behavior, the UTR Specialist places a check in the "Didn't Do" column and writes his/her initials.

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
R.J.	✓	1 Target: WITHDRAWN	✓	R.J.
R.J.	✓		✓	R.J.
R.J.		Target Behavior: TALK TO	✓	R.J.
R.J.		OTHER PATIENTS ON THE WARD FOR AT LEAST 2 MINUTES	✓	R.J.
		Contingency: IF YOU TALK TO	✓	R.J.
		ANOTHER PATIENT FOR 2 MINUTES,	✓	R.J.
		Then I will TAKE	✓	R.J.
		COFFEE BREAK WITH YOU	✓	R.J.

WORKBOOK EXAMPLES: BEHAVIORAL TECHNIQUES—PART 2

Directions: This exercise gives you a chance to show how you would use the target section of a Behavior Contract. Each of the examples below describes typical patient problems. Using the Behavior Contracts provided, fill out a target section for each of these clients. Be sure to fill out the patient information at the top of the contract and be sure to sign each contract.

1. Katrina Jones is very quiet and shy. She rarely leaves the chair that she sits in everyday. She has no friends and cries every day. She eats very little and she is losing weight. She does not participate in occupational therapy.

2. Tommy Malen is an 18 year old. He was admitted for a drug intoxication problem. Tommy is violent. He cusses at other patients. He also yells out for no reason. He hits other patients. He is a pretty nasty guy.

Behavior Contract

Patient:_____ Date:_____ UTR Spec._____

Good from_____ to_____ Next appointment:_____

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		2 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		3 Problem:_____		
		Target Behavior:_____		

continued

Behavior Contract (con't)

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		Contingency: If_____ Then:_____		
		4 Problem:_____ Target Behavior:_____		
		Contingency: If_____ Then:_____		

BONUS: Catch the patient being GOOD	Did Do	Initial
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		

I agree to the above stated goals for this week

Signature of UTR Spec:_____

Signature of Client:_____

Behavior Contract

Patient:_____Date:_____UTR Spec._____

Good from_____to_____Next appointment:_____

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		2 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		3 Problem:_____		
		Target Behavior:_____		

continued

Behavior Contract (con't)

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		Contingency: If_____ Then:_____		
		4 Problem:_____ Target Behavior:_____		
		Contingency: If_____ Then:_____		

BONUS: Catch the patient being GOOD	Did Do	Initial
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		

I agree to the above stated goals for this week

Signature of UTR Spec:_____

Signature of Client:_____

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EXAMPLES FROM YOUR DAY: BEHAVIORAL TECHNIQUES—PART

Directions: These Behavior Contracts give you a chance to show you understand how to fill out the Target Section. There are three parts to fill out. Next to Problem, write any current problem a patient on your ward experiences. Next to Target Behavior, write each specific behavior you can work on with the patient to alleviate the problem area. Next to Contingency, write what reinforcer the patient can earn for doing the correct target behavior. Be sure to fill out the patient information at the top of the page. Also be sure to sign and date each contract.

example:

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem: Dirty room		
		Target Behavior: Make bed by 9:00 A.M.		
		Contingency: If your bed is made by 9:00 A.M. Then: you get 5 extra min. of recreation time.		

Behavior Contract

Patient:_____ Date:_____ UTR Spec._____

Good from_____ to_____ Next appointment:_____

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		2 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		3 Problem:_____		
		Target Behavior:_____		

continued

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		Contingency: If_____ Then:_____		
		4 Problem:_____ Target Behavior:_____		
		Contingency: If_____ Then:_____		

BONUS: Catch the patient being GOOD	Did Do	Initial
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		

I agree to the above stated goals for this week

Signature of UTR Spec:_____

Signature of Client:_____

Behavior Contract

Patient:_____ Date:_____ UTR Spec._____

Good from_____ to_____ Next appointment:_____

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		2 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		3 Problem:_____		
		Target Behavior:_____		

 continued

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		Contingency: If_____ _____ Then:_____ _____		
		4 Problem:_____ _____ Target Behavior:_____ _____ _____		
		Contingency: If_____ _____ Then:_____ _____		

BONUS: Catch the patient being GOOD	Did Do	Initial
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		

I agree to the above stated goals for this week

Signature of UTR Spec:_____

Signature of Client:_____

REVIEW: BEHAVIORAL TECHNIQUES—PART 2

Directions: This exercise gives you a chance to go back over (to review) the skills involved in using a Behavior Contract that you have learned about in this module. You will need to know how to use the contract before going on to role-plays. Write a short definition for each contract. Describe each section and how you use it.

Target Section: _____

_____

_____

Contingency (If, Then) Section: _____

_____

_____

Did Do/Didn't Do: _____

_____

_____

Initial (Signing Your Name): _____

_____

_____

SELF-QUIZ: BEHAVIORAL TECHNIQUES—PART

Directions: Read this case history. Use the Behavior Contract provided. Fill in the Target Section of the contract. List the problem areas. Cite the specific, pinpointed behavior. Set up contingencies using positive reinforcers to help this patient with his behavior.

Case history

This twenty-five year-old single male currently on the unit has a history of several psychiatric hospitalizations as well as a history of drug and alcohol abuse.

He is untidy, careless in his personal cleanliness. He has grown long hair, a beard and refuses to cut his fingernails.

His eye contact is poor and he often makes unusual facial expressions. In speaking he often mumbles or rambles. He is alert to events on the unit, is able to walk about and seems to be in good physical health.

From reading his social history you learn he enjoys reading science fiction novels and playing a guitar.

Now use the Behavior Contract to target problem areas that you might work on with this patient. Also make up contingencies that might work.

Behavior Contract

Patient:_____ Date:_____ UTR Spec._____

Good from_____ to_____ Next appointment:_____

Initial	Didn't Do	TARGET SECTION	Did Do	Initial
		1 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		2 Problem:_____		
		Target Behavior:_____		
		Contingency: If_____		
		Then:_____		
		3 Problem:_____		
		Target Behavior:_____		

continued

Initial	Did Do	TARGET SECTION	Did Do	Initial
		Contingency: If ____		
		Then: ____		
		4 Problem: ____		
		Target Behavior: ____		
		Contingency: If ____		
		Then: ____		

BONUS Catch the patient being GOOD	Did Do	Initial
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		
Target Appropriate Behavior:		
Reinforcement:		

I agree to the above stated goals for this week

Signature of UTR Spec: _____

Signature of Client: _____

Preparation

Read and Study Printed Materials

Participant's Workbook

Module 6: Behavioral Techniques - Part 2

- Overview
- Supplementary Reading
- Behavior Contract (sample)
- Exercises
  - Workbook Examples
  - Examples From Your Day
  - Review
  - Self-Quiz

Background Readings

Kazdin, Behavior Modification in Applied Settings, 1980, pp. 149-160.

Madsen & Madsen, Teaching Discipline, 1974.

Rimm & Masters, Behavior Therapy, 1979, pp. 182-183.

Obtain and Preview Video Materials

Software

Blank videotapes

Equipment

Video recorder
Video monitor
Video camera
Microphone

Implementation

Orientation

1. Introductory Discussion (30 minutes)

a. Ask participants to turn to the first page of Module 6 in the Participant's Workbook. Read aloud, or ask participants to read, the "Participant Outcomes" section.

b. Begin the discussion by going over the concepts of Behavior Therapy that were learned in the previous module. Remind participants that the primary behavioral skills are targeting, contingency, and positive reinforcement. These techniques must be learned and practiced if the UTR Specialist is to properly implement Behavior Therapy. Also, mention again that Behavior Therapy deals with behavior itself and not with the underlying causes of behavior. For instance, if a given patient is constantly griping about other people, in Behavior Therapy we do not work with that patient's "bad disposition"; rather, we work with the behavior itself, i.e., griping. The objective is not to change the "disposition", it is to encourage the patient to stop griping by using effective behavioral techniques.

c. Explain to participants that in order for behavioral techniques to be effective, they must be consistantly and systematically implemented. Be sure that participants understand the meaning of the word "systematic". Then introduce the Behavior Contract: a systematically designed tool for using behavioral techniques. (A sample copy can be found in the workbook following the "Overview" section of Module 6.) Discuss the various sections of the contract (the target section, the contingency section, and the bonus section) and explain the function of each section.

2. Instruction (30 minutes)

a. Read aloud, or ask participants to read, the "Overview" section in Module 6. Make sure all of the main points are thoroughly covered. Also encourage the participants to read the articles on Behavior Therapy found under the "Supplementary Reading" section in Module 6. These may be read aloud, if desired.

b. Have participants complete the "Workbook Examples", "Examples From Your Day " and "Review" exercises in the workbook. These exercises ask the participants to: 1) fill out the target section of the Behavior Contract using examples already given; 2) fill out the target section using their own examples; and 3) go back over what they have learned about the Behavior Contract thus far. (Remember: participants need not complete all of the above exercises; rather, these exercises should be used based on time and participant needs.)

c. After participants have completed the assigned exercises, lead a discussion of their responses. Be sure to give participants feedback on their written work (e.g., tell them whether they are using the contract correctly. Give some examples of how the contract should be used).

d. Remind participants that after the first break they will be practicing role-plays in front of the video camera. Ask the participants to think about how they might role-play using the Behavior Contract.

Break (10 minutes)

1. Role-Play (55 minutes)

a. Divide participants into groups of three, and have each group choose a UTR Specialist, a patient, and an observer.

b. The patient chooses a problem area (nervousness). Then the UTR Specialist uses the Behavior Contract to target specific behaviors related to the problem area (e.g., patient bites his/her fingernails). In order to fulfill the purpose of the Behavior Contract, the UTR Specialist and the patient must agree upon both the Problem area and the targeted behaviors. For each targeted behavior, the UTR Specialist and the patient should set up and agree upon a contingency (e.g., if you quit biting your nails, then I'll let you watch T.V. one hour each evening.) The observer writes down what happens for later discussion. The video equipment may be used to record either one group's experience or portions from several groups. Select one participant as the camera operator (be sure to change operators so that all participants may role-play). For the first five minutes the UTR Specialist role-plays and, for the next five minutes, he/she discusses the experience with the patient and the observer. Participants then change roles until each participant has had a chance to play each role.

c. After each member has played each role, the videotaped session is shown so that the participants can review and discuss targeting on the Behavior Contract. The discussion should include (a) the importance of using the contract, and (b) how it feels to use it.

Break (10 minutes)

Review

1. Self-Quiz (25 minutes)

a. Have the participants complete the "Self-Quiz" in Module 6 of the workbook. This exercise will test their ability to take a patient case history, target specific behaviors for the patient to work on, and set up a contingency for each target. After all participants have completed the quiz, lead a discussion of their responses, and ask the participants how they arrived at their answers. You and the participants may then discuss some reasons for varying responses.

b. Through the observation of group role-playing and videotaped interaction, you will complete the "Behavioral Techniques - Part 2" section of the "Participancy Competency Chart" (see appendix).

2. Closing Discussion (20 minutes)

Encourage a discussion of the main points that were covered in this module and review several plans for practicing behavioral techniques. The discussion should include a summary of this module, how it relates to the participants' work, and how it relates to the next module, "Behavioral Techniques - Part 3".

APPENDIX C

STATEWIDE TRAINING LINKED TO STAFF LEVELS AND ADVANCEMENT

Texas: Outline of subjects included in each of the five curricula standards for the minimum training requirements of five successive classifications of para-professionals and the continuing education modules used in conjunction with training requirements for further advancement.

Texas Department of Mental Health and Mental Retardation
Curriculum Standards

PARAPROFESSIONAL TRAINING: MHMR AIDE TRAINEE

APPLICABILITY:

The following curriculum standards represent the minimum requirements for the pre-service training of entry level MHMR Aide Trainees prior to reporting to the work station for duty.

PREREQUISITES:

1. Completion of TDMHMR Orientation as required by Commissioner's Memorandum dated September 7, 1979.

2. Completion of Emergency Care Training as required by Commissioner's Memorandum dated July 23, 1979, with the exception of Cardio-pulmonary Resuscitation training which may be completed following pre-service training, but during the probationary period.

CORE CURRICULUM OUTLINE:

10000 Adaptive Techniques

10100 Basic Health Care Skills

10101 Medications Observations

10300 Working with Clients

10301 Principles of Observations
10302 Prevention and Management of Aggressive Behavior (PMAB-I)

20000 Managing Skills:

20100 Reporting Procedures

20101 Guidelines for Reporting

20200 Basic Employee Safety

20201 Body Mechanics
20202 Restraint and Seclusion
20203 Disaster Planning

30000 Human Needs and Services

30100 Human Needs

30101 Fundamentals of Client Rights
30102* Introduction to Mental Illness (30102a - Spanish version)
30103* Introduction to Mental Retardation (30103a - Spanish versi
(* Select one dependent upon facility assignment and clients served)

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SERVICES ASSISTANT

APPLICABILITY:

1. The following curriculum standards represent the minimum requirements for the training of MHMR Aides during the probationary period.

2. Successful demonstration of the competencies required by this curriculum is necessary for satisfactory completion of the probationary period as evaluated by the supervisor and promotion to MHMR Services Assistant.

PREREQUISITES:

1. Successful demonstration of required pre-service MHMR Aide Trainee competencies.

CORE CURRICULUM OUTLINE:

11000 Adaptive Techniques

11100 Basic Health Care Skills

- 11101 Handwashing
- 11102 Vital Signs - Temperature, Pulse and Respiration
- 11103 Vital Signs - Blood Pressure
- 11104 Height and Weight Measurement

11200 Basic Personal Care Skills

- 11201 Oral Care
- 11202 Care of Hair and Nails
- 11203 Care of Eyes, Ears and Nose
- 11204 Toileting
- 11205 Bathing
- 11206 The Balanced Diet

11300 Working With Clients

- 11301 The New Client
- 11302 Client Sexuality
- 11303 Introduction to Behavior Therapy (BT-I)
- 11304 Protection of Self and Others (PMAB-II)
- 11305 Methods of Restraint (PMAB-III, being developed)

(Continued)

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SERVICES ASSISTANT

21000 Managing Skills

21100 Reporting Procedures

21101* Problem Oriented Record System (PORS) - Mental Health
21102* Problem Oriented Record System (PORS) - Mental Retardation
(* Select one dependent upon facility assignment and clients served)

Texas Department of Mental Health and Mental Retardation
Curriculum Standards

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SPECIALIST I

APPLICABILTIY:

1. The following curriculum standards represent the minimum requirements for the pre-training of MHMR Services Assistants or others to qualify for eligibility as an MHMR Specialist I.

2. MHMR Services Assistants who do not wish to compete for MHMR Specialist I positions, or who are not selected for such positions, shall meet the continuing education requirements within these standards.

3. All employees classified as MHMR Services Assistants shall receive Behavior Therapy training, within the first six months following appointment to MHMR Services Assistant, as defined by Commissioner's Memorandum dated June 1, 1981.*

PREREQUISITES:

1. Satisfactory completion of the probationary period and successful demonstration of required MHMR Aide and MHMR Services Assistant competencies and prerequisites.

CORE CURRICULUM OUTLINE:

12000 Adaptive Techniques

12100 Working with Clients

12101 Developing Client Independence
12102 Organizing Client Activities
12103* Observing and Measuring Behavior (BT-II)
12104* How to Increase Behavior (BT-III)
12105* How to Decrease Behavior (BT-IV)
(* Required for MHMR Assistants by Commissioner's Memorandum dated June 1, 1981)

22000 Managing Skills

22100 Work Area Management

22101 Introduction to Managing Skills
22102 Introduction to Work Area Management
22103 Interdisciplinary Team Participantion (Client Staffing)

(Continued)

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SPECIALIST I

22200 Introduction to Daily Supervision

- 22201 On-the-Job Orientation of New Employees
- 22202 How to Train Employees
- 22203 Worker Participation and Delegation

32000 Human Needs and Services

32100 Human Needs

- 32101 Introduction to Human Growth and Development
- 32102 Cultural Awareness
- 32103 Working with Clients' Family and Visitors
- 32102** or
- 32103** Introduction to Mental Illness or Mental Retardation
  (** Selection of the alternate topic from the one completed as an MHMR Aide Trainee)

CONTINUING EDUCATION:

As an annual requirement, all MHMR Services Assistants shall complete no fewer than three (3) Continuing Education modules or other units of instruction as determined with the supervisor. For employees who wish to qualify for MHMR Specialist I, demonstration of competencies contained in core curriculum above may be considered as meeting this Continuing Education requirement.

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SPECIALIST II

APPLICABILITY:

1. The following curriculum standards represent the minimum requirements for the pre-training of MHMR Specialist I or others to qualify for eligibility as an MHMR Specialist II.

2. MHMR Specialist I who do not wish to compete for MHMR Specialist II positions, or who are not selected for such positions, shall meet the continuing education requirements within these standards.

PREREQUISITES:

1. Successful demonstration of required competencies for MHMR Aide, including pre-service training, MHMR Services Assistant, and MHMR Specialist I classifications.

CORE CURRICULUM OUTLINE:

13000 Adaptive Techniques

13100 Working with Clients

13101 Supporting Client Activities
13102 Principles of Client Counseling

23000 Work Area Management

23101 Scheduling Regulations (Shifts and Patterns)
23102 Inventory Controls
23103 Worker's Compensation

23200 Managing Human Resources

23201 Interviewing Prospective Employees
23202 Position Descriptions
23203 Performance Standards
23204 Performance Evaluations
23205 Introduction to Positive Performance Program

(Continued)

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SPECIALIST II

33000 Human Needs and Services

33100 Utilizing Resources

33101 Problem Solving
33102 Matching Needs and Resources
33103 Utilizing Volunteer Services

33200 Client Advocacy

33201 Right to Active Programming, Training or Treatment
33202 Public Responsibility Committees

CONTINUING EDUCATION:

As an annual requirement, all MHMR Specialists I shall complete no fewer than three (3) Continuing Education modules or other units of instruction as determined with the supervisor. For employees who wish to qualify for MHMR Specialist II, demonstration of competencies contained in core curriculum above may be considered as meeting this Continuing Education requirement.

Texas Department of Mental Health and Mental Retardation
Curriculum Standards

PARAPROFESSIONAL TRAINING: *To become eligible for* MHMR SUPERVISOR

APPLICABILITY:

1. The following curriculum standards represent the minimum requirements for the pre-training of MHMR Specialists II or others to qualify for eligibility as an MHMR Supervisor.

2. MHMR Specialists II who do not wish to compete for MHMR Supervisor positions, or who are not selected for such positions, shall meet the continuing education requirements within these standards.

PREREQUISITES:

1. Successful demonstration of required competencies for MHMR Aide, including pre-service training, MHMR Services Assistant, and MHMR Specialists I and II classifications.

CORE CURRICULUM OUTLINE:

14000 Adaptive Techniques

24000 Managing Skills

24100 Managing Human Resources

- 24101 Functions of Management
- 24102 Leadership Concepts
- 24103 Interviewing Techniques, Permissible and Impermissible Inquiries
- 24104 Selection of Qualified Personnel
- 24105 Guiding Employee Growth
- 24106 Employee Turnover
- 24107 Motivation and the Supervisor

34000 Human Needs and Services

34100 Service Programs

- 34101 State Hospital Programs
- 34102 State School Programs
- 34103 Community Service Programs
- 34104 Referral, Placement and Admissions

(Continued)

PARPROFESSIONAL TRAINING: *To become eligible for* MHMR SUPERVISOR

CONTINUING EDUCATION:

As an annual requirement, all MHMR Specialists II shall complete no fewer than three (3) Continuing Education modules or other units of instruction as determined with the supervisor. For employees who wish to qualify for MHMR Supervisor, demonstration of competencies contained in core curriculum above may be considered as meeting this Continuing Education requirement.

Texas Department of Mental Health and Mental Retardation
Curriculum Standards

PARAPROFESSIONAL TRANING: MHMR SUPERVISOR CONTINUING EDUCATION

APPLICABILITY:

1. The following curriculum standards represent the minimum requirements for employees appointed to the position of MHMR Supervisor.

2. Experienced MHMR Supervisors should counsel with their supervisors regarding continuing career opportunities in Mental Health and Mental Retardation and the acquisition of technical or professional credentials appropriate to current or future job assignments.

CONTINUING EDUCATION:

As an annual requirement, all MHMR Supervisors shall complete no fewer than three (3) Continuing Education modules or other units of instruction in the areas of Management or Supervision as determined with the supervisor.

Texas Department of Mental Health and Mental Retardation

PARAPROFESSIONAL TRAINING: MHMR SERVICES SERIES

CONTINUING EDUCATION RESOURCES

The following modules have been developed as continuing education resources for the training of MHMR Service Series personnel. It is intended that this listing will be expanded as facilities develop other instructional materials which, with approval by the Central Office for Staff Development, will become available for systemwide use. Core curriculum modules for each advancing classification within the MHMR Service Series may also be considered as continuing education for the preceeding classification.

15000 Adaptive Techniques

15001 Reality Orientation
15002 Introduction to Psychotherapies
15003 Enemas
15004 Collection of Specimens
15005 Introduction to Feeding (Required for all State School MHMR Aides)
15006 Aversive and Special Techniques to Decrease Behavior (BT-V)
15007 Special Behavior Therapy Programs (BT-VI)
15008 Techniques for Recovering Objects from Aggressive Persons (PMAB-IV)

25000 Managing Skills

A set of instructional materials has been developed by the San Antonio State Hospital under an Intergovernmental Personnel Act Contract No. 1816 for entry level professional staff. They also may be considered for paraprofessional continuing education.

25001 Introduction to Management
25002 The Planning Function
25003 Interviewing and Selecting Procedures
25004 Handling Disciplinary Problems and Grievances
25005 Performance Standards and Evaluations
25006 Orienting and Training New Employees
25007 Management by Objectives

(Continued)

PARAPROFESSIONAL TRAINING: CONTINUING EDUCATION RESOURCES

35000 Human Needs and Services

35001 The Down's Syndrome Client
35002 The Profoundly Mentally Retarded Client
35003 Introduction to Alcoholism
35004 Introduction to Chemical Dependencies
35005 The Client with Diabetes

45000 Other

45001 (30102a) Introduction a la Enfermedad Mental (Spanish) version of Introduction to Mental Illness)
45002 (30103a) Introduction a la Retrazo Mental (Spanish) version of Introduction to Mental Retardation)
45003 Elementary Spanish for the English Speaker I
45004 Elementary Spanish for the English Speaker II

APPENDIX D

STATEWIDE AGREEMENTS BETWEEN COLLEGES AND THE STATE MENTAL HEALTH AGENCY

Part 1	Maine:	Syllabus and Course Schedule for Introduction to Supervision
Part 2	Alabama:	Instructional Outline and Objectives for Behavior Modification II

Part I

Maine: Syllabus and Course Schedule for Introduction to Supervision

This course was developed by Bangor Community College in response to an identified training need of the Maine Department of Mental Health and Mental Retardation in conjunction with the agreed upon curriculum for an associate degree program.

UNIVERSITY OF MAINE AT ORONO
BANGOR COMMUNITY COLLEGE
HUMAN SERVICE PROGRAMS

99 HSV --- Introduction to Supervision (BMHI)
Fall 1982
Instructor: P. O'Neil

COURSE SYLLABUS

DESCRIPTION

The essence of this course will be to establish an understanding and appreciation of all the theoretical concepts that come into focus of clinical supervision. Issues related to the management process, the decision-making process and various leadership theories will be enhanced by group practical applications.

OBJECTIVES

- to understand essential concepts of clinical supervision
- to understand the leadership theories of Maslow, and McGregor and the importance they have played in the development of motivational techniques
- to become effective in implementing decision-making skills
- to implement group management skills

METHODS OF PRESENTATION

Classroom lecture followed by group discussion
Films
Assigned textbook readings, handouts and exercises
Team Exercises
Role Play Models

EVALUATION

25% Classroom participation and role playing
25% Team exercise presentations
25% Preliminary Quiz
25% Final Evaluation (P/F)

ATTENDANCE

Attendance is expected at all classes. Most classroom lectures will relate to group projects and group discussions that will follow a lecture. Should a student miss a scheduled exam or project --immediate

notification to the instructor will be expected.

REQUIRED TEXT

Hart, Gordon M., The Process of Clinical Supervision, University Park Press, Baltimore, MD, 1982.

OTHER SOURCES

Myers-Briggs Type Indicator
Personal Attributes Questionnaire
Life Crises Exercise
Subartic Survival Situation
Motivational Aides

*** IN ANY CLASS ROLE PLAYING MODES
CONFIDENTIALITY IS REQUIRED

UNIVERSITY OF MAINE AT ORONO
BANGOR COMMUNITY COLLEGE
HUMAN SERVICE PROGRAMS

99 HSV — Introduction to Supervision
Fall 1982 (BMHI)

Instructor: P. O'Neil
Tuesday, 4:30 - 7:00 p.m. K-3

COURSE SCHEDULE

DATE	TOPIC	ASSIGNMENT
9/7	ORIENTATION, Distribution of schedule & syllabus	Handout
9/14	INTRODUCTION TO CLINICAL SUPERVISION	pp. 3-25
	Conceptual Look at Clinical Supervision and Basic Models	
9/21	Explanation & Discussion of Models	pp. 53 Handout
9/28	Maslow -- Hierarchy of Needs Discussion	Handouts
10/5	Theory X, Theory Y The Decision-Making Process	*Film
10/12	Skill Development Models	pp. 55-94 Handouts
10/19	Personal Growth Model	pp. 95-127
10/26	Integration Model	pp. 129-156
11/2	Practice of Clinical Supervision Concepts & developmental stages of clinical supervision	pp. 157-158 pp. 159-190
11/9	Developmental Stages Discussion	Handout
11/16	Implementing Supervision	pp. 191-238
11/23	Concerns of Implementing supervision -- Continuation	Handout
11/30	Role Playing Models Disucssion	Journal Article Due
12/7	Summarizations, Evaluations Review	
12/14	Journal Discussion Review, Evaluation	
12/21	FINAL EXAM	

Part 2

Alabama: Instructional Outline and Objectives for the Behavior Modification II

This course is part of the Alabama Department of Mental Health's curriculum guide for work-education linkage programs. The program results in an associate degree in Mental Health Technology.

BEHAVIOR MODIFICATION II

DESCRIPTION: This course deals with techniques used to change behavior patterns. It is recommended that students be required to demonstrate appropriate use of these techniques in actual or role play situations.

INSTRUCTIONAL OUTLINE

I. Introductory discussion of the course, course requirements and relationship to MHT program requirements: OBJECTIVE 1

II. Demonstration of the student's ability to apply the following behavioral principles/techniques: OBJECTIVE 2

- A. Targeting of both positive and negative behaviors for change: OBJECTIVES 3 & 4
- B. Reinforcing behavior: OBJECTIVE 5
- C. Shaping behavior: OBJECTIVE 5
- D. Prompting and fading: OBJECTIVE 5
- E. Establishing stimulus control: OBJECTIVE 5
- F. Training discriminative skills: OBJECTIVE 5
- G. Contracting for behavior change: OBJECTIVE 6
- H. Extinguishing behavior: OBJECTIVE 5
- I. Using aversive techniques: OBJECTIVE 5

III. Reinforcement of behavior

- A. Using various schedules of reinforcement (chapter 6 of Whaley & Malott; chapter 6 of Kazdin): OBJECTIVE 5
- B. Using time-dependent schedules of reinforcement (chapter 7 of Whaley & Malott): OBJECTIVE 5
- C. Using conditioned reinforcement and the token economy (chapter 15 of Whaley & Malott): OBJECTIVE 5
- D. Increasing the effectiveness of reinforcement (chapter 17 of Whaley & Malott): OBJECTIVE 5

IV. Punishment and negative reinforcement of behavior (chapters 18 & 19 of Whaley & Malott; chapter 7 of Kazdin): OBJECTIVES 5, 6, 7 & 8

INSTRUCTIONAL OUTLINE (continued)

V. Response maintenance and transfer of training (chapter 18 of Whaley & Malott; chapter 11 of Kazdin): OBJECTIVE 5

VI. Technique variations to enhance client performance (chapter 12 of Whaley & Malott; chapter 9 of Kazdin): OBJECTIVES 5 & 9

VII. Evaluation of a behavior modification program (chapter 5 of Kazdin): OBJECTIVE 2

Suggested Textbooks: Kazdin, Alan. Behavior Modification in Applied Settings. Dorsey Press: Homewood, IL, 1980.

Whaley, Donald and Malott, Richard W. Elementary Principles of Behavior. Prentice-Hall, Inc., Inglewood Cliffs, NJ, 1971.

BEHAVIOR MODIFICATION II

	Instructional Objectives	SREB Worker competency
1.	The instructor reinforces, through modeling and information delivery, the importance of facilitative relationships (attentive behaviors) and environments, the use of language and expressions that are understood by the receiver, and the "reading and responding" to "feeling tones" of clients and others as they apply to behavior modification techniques.	(02:1) (07:4,6) (21:2,8) (06:5) (07:4,6,7)
2.	The instructor illustrates the necessity of following approved service plan, documenting client behavior (baseline, behavior changes), and proper (agency acceptable) methods for modifying client service plans.	(02:2,3,7,8) (06:2,9) (32:14) (28:10) (07:1,8)
3.	The instructor demonstrates and provides practice in defining target behaviors, establishing baselines, and behavior recording techniques.	(02:4,7) (28:1)
4.	The instructor explains/demonstrates the necessity of targeting behaviors which are appropriate to client need (i.e., independent living skills), level of functioning and daily living routines and schedules.	(06:5,7) (21:7,9,10)
5.	The instructor illustrates how to accelerate and decelerate behavioral responses of clients through stimulus control, including insuring that environmental conditions are maximally conducive to learning.	(06:6) (06:11)
6.	The instructor explains and illustrates the application of behavior modification principles and techniques in violent/destructive behavior control.	(32)
7.	The instructor reviews the components of behavior contracting (client participation in the plan, commitment to the plan, renegotiation, if necessary) and illustrates the relationship of these components to a service plan.	(03)
8.	The instructor explains the ethical and legal implications of behavior modification programs and medication as they relate to client rights, confidentiality, privacy, informed consent and agency policies and reporting procedures.	(02:5,8) (21:6) (02:8) (07:2,3,5) (21:13)

Instructional Objectives (continued)	SREB Worker Competency
9. The instructor explains and illustrates the application of behavior modification principles and techniques to groups.	(28)

APPENDIX E

STATEWIDE TRAINING FOR SPECIFIC SUBJECTS

Part I	Maryland:	Career Development Specialist Curriculum (functional assessment, task analysis, and skill training for community living)
Part 2	Colorado:	The Integration of Therapy and Case Management
Part 3	Florida:	Management and Supervision in Mental Health Setting

Part I

Maryland: Career Development Specialist Curriculum

A program to teach functional assessment, task analysis, and skill training for preparing chronically mentally ill persons to live as independently as possible in a less restrictive environment.

Module on Performance Training, excluding training aids

Module on Crisis Management, including training aids

INTRODUCTION - PERFORMANCE TRAINING

The purpose of this Unit is to introduce the concepts and practices associated with the application of stimulus-control training. The skills of task analysis, stimulus control, and reinforcement acquired by trainees in the Unit will enable them to work in one-on-one situations to give the skills necessary for self-maintenance in the community to residents being treated for chronic mental illnesses.

The Unit focuses upon the application of learning theorists such as Marc Gold, Thomas Bellamy and Richard Walls. It minimizes the importance of traditional behavioral treatments which employ token economies, extensive use of rewards, and use of negative reinforcement. However, those behavioral techniques are presented as means to maintain and increase the use of skills acquired through stimulus-control training.

The foundation of the method of instruction presented in this Unit is Task Analysis: the division of a task into parts which are small enough to be learned, but large enough to have meaning to the learner. Methods of task presentation and use of a hierarchy of stimulus cues provide the remainder of the method.

This Unit also employs a 2 x 2 matrix to delineate the skills which should form the core of the training curriculum of a mental health facility interested in preparing returning residents to reside in the community with reduced community supports.

The skills acquired by the trainees in Performance Training have direct application to the amelioration of skill deficiencies assessed through Functional Assessment procedures presented elsewhere in the CDS CURRICULUM.

While it is likely that a number of facility personnel, expecially occupational therapists, will be familiar with the processes of task analysis, it is just as likely that few personnel will have experience in the application of stimulus control techniques in a skill training situation.

In this Unit the trainer serves in a technical role to assist trainees in the development of their own instructional skills. With each practice application of Performance Training techniques, the trainer would increase the quality of performance demonstrated by trainees so that they will succeed in their practice one-on-one sessions with a person currently residing in the mental health facility.

CAREER DEVELOPMENT SPECIALIST CURRICULUM

UNIT: PERFORMANCE TRAINING

TOPIC: "PERFORMANCE TRAINING THROUGH USE OF STIMULUS CONTROL TECHNIQUES, TASK ANALYSIS AND REINFORCEMENT"

PURPOSE: TO PROVIDE KNOWLEDGE, SKILLS, AND EXPERIENCE IN THE APPLICATION OF TASK ANALYTIC TECHNOLOGY TO INCREASE THE FUNCTION CAPACITY OF CHRONIC PATIENTS TO PERFORM ESSENTIAL SELF-MAINTENANCE ACTIVITIES ASSOCIATED WITH COMMUNITY LIVING.

OBJECTIVES: UPON COMPLETION OF THIS UNIT PARTICIPANTS WILL:

1. Be able to prepare a CONTENT TASK ANALYSIS of a number of tasks associated with community living such as:

   A. PERSONAL HYGIENE

      1) Bathing
      2) Washing Clothes
      3) Ironing Clothes
      4) Brushing Teeth
      5) Groomi
         Hair

   B. FOOD AND NUTRITION

      1) Purchase Food
      2) Prepare Food
      3) Consume Food
      4) Clean Utensils
      5) Dispose of Trash
      6) Clean Kitchen Area

   C. HOUSEWORK

      1) Make Bed
      2) Store Dirty Clothes
      3) Dust
      4) Cleaning
         A) Scrubbing
         B) Mopping
         C) Vacuum

   D. COMMUNICATION

      1) Request Assistance
         A) Fire - Telephone
         B) Medical - Telephone
         C) Emotional - Telephone
      2) Orders/Payments
         A) Pay Bills By Ma
         B) Order By Mail
      3) Letters and Cards

2. Be able to perform a PROCESS TASK ANALYSIS of the instructional activities associated with learner acquisition and retention of activities associated wit community living.

   A. IDENTIFIICATION OF ALTERNATIVE MEHTODS

      1) Methods Requiring Less Judgement
      2) Methods Requiring Less Activity
      3) Methods Requiring Less Complex Activity

B. SPECIFICATION OF ASSOCIATED ENTERING COMPETENCIES

1) Discriminations
2) Associations

C. PREPARATION FOR TASK PRESENTATION

1) Single Pieces of Learning
   A)EXAMPLES
      (1) Match-to-Sample
      (2) Paired Associates
      (3) Oddity

   B) REQUIREMENTS
      (1) Recognition
      (2) Recall
      (3) Simultaneous Presentation
      (4) Sequential Presentation

2) Multiple Pieces of Learning
   A) FORMATS
      (1) Forward Chaining
      (2) Backward Chaining
      (3) Total Task Presentation

3. Be able to use appropriate PROMPTS to direct learner activity

A. HEIRARCHY OF PROMPTS
   1) Physical
   2) Gestural
   3) Verbal

B. CATEGORIES OF PROMPTS
   1) Physical
      A) Total Manipulation
      B) Partial Manipulation
      C) Strong Guidance
      D) Touching

   2) Gestural
      A) Pointing
      B) Match-to Sample
      C) Demonstration
      D) Modeling

   3) Verbal
      A) Verb Alone As Command
      B) Object (Noun) Alone to Cue
      C) Phrase As Guidance
      D) Complete Sentence As Direction

4. Be able to make appropriate corrections to facilitate task acquisition by:

   A. Stopping Task Activity
   B. Formulation of "Mini-Chains"
   C. Provision of Massed Trials
   D. Reinforcement for Chain Completion
   E. Linking "Mini-Chains" into Task Chains

5. Be able to facilitate generalization and transfer of task competancies through:

   A. Use of High Acquisition Criteria
   B. Use of Over-learning
   C. Environmental Fading with Feedback

6. Will have worked on a one-to-one basis with a chronically mentally ill individual to build a task competancy through application of stimulus control techniques, task analysis and reinforcement by:

   A. Identifying critical community living skills which can be acquired, practiced and reinforced in the hospital/community setting

      1) Application of identified Psychosocial assessmer checklists.
      2) Application of the SKILL/ENVIRONMENT MATRIX

   B. Identifying an individual whose probability of community re-entrance and maintenance would be increased through development of a skilled competar

   C. Obtaining ward staff support and assistance in the skill development program.

   D. Obtaining support of the learner for participation in the skill development program.

   E. Training the individual to criterion in the selecte skilled competancy.

   F. Arranging for maintenance of the performance throu provision of:

      (1) Opportunities to practice the skill
      (2) Provision of appropriate reinforcement
      (3) Planning for transfer of performance to other environments.

FORMATS OF EXPERIENCE

1. Classroom Instruction to:
   - A. Identify and Develop Concepts
   - B. Introduce Instructional Processes
   - C. Provide Direction and Support

2. Group Discussion to:
   - A. Clarify Understandings
   - B. Share Experiences and Reactions
   - C. Share Resource Materials

3. Films to:
   - A. Review Reinforcement Concepts and Practices
   - B. Introduce
     - 1) Task Analysis
     - 2) Stimulus Control Techniques
     - 3) Non-Traditional Uses of Reinforcement

4. Supplemental Workbooks to:
   - A. Develop Basic Behavioral Orientation
   - B. Practice Reinforcement Techniques

5. Demonstrations and Simulation to:
   - A. Practice Application of Concepts
   - B. Overcome Resistance to innovation
   - C. Gain Confidence in Instructional Capacity

6. Individual Training Sessions to:
   - A. Overcome Resistance of Other Personnel
   - B. Identify Performance Deficits
   - C. Encourage Ward Participation
   - D. Apply Learned Concepts

SOURCES OF INSTRUCTIONAL INFORMATION

1. Film Sources
   - A. "Reinforcement Therapy"
   - B. "Try Another Way Training Library"

2. Texts
   - A. "Behaviorism: Plain and Simple", Beziat & Sellars
   - B. "Vocational Rehabilitation of Severely Mentally Retarded Adults", Bellamy, Horner, and Inman
   - C. "Did I Say That", Marc W. Gold
   - D. "Try Another Way Training Guide", Marc Gold and Associates

INSTRUCTIONAL PROCESS:

WARM-UP: It is important that participants recognize the pragmatic value of the study of the behavioral concepts in this Unit To that end, the WARM-UP should provide opportunities for participants to "buy-in" by:

1. Asking participants to identify the "zero order" tasks which either keep individuals in the institution or have caused them to return to the institution after a brief period of unsuccessful community adjustment. O.H.H.O. #1

   A. Ask a participant to serve as Recorder and to write the zero order tasks on a chaulkboard or flip chart

   B. For each zero order task, ask participants to identify the institutional program which would be most responsible for insuring pre-return competancy of the individual. Use O.H.H.O. #2

   C. For each "zero order" task ask the person offering the behavior to say if the individual-in-question "knew how to do it, but didn't", or "probably didn' know how to do it when they left the hospital cente

2. Place the behaviors into one of two columns marked "Didn't Do", or "Didn't Know How". Use O.H.H.O. #3

3. Explain that traditional behavioral programs in hospit Centers relied upon "Reinforcement Training/Therapy" to change behavior.

4. Review "Reinforcement Training" by using O.H.H.O. #4

5. Explain that Reinforcement Control is best used to regulate a behavior known to the individual through reinforcement, punishment or extinction but...

6. Reinforcement is less effective when used to build a previously unknown behavioral competancy. In such cases "Task Analytic Technology" is proving to be more effective. Show O.H.H.O. #5

FILM "REINFORCEMENT THERAPY" (Or Equivalent Demonstration Film)

1. Introduce Film by saying that we will now see a series of applications of traditional reinforcement therapy.

2. Show Film

CONTENT AND PROCESS TASK ANALYSIS:

1. Introduce the TRAINING CURRICULUM MATRIX as a means to determine responsibility and propriety for training task selection. Use O.H.H.O. #10 and O.H.H.O. #11

2. Have group use the TRAINING CURRICULUM MATRIX to sort out responsibility for the "zero order" tasks previously listed. Use O.H.H.O. #12

3. Review O.H.H.O. #13 to review the sources of instructional power associated with Task Analytic Technology.

4. Use O.H.H.O. #14 to show the difference between CONTENT TASK ANALYSIS and PROCESS TASK ANALYSIS.

FILM: "CONTENT TASK ANALYSIS"

1. Use O.H.H.O. #15 to develop awareness of the difference between METHOD and CONTENT.

2. Allow group to complete O.H.H.O. #15 to practice sensitivity to METHOD.

3. Show Film

4. Form 4 task groups, one for each of the four quadrants of the TRAINING CURRICULUM MATRIX. Use of O.H.H.O. #16 each group to brainstorm as many alternative METHODS as possible for each task. Have groups report their product.

HOMEWORK:

Each participant will prepare a CONTENT TASK ANALYSIS for one of the REQUIRED-INSTITUTION, or REQUIRED-COMMUNITY tasks on the matrix. Assign a specific task to each participant. Collect analyses at next meeting.

PREPARING FOR ONE-TO-ONE TRAINING SESSIONS:

1. Explain that as part of this Program, each participant will identify, assess and train a chronic patient to criterion in at least one "zero order" task.

2. Each person must now plan for that process by considering the following factors:

   A. Personal access to chronic patients
   B. Relationships with "ward" personnel
   C. Possible procedural problems
   D. Possible solutions to procedural problems
   E. Strategies for gaining ward active support

FILM: "TRY ANOTHER WAY" (Or "Both Sides of the Street")

1. Introduce Film by saying that we will now see a totall different behavioral approach to training based upon Task Analytic Technology which is proving to be highly effective in developing new competancies.

2. Show Film

3. Ask participants to comment upon differences and similarities between the methods of instruction seen in the two films (Organization of Training Area, Use of Reinforcement, Verbalizations, etc.)

INTRODUCTION TO TASK ANALYSIS:

1. Provide "Paper Folding Activity Sheet" to each participant and run the exercise according to the instructions. Make sure that the "learner" in the application part of the activity does exactly what he/she is told.

2. Explain that the purpose of this activity was to show that even simple tasks are actually rather complex whe you task analyze them to see all that is really requir to produce an expected result.

3. Provide detailed information about "Steps" in a Task Analysis using O.H.H.O. #6 and O.H.H.O. #7

4. Explain that Industrial Engineers use the words on O.H.H.O. #8 and O.H.O. #9 to write their task analyses Suggest that participants get used to using them as we

HOMEWORK:

1. Using the CONTENT TASK ANALYSIS FORMS provided in thei manual, participants will perform a CONTENT TASK ANALY of the following tasks for presentation and review at a subsequent class meeting:

   A. Making a bowl of hot soup using either canned or pouched prepared soups.
   B. Folding a long-sleeved sweater for placement in a drawer.
   C. Washing and drying their face and neck.

2. Find a chronic patient who is unable to perform one or more "zero order tasks". Prepare a task analysis of that task which might be used later in a training program.

Allow time for thinking and then turn into a group activity through discussion of each variable above and recording items discussed on a chaulk board.

HOMEWORK:

Make arrangements to train a chronic patient to criterion in a "zero order" task agreeable to patient, ward staff and participant.

FILM: "CONTENT AND PROCESS"

1. State that it is possible to employ the same METHOD with two very different types of people by varying the steps in the CONTENT TASK ANALYSIS, or by using different PROCESS TASK ANALYSES to teach the same CONTENT. O.H.H.O. #17 to illustrate this point.

2. Show Film

3. Introduce and review O.H.H.O. #18 to present the various components of PROCESS TASK ANALYSIS which will be explored in greater detail later.

INTRODUCTION - CRISIS MANAGEMENT

In this Unit the CDS CURRICULUM addresses the last of the Immediate Needs of individuals returning to less restrictive environments following residential treatment for chronic mental illnesses. Emphasis in this Unit is placed upon linking the individual to the sources of crisis support in the community and preparing the individual to manage problems before they reach crisis stages.

Crisis prevention techniques addressed in this Unit include identification of sources of support, trial visits and establishment of personal contacts within community agencies, increasing awareness of the crisis potential inherent in common situations, and attention to pre-release planning to reduce the probability of early crisis.

The initial hours, days and weeks following return to community living carry the possibility of great stress and crisis. The adjustment demands of transition are great and uncommon experiences in the lives of individuals treated for chronic mental illnesses. Success in avoiding and resolving early crisis increases the probability of long term deinstitutionalization and is a major goal in hospital-community programming.

In this Unit, the trainer will serve as a facilitator to: identify common crisis situations which have caused individuals to return prematurely to residential treatment facilities, identify pre-release activity which can better prepare individuals to avoid or survive those crisis situations, and identify community crisis support networks into which returning individuals might be integrated.

The intent of this Unit is to impact upon the pre-release planning and preparation of individuals to return to the community so as to increase the probability of successful early transition and integration.

CAREER DEVELOPMENT SPECIALIST CURRICULUM : CRISIS MANAGEMENT

TOPIC: "CRISIS MANAGEMENT"

PURPOSE: TO PREPARE MENTAL HEALTH WORKERS TO ASSIST RETURNING INDIVIDUALS TO AVOID, REDUCE AND MANAGE STRESS WHICH MIGHT OTHERWISE THREATEN THEIR READJUSTMENT TO LIVING IN A LESS-RESTRICTIVE SETTING

OBJECTIVES: UPON COMPLETION OF THIS UNIT THE PARTICIPANT WILL:

1. Be able to identify and differentiate between three types of crisis related stress.
2. Be able to survey common community living environments to pin-point likely stress causing elements.
3. Be able to design a progressive series of discussion and role-play situations to prepare returning individuals to avoid, reduce and manage stress.

FORMATS OF EXPERIENCE:

1. Classroom Instruction to:
   - A. Obtain common definitions and categories of stress
   - B. Practice identification of stress types and stress potential in common situations
   - C. Develop a stress management program
2. Individual Experience to :
   - A. Practice use of the stress management lesson
   - B. Assist a person slated for community re-entry to manage one or more potentially stressed situations

PRESENTATION:

WARM-UP: Ask group members to identify the situations and conditions in their work and home-life which cause them to feel stressed. Discuss the situations and how they handle the stress.

Then ask, "What is the difference between a stressful situation and a crisis?" Discuss the answers.

GROUP INSTRUCTION:

A. REVIEW first three overhead/hand-outs.

B. *ASK individuals to categorize the stress they discussed in "WARM-UP" using the classification scheme presented.*

C. *COMPLETE INDIVIDUALLY and DISCUSS in group "Potential Stress Within Common Situations" and "List of Potential Stress-Filled Situations"*

D. *Review the five step sequence on "Preparation to Manage Stress in the Community"*

E. *Have each individual complete "Stress Management Preparation Sequence" and review when completed with another member of the group. Discuss any major questions in large group.*

INDIVIDUAL ACTIVITY:

A. *Use the "Stress Management Preparation Sequence" with one or more persons slated for community re-entry.*

B. *Develop additional materials to use with other persons.*

HOMEWORK: INDIVIDUAL ACTIVITY: *List as many techniques that you know of through which individuals reduce the stress they feel. Then, determine how many of them are available to individuals in the institution. Would use of these techniques in the community by a person known to have been institutionalized attract negative attention?*

GROUP ACTIVITY: *Share the results of the INDIVIDUAL ACTIVITY.*

CRISIS MANAGEMENT

DEFINITIONS:

CRISIS:	AN UNSTABLE OR CRUCIAL TIME OR STATE OF AFFAIRS WHOSE OUTCOME WILL MAKE A DECISIVE DIFFERENCE FOR BETTER OR WORSE
STRESS:	A PHYSICAL, CHEMICAL OR MENTAL FACTOR WHICH CAUSES BODILY OR MENTAL TENSION AND MAY BE A FACTOR IN DISEASE CAUSATION
MANAGEMENT:	CONTROL OVER OUTCOMES

PREPARATION TO MANAGE STRESS IN THE COMMUNITY

A SERIES OF ACTIVITIES BEGINNING WITH DISCUSSION AND ENDING WITH SIMULATION PROVIDE A GRADUAL PROGRAM OF PREPARATION. THE SEQUENCE OF ACTIVITIES IS:

1. DISCUSSION: HOW WOULD YOU FEEL IF . . .

   ONE MORNING A ROOMMATE ACCUSED YOU OF STEALING HIS/HER TOOTHBRUSH AND COMB?

2. CHOICE: CONSIDERING HOW YOU WOULD FEEL, WOULD YOU DO "A" OR "B"?

   A. TRY TO CALM THE PERSON DOWN AND EXPLAIN THAT YOU DIDN'T STEAL THE ITEMS.

   B. FEEL HURT AND WALK AWAY.

3. RESPONSE: CONSIDERING HOW YOU WOULD FEEL, WHAT WOULD YOU DO?

4. SIMULATION: LET'S PRETEND THAT I AM YOUR ROOMMATE AND ONE MORNING I COME RUNNING INTO YOUR ROOM AND SAY, "YOU STOLE MY COMB AND TOOTHBRUSH. GIVE THEM BACK BEFORE I HIT YOU". SHOW ME WHAT YOU WOULD DO.

5. REFLECTION: DO YOU REMEMBER WHAT YOU DID WHEN _____ ACCUSED YOU OF STEALING THE COMB AND TOOTHBRUSH? WHAT DO YOU THINK OF THE WAY YOU HANDLED THAT SITUATION?

STRESS MANAGEMENT PREPARATION SEQUENCE

SELECT A SITUATION WHICH MIGHT CREATE UNDUE STRESS IN A PERSON WHO WILL BE RETURNING TO THE COMMUNITY IN THE NEAR FUTURE. DESCRIBE THE SITUATION BELOW AND THEN PREPARE THE SEQUENCE OF PREPARATORY ACTIVITIES THROUGH WHICH THE PERSON MIGHT PROGRESS.

DESCRIPTION OF SITUATION: _____

_____

_____

1. HOW WOULD YOU FEEL IF . . . _____

_____

_____

_____

2. WHAT WOULD YOU DO? "A": _____

_____

"B": _____

_____

3. WHAT WOULD YOU DO IF . . .

4. LET'S PRETEND THAT _____

_____

_____

_____

_____

_____

SHOW ME WHAT YOU WOULD DO.

5. DO YOU REMEMBER WHEN . . .

IN A SMALL GROUP, ROLE PLAY THE SEQUENCE, TAKE TURNS AND EXCHANGE ROLES.

POTENTIAL STRESS WITHIN COMMON SITUATIONS

Analyze the descriptions of the following situations to isolate possible opportunities for Informational, Social Process, and Reactionary Stress.

1. An individual is residing in an apartment with three other adults who have returned to community life after residential treatment. The parents and nine year old sister of one of the other residents come at dinner time for an unannounced visit.

   INFORMATIONAL STRESS: _____

   SOCIAL PROCESS STRESS: _____

   REACTIONARY STRESS: _____

2. An individual in her third week of community living awakes to find only one dose of medication on hand. She was told that the drug must be taken twice each day if she is to remain "well".

   INFORMATIONAL STRESS: _____

   SOCIAL PROCESS STRESS: _____

   REACTIONARY STRESS: _____

3. A person is continually bothered by a large agressive person who wants "a smoke".

   INFORMATIONAL STRESS: _____

   SOCIAL PROCESS STRESS: _____

   REACTIONARY STRESS: _____

LIST OF POTENTIAL STRESS - FILLED SITUATIONS

Describe 3 situations that might be found in a residential setting which could create each of the three kinds of stress we have discussed:

1. INFORMATIONAL STRESS: _____
2. SOCIAL PROCESS STRESS: _____
3. REACTIONARY STRESS: _____

Describe 3 situations that might be found in a day program setting which could create each of the three kinds of stress we have discussed:

1. INFORMATIONAL STRESS: _____
2. SOCIAL PROCESS STRESS: _____
3. REACTIONARY STRESS: _____

Describe 3 situations that might be found in a reactional activity setting which could create each of the three kinds of stress:

1. INFORMATIONAL STRESS: _____
2. SOCIAL PROCESS STRESS: _____
3. REACTIONARY STRESS: _____

CRISIS MANAGEMENT - APPROACHES

PREVENTION OF CRISIS

1. PLANNING TO MAINTAIN STABILITY
2. PRACTICE IN STRESS REDUCTION
3. PREPAREDNESS FOR SITUATIONAL VARIABLES

RESOLUTION OF CRISIS

1. PRACTICE IN PROBLEM SOLVING
2. PRACTICE IN CONTINGENCY MANAGEMENT
3. PROVISION OF DIRECTION AND SUPPORT

TYPES OF CRISIS RELATED STRESS

1. INFORMATIONAL STRESS

IS EXPERIENCED BY THE INDIVIDUAL WHEN A PARTICULAR PIECE OF KNOWLEDGE OR INFORMATION IS CALLED FOR BY THE ENVIRONMENT AND IS UNAVAILABLE FOR APPLICATION BY THE INDIVIDUAL.

EXAMPLES: HOW TO MAKE THE WASHING MACHINE WORK.
HOW TO USE A PUSHBUTTON PHONE.
HOW TO COMPLETE A MEDICAL ASSISTANCE APPLICATION.

2. SOCIAL PROCESS STRESS

IS EXPERIENCED BY THE INDIVIDUAL WHEN AN ACCEPTED SOCIAL RITUAL IS REQUIRED BY THE ENVIRONMENT WHICH CAN NOT BE APPLIED BY THE INDIVIDUAL.

EXAMPLES: HOW TO ASK A STRANGER TO LET YOU PASS BY.
HOW TO RESIST A HIGH-PRESSURE SALESPERSON.
HOW TO PARTICIPATE IN A GROUP ACTIVITY.

3. REACTIONARY STRESS

IS EXPERIENCED BY THE INDIVIDUAL WHEN CALLED UPON TO PROCESS THE REACTION OF ANOTHER PERSON OR GROUP TO A PERSONAL ACTION (INITIATORY OR REACTIVE).

EXAMPLES: HOW TO RESPOND TO THE ANGER OF OTHERS.
HOW TO RESPOND TO A DISPLAY OF AFFECTION.
HOW TO RESPOND TO INDIFFERENCE.

Part 2

Colorado: The Integration of Therapy and Case Management

A program for employees with clinical skills to teach case management skills and the integration of case management and therapy.

Lecturette and exercise phases of the instructional material on Comprehensive Clinical Service

5. Lecturette 2

Start: 11:20 A.M.

End: 11:45 A.M.

Time Required: Lecture - 12 minutes, Drill and Questions - 13 minutes = 25 minutes

Materials: Table 6 for Ps, transparency of table 6 for trainer.

Content: Comprehensive clinical service to the chronically mentally ill adult in the community.

Therapy (definition and examples)

Case Management (definition and examples)

Instructions: This phase of training is similar in format to part 3, i.e., trainer lecture with interspersed participant drill.

Outline of Content:

A.1. Comprehensive services-goal: to help client solve "the problem"- i.e., to help client meet needs in community in most independent setting possible.

Trainer-Stress: (1) Use of general concept gives overall perspective to daily decisions

(2) Model is about individual client direct service, not C & E, program development, affiliation agreements. That is, not about system level activities

A.2. Comprehensive Service - composed of 2 sub-classes of activities, distinguished by goals, what they aim to change.

stress: of equal importance

a. Therapy: Goal is client behavior change and growth.
Directed at primary and secondary disabilities.

All treatment included here: chemo - } therapy
behav. mod. } therapy
rehab. } therapy
psycho - } therapy

They help client meet needs independently by making client more able.

b. Case Management: Goal is to improve client's relationship to resource network

Directed at restructuring and changing this relationship, so that client's access is improved - easier, more effective, more independent

Attacks barriers and counterforces in the service network

Trainer-stress: Each category has both assessment and intervention aspects (to be covered in P.M.)

Open up to questions at this point.

*Refer Ps to Table 6 in their packets and project transparency of table 6

B. Explanation of Table 6 - specific types of therapy and case management and examples

1. Organizing principle: a. Therapy - client change techniques
   b. Case management - resource network change, a change in client's access or relationship to it.

2. 4 types of therapy: a. Psychotherapy: - explore conflicts and stress, stress management
   - therapeutic relationship
   - ego-supportive: counseling and guidance
   b. Provision of organization, structure, scheduling
   c. Coordinate psychiatric interventions
   d. Basic skills teaching

3. 2 types of case management: a. Resource mobilization/access - linking, referral, arranging
   b. Management of resources - cf. milieu therapy.
   Structure resources to encourage growth (May involve blocking access to overly dependent resource.)

DRILL Get Ps to speak from own experience, giving examples of the 4 types of therapy and 2 types of case management } get 1 example from each category

Trainer - stress: Ways these interventions increase client's ability to meet needs in most independent setting possible.

Examples T can use are in text (verbatim) version of lecturette

Verbatim lecturette: Lecturette 2 as usually delivered by the authors is included verbatim on the following pages for convenient reference.

Table 6. Therapy and Case Management Activities for the Severely or Chronically Mentally Ill Adult

Therapy: (Definition: Interventions with the client aimed at the client's personal behavior change and growth).

1. Psychotherapy:
   a. Explore areas of stress and conflict, relationship of stress to client's level of ego functioning, and foster development of alternative coping styles ("stress management"). Help client achieve insight about nature and dynamics of disorder.
   b. Provide emotional support and reassurance. Through development of relationship, foster self concept changes. Help client develop a sense of mastery and identity.
   c. Support reality testing and "secondary process" thinking. Counsel, give advice, "lend client your ego", set limits, model and teach problem solving skills, support productive problem solving approaches.
2. Provide structure and organization:
   Help client schedule and maintain a pattern of productive activity to meet goals.
3. Coordinate Provision of more intensive psychiatric modalities:
   Somatic therapies, 24 hour care, involuntary procedures.
4. Rehabilitate:
   Teach, model, foster development of interpersonal skills (assertiveness, social practices, etc.),domestic skills (cooking, shopping, cleaning, etc.), money management skills, personal care skills (diet, medical grooming, etc.), vocational skills and leisure time and recreational skills.

Case Management: (Definition: Interventions directed at changing the psychosocial milieu or resource network, or client's relationship to it, so that client's access to resources is improved)

1. Facilitate resource access: Find appropriate resources, apprise client, refer, accompany if needed, provide client with necessary information, contact resource, ("arrange" for services) help client with application procedures and forms, advocate for client if necessary ("linking").
2. Structure and coordinate the resource network: Advise, consult and make recommendations regarding client's characteristics and needs, and regarding the treatment plan or approach for client. Be available for joint problem solving. Manage services and resources so as to avoid fragmentation, competition and overlap.

Lecturette 2 - Comprehensive Service to Chronic/Severely Ill Clients, Therapy, Case Management

Now we have a clear, relatively simple analysis or formulation of the problem of the chronically mentally ill adult in the community. We've also has some practice using these concepts in talking about actual clinical situations, the kinds that confront us daily. So let's move on, now, to consider what we can do in these situations to help the client.

Comprehensive Service: Our model that we're exploring today is a way of systematizing the process of what we call comprehensive service to or comprehensive care for the chronically mentally ill. The goal of this process derives directly - and simply - from the formulation of the problem as we've covered it. The goal is to assist individual clients to meet their needs in the community as independently as possible. We think it's good to start with this kind of simple, general concept so as to be able to keep one's overall goal clearly in view at all times. You can then derive your intervention strategies from this general principle according to your formulation of needs, of the environment or community, of independence, of what would be helpful, and so on.

We'd like to stress here that we are talking about work with individual clients, or work on behalf of an individual client. We're not talking about program development, like setting up a residential facility, and we're not talking about "C & E", like public speaking to make the community more aware of the needs of clients, or even about developing community support networks - making affiliation or liaison agreements, etc. These kinds of system level intervention or changes are very important and we don't mean to imply any devaluing of them by excluding them from today's discussion. But they are simply not what we will be focusing on today.

17.

We view the process of comprehensive service delivery as being composed of two types of activity. One way to distinguish them is by their goals, that is, by what they aim to change. They are of equal importance.

Therapy: The first one I'd like to cover is what we call therapy. The goal of the assessment and intervention strategies in what I call the therapy domain is the client's personal behavior change or client growth. Going back to the formulation of the problem of the client earlier today, we can see that the therapy process, or therapy part or aspect of the process, is directed at assessment or identification of primary and secondary disabilities, and at helping the client overcome these or change them. Activities such as psychotherapy, behavior modification, rehabilitation, and chemotherapy all belong here, in our system, because all these activities have the same goal - client change. They help the client access resources more independently by making the client less disabled. We'll go over some specifics later.

Case Management: In contrast, the other sphere or domain of clinical activity is what we call case management. In this domain what we're trying to do is to assess and change the client's relationship to the psychosocial milieu. We want to change this relationship so that the client's access to resources in it is improved - made easier, made more effective, or more independent. Case management then, facilitates or structures the client's relationship to resources and services. In terms of the schematic formulation of the problems of the client, then, case management attacks the second set of barriers or counterforces to client independence - or barriers to access to resources - those in the social system (or service network - or psychosocial milieu): The bureaucratic problems - fragmentation, overlap, entry paperwork, regulations - the lack of "start up" resources - problems with the family - and generally with social attitudes, beliefs and expectations about your client. It's these kinds of things, as they impinge on your individual client,

that the activities of case management are directed at assessing and changing.

These two classes of assessment and intervention, we contend, pretty much cover the field of what clinicians can do to help clients on the individual, "direct service" level. Here again, though, I'd like to highlight something. You may have noticed we keep slipping in the word "assessment" before "intervention". That's because we think of assessment activities themselves as being either of a "therapy" type or a "case management" type. We want to make it clear that assessment is always assessment <u>for</u> something, that it's very purposeful, very goal directed. So we have assessments for therapy and assessments for case management. We'll go over this more this afternoon. Are there any questions here? (Take questions here)

<u>Discussion of Table 6</u>: The way we've listed the types of interventions <u>within</u> the two parts (therapy and case management parts) of this table is not really sacred - it's just a way we broke things out - into 4 therapy areas and 2 case management areas. The most important feature to note now is the organizing principle, the distinction between therapy and case management. All the therapy activities are client change techniques or processes, and all the case management activities are directed at the resource network and the client's access or relationship to it.

Anyway, the way we have broken the two categories down in this table, what you have in therapy are four sorts of activity that we think can be distinguished. First is what would traditionally be called psychotherapy, which includes some exploration of conflict and stress, that is, some insight into what kinds of events or situations make the client do worse and better, and some stress management. It also includes the development of the therapeutic relationship giving the client some status as a valued individual. In the third category we're stressing the ego - supportive aspect of most psychotherapy with this population. That is, you provide a lot of support for the

reality principle - the difference between thought and action and do some actual guidance and counselling kinds of moves - you do give advice.

Next, we think therapists must be willing to provide some kind of time and life structure when it's needed. Clients often seem to lack the ability to organize their lives, to maintain a purposive pattern of activity to get what they need done.

Third, the therapist has to be the one to call for and coordinate psychiatrists' work (if the therapist isn't one). We hope this is self evident: The decision to ask the psychiatrist to intervene is always based on therapeutic judgement and knowledge of the particular therapies the psychiatrist can provide.

Finally, all the basic skills teaching - which so often is given "second class" status by people who call themselves "therapists" - comes in here, in the fourth category. We sometimes think we ought to put this first to give it more status, but the order isn't really indicative of anything here. Besides we wouldn't want to shock anyone.

Now, as case managers, it seems we do two main kinds of things. First, we do a lot of resource mobilization or resource access work - "hooking up", "linking", "referral", "arranging for services" are the "buzz" words here. Second, we also do some very complex, sophisticated and subtle management of these resources and services. In this capacity, we're in fact operating like milieu therapists, I think, with the community as milieu. We're trying to change and structure the resource network to meet our client's needs for growth - that is, to help the client get needs met in the most independent setting possible. An important point to note is that sometimes this may even involve denying or blocking access to a more dependent resource (like a hospital) while opening the channel to a more independent one (like a sheltered apartment). Another example might be encouraging the parents to get the client out of their house while you're helping him look for an apartment, or for a job.

Let's get some more concrete examples of the kinds of things listed in the table (Table 6) and how they help clients. I'd like to have you draw, here, on your personal experience with clients. (Trainer may wish to use the following, or a comparable, example: As an example of therapy, specifically, psychotherapy I could mention some work with a client who came in, initially in a very mixed up paranoid state, really exhibiting almost "word salad", but he got over this pretty well with meds. But a large part of my energy then went into psychotherapy. The client wanted to feel less oppressed - he always felt ashamed or that people looked down on him. He was Black, incidentally. He always was feeling that dealing with the Social Security Administration was very humiliating. Yet, his grooming was just awful, and as a result, he really looked sort of like a clown or a tramp. To me, his appearance simply invited degradation, and thwarted his chances of getting a job and hence getting away from the oppressive (and regressive and dependent) Social Security system - even though I was pretty sure he could work. He had also developed some pretty off-the-wall ideas - not really psychotic, just unrealistic - about starting some environmentally oriented political movement. He was putting a lot of energy into this. I told him, pretty much right out, two things: First, that I thought he was wasting his time with this political idea, and second that as long as he dressed like a clown or bum he would be treated as one and never get a job. This was in the context of a pretty close relationship, and I think probably the main reason he "cleaned up his act" and worked on his grooming was to please me. But he still did do it, and also started looking for a job. It took several months but eventually he did get a job in a commercial laundry. He was quite pleased with himself about all this. So this is an example of what I mean in the table under psychotherapy - specifically types "b" and "c" - and how you use it to help the client be less disabled.)

(Have P's give examples to be sure concepts of therapy and case management are clear. Reinforce two notions here, first, therapy/case management definitions and dichotomy, second, how the interventions P's bring up can be viewed as fitting into the schema (reducing disabilities or changing the resource network or client's relationship to it). Try to cover each category with at least one example. If examples do not flow freely, Trainer can continue to prompt by referring to categories in table and asking, or by giving more specific examples: (1) chemotherapy to reduce a female patient's manic excitement, thus enabling her to return to living with her husband and children. (Therapy type 3). (2) Client who has been unfairly treated by Social Security is referred to public legal services who help client go to court and get benefits re-established. (case management type 1). (3) Case manager asks vocational rehabilitation workshop to set higher standards for client who is becoming bored with tasks she is currently doing well. (Case management type 2)).

6. Exercise II (The Case of John, continued)

Start: 11:45 A.M.

End: 12 Noon

Time required: 15 minutes

Materials: Previously completed transparencies (Mark-ups) of Tables 1, 2 and 4 from Exercise I, Newsprint and felt pen

Purpose: To give participants experience in proposing therapy and case management interventions for a simulated clinical situation (John)

Instructions: Ask P's to recall the case of John, specifically, his

1. primary disabilities
2. secondary disabilities
3. resource network problems

They are to propose specific therapy or case management interventions for these problems.

Encourage use of table 6 for classification of interventions.

Encourage idea that interventions are specific to problems, and that they are designed to help client move across the resource continua.

Don't ask for a treatment plan, an organized approach, just for discrete interventions.

A more structured approach is to project transparencies with group's "Mark Ups" of tables 1, 2 and 4 which were done in Exercise I to stimulate and organize discussion.

Encourage openness, not "right/wrong" approach. Idea is to use concepts, not to propose perfect treatment.

Encourage P's to propose interventions even if they're not sure they'd succeed.

T or Co-T may record group's productions on newsprint.

Discussion points:

Trainer: You may find it best to start with reminder of John's primary disabilities. What would help his thought disorder? Encourage explcration of other techniques, additional to medications - support of reality sphere, provision of reality feedback. Agitation - could list initiation of supportive emotional relationship. Belligerence - could mention setting limits.

Resource problems: Lack of start up resources provides opportunity for a variety of case management moves: How to get $ until SSI is transferred is most likely place to start. T could also point out that to do CM, John will probably need to sign information release forms. How to engineer this, given his paranoia, is good therapy exercise. Other case management springs from need to deal with criminal justice system - pressure for hospitalization, inability to communicate with lawyer. Suggestion: have P's deal with possibility that John could be managed in hospital alternative, and explore what case management needs to be done with judge. Use of residential alternatives: view as both treatment (helps manage symptoms) and case management (provides food and shelter). What kind of case management and what therapy would P's propose for John's pattern of not engaging in aftercare/followup? Could propose: closer linkages (CM) guided participation or modelling (T).

Longer-term therapy interventions: teach work skills, independent living skills.

As intermediate step towards work - could propose partial hospitalization modality or day-programming - to build pattern of structure and organization. How would P's suggest beginning to build this in the 1st week?

Self-concept problems: What (therapy) interventions would be useful to begin to combat John's idea that he "can't make it on his own?" Might suggest that his participation in the service delivery process - in each intervention - be maximal construe his behavior as "purposive". How to cut through pattern of not following through, regressing, acting out, and getting back to hospital? Would be a factor in a decision (therapeutic decision) not to hospitalize. Would P's entertain idea of treating client in jail to help cut through this process? Or working with judge to structure a short jail stay contingent on treatment and no further acting out?

Comment:

Throughout exercise, maintain attitude and group norm or exploration, openness, and non-judgemental approach. It is not so much a matter of whether P's propose the "right" interventions, but that the concepts of therapy and case management are being used, and the idea that interventions are problem-directed.

**Note: Over lunch break, T must tabulate responses to Pre Quiz (I and II) for afternoon's review. See #7 (below) for details of tabulation.

VIGNETTE 1--TRAINING VERSION

Case of John--Assessment stage only

John is a 23 year old single man who has been brought to the Mental Health Center by a sheriff's deputy from jail where he was lodged last night. He has been arrested and released three times in the previous week for sleeping in the park. However, on his most recent (4th) arrest yesterday, he became agitated, belligerent and scuffled with the officers who contacted him, claiming they were "angels of God". He was jailed overnight.

When he appeared the next day before the judge, he was described as irrational, voicing loosely connected, sometimes contradictory ideas about a "Holy conspiracy" of which he was both a member and a victim. His defense attorney seemed genuinely puzzled. The judge ordered him brought to the Mental Health Center for "evaluation and hospitalization". The court will pay for evaluation in a hospital.

Mike is the worker on Intake. He reviews the judge's order. Also, the sheriff's deputy has the following information obtained by the jail staff, in addition to a description of what went on in court. John is from upstate New York. He has been in Boulder ten days. He apparently hitchhiked to Boulder, although he was apparently trying to get to San Francisco. He reports he has been hospitalized "many times" for mental illness, "chronic indifferent type". He is on SSI and Medicaid in New York and has $25 cash from his last check. He has never worked. His family now refuse to have anything to do with him because he's "irresponsive". When asked why he was sleeping in the park even though it was raining, he said it had been "revealed as the thing to do". He eats only vanilla milk shakes from the Red Barn for what he refers to as "spiritual reasons". He feels he is "immune from disease" - also for spiritual reasons - at least until "the Father disposes" of him. He had asked for "something for sleep" and the jail nurse had had the on-call jail physician prescribe 100 mg. Thorazine, which John said he had had "many times" in the past when he was "edgy" as he has been lately.

Mike interviews John. John is intermittently quite delusional and makes it amply clear that he has hallucinations and thought insertion: He feels the police are controlling his thoughts electronically. He also feels the municipal citations he has gotten for his illegal acts are a message that he is about to be "eliminated" because they are "yellow, the color of urine". Although at times Mike is able to calm John, and in fact take a moderately good history, at other times he is agitated, standing up and pacing about the interview room. He is quite d ressed with the interference with his thinking.

Mike discovers that this is not the first time John has been arrested, but is in fact one of a number of quite similar charges, for minor, but highly visible disturbances. He has spent over 50% of his time since age 18 in hospitals, with over ten admissions. When discharged, he is placed in a boarding home. He is given, at discharge, appointments at an aftercare clinic near the boarding home. However, he rarely goes to the appointments because he "doesn't like strangers" and feels the people at the clinic "don't care about" him or really want to help him. He has no friends or acquaintances outside the boarding home. Daily activities there are limited to watching TV. Eventually he runs out of medication, which even now in his psychotic state he admits helps keep his "mind clear and moods mellow". A short time later, usually within two months of discharge, he has a run-in with the police, a judge orders him evaluated and he is rehospitalized.

He has mixed feelings about hospitalization. He likes his freedom, but he also likes the social contact, attention and activities that come as part of hospitalization. He feels the hospital staff care about him.

His repeated admissions to hospitals, though, have led him to feel he "can't make it" on his own and that he is compelled to live "between heaven and hell" (though it is unclear exactly what this means). But, he says, it was "revealed" to him after he ran out of medicine last time that he should go to California and that there was a "mission" for him there.

Since arriving in Boulder, he has felt increasingly isolated, frightened and intimidated by people. He did not want to contact any social agencies, even though the police had suggested this to him and even given him a ride out to the Mental Health Center after his first arrest, because he

felt the New York mental health system has "set up" the people in Colorado against him - though he did not tell the police about this idea.

Mike asks John about the medication he took the previous night. He reports it had only a slight effect. He questions whether this was "real" medication. But he is willing to try it "one more time only" if he can be sure it's "real".

Part 3

Florida: Management and Supervision in Mental Health Setting

A comprehensive program to teach principles of management and organization and the skills needed for their application in many specific supervisory functions and settings.

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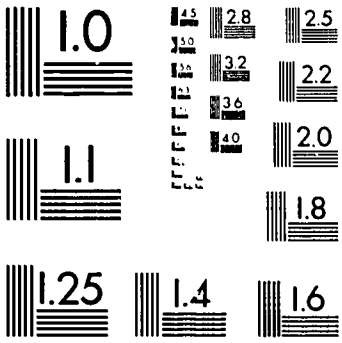

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APPENDIX F

BEHAVIOR MODIFICATION TRAINING

Outline of Objectives

Texas: The material includes the training objectives for four modules in the Texas training program. The first is required of entry-level workers in order to be promoted to the next level. The next three must be successfully conpleted within six months after promotion.

11303 INTRODUCTION TO BEHAVIOR THERAPY (BT-I)

Goal:

The participant will learn enough about behavior therapy to begin training clients.

Objectives:

1. Define behavior therapy and state three reasons why it is important.
2. Define behavior and explain how it differs from thoughts and feelings.
3. Identify 20 behaviors while observing a client (or videotape).
4. Define frequency and duration data and give three examples of each.
5. Define "reinforcer."
6. Identify presumed reinforcers having the intended effect, no effect, and an unintended effect.
7. From a description of clients and their behaviors, select reinforcers appropriate for each.
8. State three ways to increase the effectiveness of a reinforcer.
9. Describe a prompt to teach a behavior and describe how to fade the prompt.
10. Describe the shaping technique for a "spoon-to-mouth" task.
11. Define each of the following techniques to get rid of unwanted behaviors and stae which require approval: teaching incompatible behaviors, extinction, simple correction, withdrawal of privileges, time out, and aversive procedures.

The following goals and objectives for BT-II, BT-III and BT-IV, represent the minimum Behavior Therapy Training requirements for MHMR Services Assistants during the first six (6) months following appointment to that classification as defined in Commissioner's Memorandum dated June 1, 1981.

Prerequisites include satisfactory completion of the probationary period and successful demonstration of required MHMR Aide Trainee and MHMR Services Assistant competencies.

12103 OBSERVING AND MEASURING BEHAVIOR (BT-II)

Goal:

The participant will learn how to define, observe, record and evaluate behavior.

Objectives:

1. State three reasons why observing and recording behavior is important.
2. Define and select a measurable behavior and count the number of times it occurs.
3. Given three behaviors, name the appropriate method of data collection for each.
4. From the data collected in objective two, label and plot points on a graph.
5. State two reasons why baseline data are important and state two rules of baseline data collection.
6. Read graphs of behavior therapy programs and state whether or not the programs are working.

12104 HOW TO INCREASE BEHAVIOR (BT-III)

Goal:

The participant will learn how to increase appropriate client behaviors.

Objectives:

1. Define primary and secondary reinforcers.
2. From a description of clients and their behaviors, select appropriate reinforcers.
3. List four important things in making sure that a reinforcer is effective.
4. Define continuous reinforcement and intermittent reinforcement; explain what ratio schedules and interval schedules are.
5. Define shaping and explain the circumstances in which it should be used.
6. Given a description of a client and a target behavior, specify at least four steps in shaping the behavior.
7. Define backward and forward chaining and give three examples of behaviors that might best be taught by the technique of chaining.
8. Describe how to introduce prompts in a step-by-step fashion of increased assistance in a skill training program.
9. Describe how to fade prompts.
10. Define generalization and state four ways of increasing the likelihood of generalization and maintenance of behavior change.

12105 HOW TO DECREASE BEHAVIOR (BT-IV)

Goal:

The participant will learn to decrease inappropriate client behaviors.

Objectives:

1. List three ethical issues involved in the use of behavior therapy to decrease behavior.
2. Define differential reinforcement of incompatible behavior (DRI) and differential reinforcement of other behavior (DRO) and explain how these techniques may be used to decrease behavior.
3. Define stimulus change, satiation and extinction and explain how these techniques may be used to decrease behavior.

APPENDIX G

ASSESSING THE NEED FOR AND ARRANGING COMMUNITY SUPPORT SERVICES

Description of Objectives

Indiana: The following material is from the Mental Health Technician basic training program. The two modules included are part of a series on Client Advocacy Skills; Three modules preceding these deal with defining advocacy, combatting prejudice, and defending client rights.

Area: Client Advocacy Skills

Module: Taking Action

Time Estimate: 3 hours

Description: This module presents a systematic method for advocating. This approach includes: needs assessment, identification of resources, strategy, and follow-up. This method will enable the MHT to advocate effectively and efficiently in many different problem situations. This material is presented in context of promoting self-advocacy, the ultimate goal of all advocacy activities.

I. Goal: The MHT will be familiar with a basic method of advocacy which will enable him/her to work effectively in problem situations.

Objectives:
1. The MHT will describe the components of an advocacy action plan.
2. The MHT will apply the basic components of needs assessment.
3. The MHT will demonstrate an ability to gain client commitment to an action plan.
4. The MHT will explain the importance of resources and indicate their general use.
5. The MHT will describe the process of preparing a plan for action.
6. The MHT will discuss the importance of follow-up.

II. Goal: MHTs will be able to use their advocacy skills in practical situations and in context of self-advocacy.

Objectives:
1. MHTs will evaluate client advocacy situations in terms of the components of an action plan.
2. MHTs will demonstrate their advocacy skills by identifying and acting upon a real need situation in their facility.

Equipment: Large, paper pads and felt-tip markets (optional)

Material:

1. Sturgeon, Suzanne, et al., Advocate! A Manual on the Rights of the Developmentally Disabled, The Indiana Protection and Advocacy Service Commission for the Developmentally Disabled, Indianapolis, Indiana, 1980.

   This booklet includes a basic guide for planning for action. It partially fulfills Goal I.

2. Way To Go, University Park Press, Baltimore, Maryland, 1978.

   This book includes information concerning preliminary planning for advocacy activities as well as an approach to action. This partially fulfills Goal I.

3. Rude, C.D. (ed.), Action Through Advocacy, A Manual for Training Volunteers, Research and Training Center for Mental Retardation, Texas Tech University, Box 4510, Lubbock, Texas 79409, 1980.

   This book includes an exercise in resource identification. It partially fulfills Goal I.

Area: Client Advocacy Skills

Module: Using and Improving Community Resources

Time Estimate: 1 hour, 45 minutes

Description: MHTs can encourage client self-advocacy by serving as a link between the client and needed community resources. In this module, MHTs will gain skills as representatives of their agency with the public. Most importantly, MHTs will learn to identify community resources that are needed by clients to be independent so that they can refer clients and other advocates to those agencies. As client advocates and community members, MHTs must also be involved in the continual effort to improve community resources so that clients will have less difficulty functioning independently. In this module MHTs will be introduced to issues of community change by experiencing a planning process.

I. Goal: MHTs will learn to be public representatives at their agency so that they may inform the public and other advocates accurately.

Objectives:
1. MHTs will be able to explain the purpose of the agency.
2. MHTs will be able to identify services provided, and state limitations of service.
3. MHTs will be able to represent the agency and its services positively.
4. MHTs will be able to give accurate information about eligibility for and availability of services.

II. Goal: MHTs will understand the community in which they serve in order to take into account community circumstances when advocating and providing service.

1. MHTs will be able to demonstrate awareness of the unique social characteristics of the community and the region.
2. MHTs will be able to identify the sociocultural, economic, and political influences within the community.
3. MHTs will be able to identify the major social policies and other means employed to deal with community concerns.
4. MHTs will be able to analyze these social policies and assess their impact upon mental health service.
5. MHTs will be able to identify gaps in existing policy and/or social programs.

III. Goal: MHTs will be able to identify formal and informal resource networks in order to refer clients, other advocates and the general public to the most appropriate resource.

Objectives:
1. MHTs will define formal and informal resources.
2. MHTs will identify formal social service resources that are relevant to the team's practice.
3. MHTs will provide accurate information concerning eligibility for and availability of services provided by these agencies.
4. MHTs will develop a personal resource bank of agencies and other community resources including a file of contact persons.
5. MHTs will locate individuals, groups, and organizations that can serve as resources yet lie outside the formal social service network.
6. MHTs will identify the resources used most often by the segment of the community of direct concern to the team.

IV. Goal: MHTs will be able to apply community planning skills when challenged to allocate and improve community resources to demonstrate community planning ability.

Objective:
1. MHTs will simulate a community planning and resource allocation activity.

Equipment:
Audio cassette
Filmstrip projector

Material:

1. Sturgeon, Suzanne, et. al., Advocate! A Manual on the Rights of the Developmentally Disabled. Indiana Protection and Advocacy Commission for the Developmentally Disabled, Indianapolis, Indiana, 1980.

   Pages 46-81 of the Manual provide forms for the start of a personal community resource bank (Goal III. Objective 4).

2. "Community Resources and Relations," Life Project, 1976. Waisman Center, University of Wisconsin, Madison, Wisconsin.

   This self-instructional booklet describes types of community resources and suggests procedures for using them effectively.

3. Tracy, M. et. al., Impact: Planning Regional Services (Simulation), Indiana University Developmental Training Center, Bloomington, Indiana, 1976.

   This simulation challenges the players to reach consensus regarding allocation of community resources when there are different perspectives and opinions about the problems.

APPENDIX H

TRAINING SUBJECT CATEGORIES USED TO ANALYZE CONTENT OF TRAINING PROGRAMS

Health and Personal Care

- emergency--CPR, first aid, etc
- body mechanics for transfer
- infection control
- bathing, feeding, etc
- health care vital signs
- care and use of equipment

Violent/Assaultive Behavior

- prevention, protection, control
- use of restraints, policy

Medications

- pharmacology psychotropic drugs
- medication observation

Observation, Recording, Communications

- observation techniques
- recording skills/policy
- filing

Case Management Treatment Planning

- problem identification
- problem solving/treatment plan
- teaming - introduction, roles, policy
- teaming - group skills
- monitoring and evaluating treatment
- preparation for transfer

Theory and Knowledge Base

- human development
- sociocultural
- personality theory
- introduction to mental health
- classification of mental illness
- psychotherapy theory/methods
- sexuality
- mental health services - agency
- mental health services - system

Treatment Skills

communication/empathy skills
interviewing--general
therapeutic counseling
group counseling
counseling--substance abuse
counseling--family members
crisis intervention--suicide, etc.
behavior modification
teaching skills--general
activity therapy
independent living/ADL training
other training
referral/developing community support

Administration

general management/planning
supervision
hiring
orientation and training

Other

confidentiality
patient rights
advocacy
patient safety--fire, etc.
orienting new clients
working with volunteers
community meetings

APPENDIX I

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