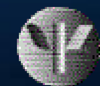
APA Recovery to Practice Curriculum

Instructions for Delivering the Curriculum



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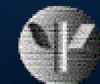
Background

- People with serious mental illnesses (SMI) can and do recover from the devastating effects of these illnesses
- Psychologists are crucial to helping individuals achieve recovery and attain a satisfying and productive life, BUT
- Psychologists do not receive the specialized training needed for this work in existing training programs
- This new curriculum is intended to fill this void
- The curriculum is aimed at training psychologists in the concepts and practices needed to assist those with serious mental illnesses recover and attain their full functional capacity
- The overarching goal of the APA Recovery to Practice Curriculum is to provide doctoral level psychology students with:
  - Knowledge of the concept of recovery from severe mental illness and
  - Knowledge of rehabilitation assessments and evidence based and emerging practices to assist individuals with severe mental illnesses to achieve their goals and full potential. These are known as psychosocial rehabilitation (PSR) interventions



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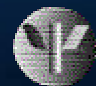
Background, cont'd

- SAMHSA awarded APA a contract to develop a training curriculum in recovery principles and psychosocial rehabilitation practices for the profession of psychology
- The curriculum was developed in 2011 – 2012 and pilot tested in 2012 – 2013
- The curriculum has 15 topical modules; each is based on the latest scientific literature
- Each module reviews the literature, includes a short learning quiz, and includes a learning exercise designed to reinforce the content of the module
- The curriculum provides training for psychologists in the latest assessment and intervention methods for this population
- The curriculum is being released to doctoral programs, internship and post doctoral training sites

Curriculum Modules

- Instruction Module
- 1. Introduction to Recovery
- 2. Recovery, Health Reform and Psychology
- 3. Assessment
- 4. Partnership and Engagement
- 5. Person Centered Planning
- 6. Health Disparities
- 7. Interventions I
- 8. Interventions II
- 9. Interventions III
- 10. Forensic and Related Issues I
- 11. Forensic and Related Issues II
- 12. Community Inclusion
- 13. Peer Delivered Services
- 14. Systems Transformation
- 15. Scientific Foundations



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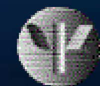
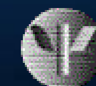
Incorporating Consumers as Teachers

- It is important that individuals who have experienced serious mental illness are incorporated into the delivery of each of the curriculum modules.
- It is strongly encouraged that consumers be an integral part of the teaching experience. This can be accomplished through:
  - Having consumers serve as co-trainers
  - Inviting consumers to classes to be guest speakers
  - Showing films or other media that have been produced for teaching the experiences of consumers



Important Considerations

- In order to ensure adequate preparation and support for participants, it may be important to provide advance training and after class debriefing, especially where issues related to trauma have been raised and discussed.
- Everyone should note the importance of establishing an environment where everyone feels comfortable and safe sharing information.
- Confidentiality must be assured for all information that is shared and any discussions that take place.
- No personal information should be shared with anyone who is not part of the class and discussions about personal information that may have been disclosed in the class should not occur outside the classroom.
- Information that is shared should never be used to affect an individual's status in the program.



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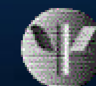

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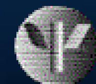
APA Recovery to Practice Curriculum

1. Introduction to Recovery

Introduction to Recovery Based Psychological Practice

- Historical Context
  - Until the mid-1970s, conventional wisdom regarded a serious mental illness as a deteriorating, debilitating disease
    - Repeated hospitalizations
    - Focus on symptom reduction
    - Power was in the hands of the provider
    - Recovery from serious mental illness was thought NOT possible
- We now know recovery and return to a satisfying life is possible with appropriate rehabilitation interventions



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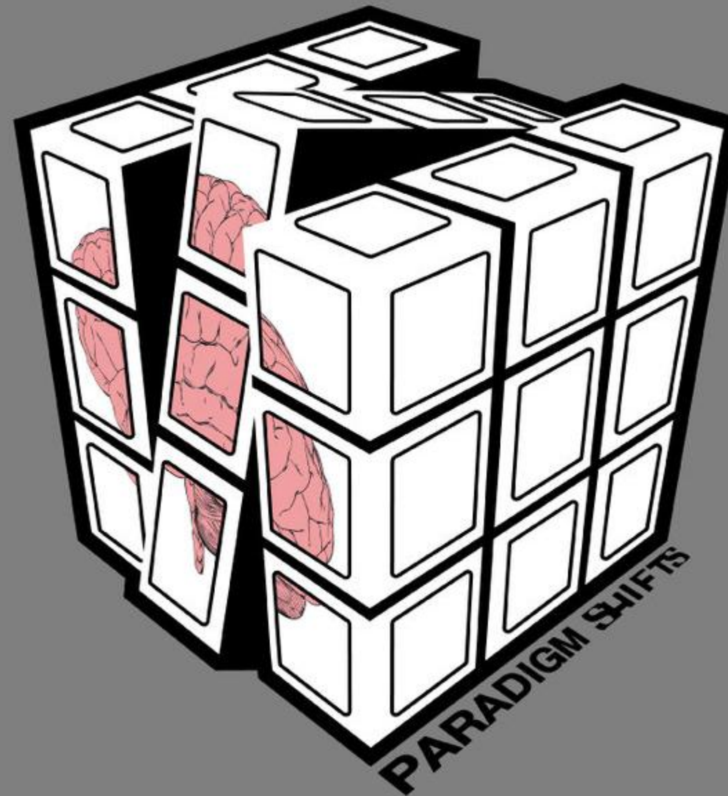
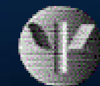
Introduction to Recovery Based Psychological Practice

- Evolution of the Recovery Movement





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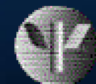
Introduction to Recovery Based Psychological Practice

- What is Recovery?

  "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2012)

  "Recovery is what people with illnesses and disabilities do" (Anthony, 2002)

  "Treatment, case management, support and rehabilitation are the things that practitioners do to facilitate recovery" (Anthony, 2002)



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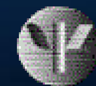
Introduction to Recovery Based Psychological Practice

- 10 Guiding Principles of Mental Health Recovery

1. Self-Direction
2. Individualized and Person-Centered
3. Empowerment
4. Holistic
5. Non-Linear
6. Strengths-Based
7. Peer Support
8. Respect
9. Responsibility
10. Hope



Introduction to Recovery Based Psychological Practice

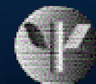
- Challenges

Mental Health System

- Practitioners have low expectations of individuals with serious mental illnesses
- Practitioners are not appropriately or adequately trained re symptoms and behaviors
- Lack of knowledge of effective interventions

Person with Serious Mental Illness

- Stigmatizing diagnoses that imply permanent disability or impairment
- Recovering from iatrogenic effects of mental health treatment system
- Detrimental effects to one's relationships, ability to learn or work, self-esteem, identity and confidence



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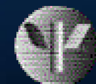
Introduction to Recovery Based Psychological Practice

- Steps
  - Recognize and embrace the philosophy of recovery
  - Get training in effective psychosocial rehabilitation interventions
  - Move from deficit-based to asset-based perspectives
  - Ensure that each individual is the decision maker for his or her own service delivery: “Nothing about us without us!”
  - Ensure community and social inclusion



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2. Recovery, Health Reform and Psychology

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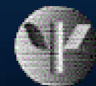
The Recovery Movement: Role of Psychologists and Health Care Reform

- Psychologists at the Evolution of the Recovery Movement
  - Visionaries
    - Beginning in mid-1970s, psychologists began writing about and researching the concept of recovery from a serious mental illness
    - Psychologists with lived experiences contributed in developing the concept of recovery
  - Research Shows
    - Between 46% - 75% of persons recover from a serious mental illness and successfully contribute to the community



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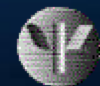
The Recovery Movement: Role of Psychologists and Health Care Reform

- Contributions
  - Both psychologists and individuals with serious mental illnesses have worked together to:
    - Lead efforts to conduct research on recovery outcomes
    - Develop and test instruments to assess functional skills
    - Develop and test rehabilitation interventions to assist the recovery process
    - Work with State and Federal governmental agencies to promote and facilitate the recovery process



The Recovery Movement: Role of Psychologists and Health Care Reform

- Traditional versus Recovery Oriented Roles of Psychologists as
  - Clinician
  - Researcher
  - Program Manager
  - Administrator / Policy Maker
- The roles are the same but the way psychologists function in those roles is very different!

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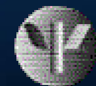
The Recovery Movement: Role of Psychologists and Health Care Reform

- Examples of Health Discrepancies for Persons with a Serious Mental Illness
  - One in four uninsured adult Americans has a mental disorder, substance use disorder, or both (National Alliance on Mental Illness and National Council for Community Behavioral Healthcare, 2008)
  - On average, adults with a serious mental illness die 25 years sooner than those who do not have a mental illness (National Association of State Mental Health Program Directors Medical Directors Council, 2006)



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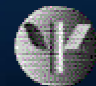
The Recovery Movement: Role of Psychologists and Health Care Reform

- Examples of Health Discrepancies for Persons with a Serious Mental Illness
  - In 2002, mental illness and substance use disorders led to $193 billion in lost productivity – more than the gross revenue of 499 of the Fortune 500 companies – and by 2013, this figure is estimated to rise to more than $300 billion (Kessler, 2008)
  - Almost one in four stays in U.S. community hospitals involved depression, bipolar disorder, schizophrenia, and other mental health and substance use disorders (Agency for Healthcare Research and Quality, 2007)
- Health care reform legislation was absolutely necessary!



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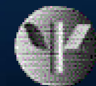
The Recovery Movement: Role of Psychologists and Health Care Reform

- Health Care Reform: Affordable Care Act (ACA), 2010
  - Immediate Benefits for People with a Serious Mental Illness:

- Individuals may be a part of their integrated primary care or behavioral health care team
- Underinsured and uninsured populations will have access to general medical care
- Access to affordable psychotherapy and psychiatric services which typically have been difficult to obtain, especially with pre-existing condition
- Ability to insure children under their parents' plans until the age of 27
- Employers can no longer deny coverage to individuals with serious mental illnesses



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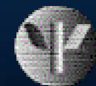
The Recovery Movement: Role of Psychologists and Health Care Reform

- ACA and Opportunities for Psychologists
  - Person-centered integrated treatment models that integrate psychologists into primary care, e.g., medical homes
  - Ability to provide most appropriate interventions on time
- Increased use of evidence based medicine
  - Demonstrate value of interventions through outcomes
  - Must design, deliver, and evaluate interventions for greater public reimbursement



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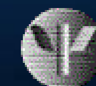

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3. Assessment

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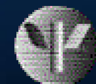
Assessment

"The cornerstone of any good treatment plan is a thorough assessment of a person's strengths and weaknesses"

(Silverstein, 2000)



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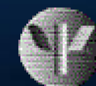
Assessment

"… every individual, no matter how severe the person's illness might be, has the capacity to continue to learn and develop." (Davidson, et al., 2008)

- Skills
- Talents
- Personal virtues & traits
- Interpersonal skills
- Knowledge gained from adversities, occupational or parenting roles
- Cultural knowledge
- Family stories
- Spirituality



Assessment

Traditional Clinical Assessments

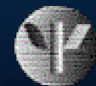
- Psychiatric diagnosis
- Problematic symptoms and behaviors
- Failures in social, educational & vocational pursuits
- Difficulties in life

Strengths Based Ecological Assessments

- Cultural knowledge
- Family stories
- Spirituality
- Knowledge gained from adversities, occupational or parenting roles

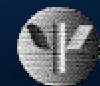
Assessment

- Components of a Strengths Based, Ecological & Functional Assessment
  - Continual process of seeking information
  - Information gathered from several life domains
  - Cultural influences are incorporated
  - Focused on positive aspects of a person's life
  - Develops skills and resources needed to facilitate recovery



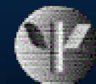
Assessment

- Strengths Based Assessment:
  - Approaches each person from the standpoint of determining:
    - Capabilities
    - Accomplishments
    - Potential
  - Considers positive factors in the person's surrounding environment:
    - Natural support network (family strengths, community supports, social service system network)
    - Each person has the potential for future accomplishments that will facilitate continuing to attain the life he or she wishes to achieve



Assessment

- Some Questions to Ask:
  - What do you call your challenge and what caused it?
  - What are you most proud of in your life?
  - What is one thing you would NOT change about yourself?
  - What are the most important things to you when deciding where to live?
  - With what cultural group(s) do you identify?
  - What kinds of things have you liked learning about?
  - What are your hopes and dreams for the future?
  - Have you ever been treated inappropriately or in ways that were harmful to you?
  - What are the things that matter most to you?



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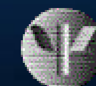

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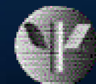
4. Partnership and Engagement

Engaging People as Partners

- The Need to Engage People with Serious Mental Illnesses in the Service Delivery System
  - Improve access to services
  - Potential to minimize the effect of crises
  - Potential to benefit from the expertise people have about the illness and need for services
  - Potential therapeutic benefits
  - Advantages of having people with lived experience involved with prioritizing and conducting research
  - Benefits of involvement in staff selection and training



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Engaging People as Partners

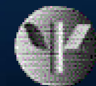
- Reasons People are Reluctant to Engage the Mental Health System

From the System Itself:

- Prior negative experiences and possible trauma

From the Individual:

- Severity of illness
- Multiple social barriers:
  - Poverty, homelessness, criminal history, ill physical health, social stigma, poor social skills, and social isolation. Need wide range of services



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Engaging People as Partners

- Historical and Cultural Barriers
  - Immigrant Populations
    - Language barriers
    - Social stigma of Behavioral Health problems / Religious beliefs on the origin of mental illness
    - Cultural beliefs and practices related to decision making
    - Distrust of authority / Previous abuse from those in authority
  - African Americans
    - Distrust of authority and systems
    - History of slavery and discrimination
    - Poverty
    - Poor education systems
    - High incarceration rates for young males

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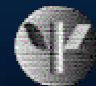
Engaging People as Partners

- Overcoming Barriers Through Assertive Outreach
  - Components of Assertive Outreach
    - Meeting the person on his or her own terms, including times and locations
    - Offering a range of services, including crisis intervention
    - Identified person available 24 hours per day
    - Risk management approach that offers safety
    - Pay attention to social factors
    - Supported access to mainstream services
    - Peer support and encouragement
    - Offering daytime activities
    - Treating persons as equals with dignity and respect
    - Help with finance and benefits
    - Finding suitable accommodations



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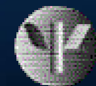
Engaging People as Partners

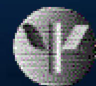
- Benefits of Partnering with People with Serious Mental Illnesses

- Minimizing the effects of crises
- Determining which services are best
- Potential therapeutic benefits
- Research participation



Engaging People as Partners

- Challenges
  - Cultural factors
  - Lack of services and resources for individuals
  - Lack of system commitment
  - Lack of training for psychologists and other professionals
  - Threatening the expertise of psychologists



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5. Person Centered Planning

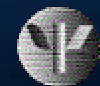
Person Centered Planning

- Concept of Person Centered Planning

- The individual with lived experience is in the driver's seat
- Based on seeing and working with people in a completely different manner
- Balance of power is shifted and decision making is shared
- Individuals are fully integrated into the communities of their choice

Person Centered Planning

- What Does Person Centered Planning Mean?
  - The right to make choices for oneself is a fundamental human right:
    - Not contingent on freedom from symptoms
    - Every person has the right to be involved in, and make decisions about services received, how and where to live, with whom to associate, etc.
    - Person centered planning is the operationalization of respect for a person's right to make these choices



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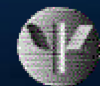
Person Centered Planning

- Importance of Culture
  - Culture impacts substantially on the planning process, decisions about services, and recovery process:
    - Religious views
    - Beliefs about mental illness - its etiology and its acceptability
    - Views regarding a person's right to make choices as opposed to having those choices made for him or herself
    - Language barriers affect ability to communicate the many important facets of a person's life and background
  - All impact the planning process and recovery outcome



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Person Centered Planning

- Concept of Person Centered Planning

Person Centered Planning

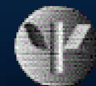
- Challenges

Mental Health System

- Providers tend to resist change and find reasons (excuses) for maintaining the status quo
- Lack of willingness to change attitudes, biases and beliefs about individuals with serious mental illness
- Inability to adapt to new way of providing services

Person with Serious Mental Illness

- Individuals are reluctant to ask for, or are not ready to participate in services
- May not be able to identify desired goals
- Uncomfortable with making choices and translating needs and wants into supporting services



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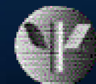
Person Centered Planning Process

INITIAL MEETING	• Get to know the individual • Start to build a relationship • Ask: Who would you like involved in this process?
ASSESSMENT	• Strengths & Challenges • Community / Environmental Resources • Current Living Situation / Current Mental Health Status
CREATING THE PLAN	• Initiated by the individual with lived experience • Goals / Objectives • Interventions
EVALUATING PROGRESS	• Led by the Person Served • Reviewing Progress / Updating Plans • Alterations as needed
MAKING TRANSITIONS	• Individual indicates a readiness to move • Planning occurs as needed / wanted by individual



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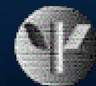
Person Centered Planning

- Keys to Person Centered Planning
  - The individual with lived experience and the person's key supporters are the most important decision makers in the process
  - Cultural factors must be addressed in the planning process
  - Collaborative and interdisciplinary teams are necessary
  - Organizations must shift the way individuals with serious mental illnesses are viewed at every level of the system - no more "Us versus them" philosophy!



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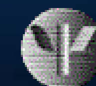

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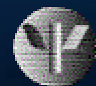
6. Health Disparities



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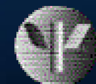
Health Disparities

- Important Facts
  - On average, people with serious mental illnesses die 25 years earlier than do people without these disorders
  - Higher rate of unnatural deaths attributed to:
    - Suicide
    - Accidents or injuries from violence
    - Traumatic events
    - Poorer health care
  - Excess rate of death from natural causes is primarily attributed to smoking and obesity



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Health Disparities

Smoking

- More severe the mental illness, the higher the prevalence of smoking
  - Therapeutic effects of smoking
  - Normalize deficits in sensory processing
  - Relieve side effects of psychotropic medications
  - Reduction in stress and anxiety

Obesity

- Prevalence of obesity far higher than the general population
  - Poor nutrition
  - Cognitive deficits
  - Poverty
  - Iatrogenic effects of medication

Health Disparities

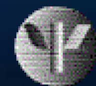
- Increased Mortality for Persons with Serious Mental Illnesses: Unnatural Factors

Suicide

- 9-10 times more at risk for suicide than the general population
- Most at risk within 90 days after discharge from a hospital, especially for a first time discharge
- The risk of suicide is greater after the first episode of psychosis

Violence

- Persons with serious mental illnesses are at increased risk of being victims of violence
- Greater for individuals experiencing their first episode of psychosis



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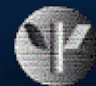
Health Disparities

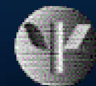
- Treatment Disparities for Communities of Color

- Less access to mental health services than non-minorities
- Often receive care that is poor in quality
- Physicians' attitudes can be different from those held about people from majority culture
- Those with serious mental illnesses may have less willingness or ability to seek treatment and/or fill prescriptions



Health Disparities

- Psychologists Must Be Aware:
  - Considerable health disparities for persons with serious mental illnesses
  - Smoking and obesity are key factors in producing health disparities for persons with serious mental illnesses
    - Psychologists should encourage people with these conditions to remain in smoking cessation and weight loss intervention programs
  - Health disparities for persons with serious mental illnesses are entwined disparities for persons of color
  - There are systematic reasons within the United States and mental health systems that produce health disparities (lack of insurance, practitioner bias, etc.)



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7. Interventions I

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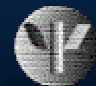
Interventions I: Guiding Principles and Integrated Framework

- Underlying Principles
  - Successful provision of services depends on:
    - Belief that recovery will occur
    - Empathic genuine, trusting relationship
    - Involvement of, and partnership with, people with serious mental illnesses in decisions about their health care
    - Culturally relevant services
    - Gender specific services for trauma
    - Recognition of need to provide services to meet goals identified by person
    - Identification of skills and resources needed for successful living



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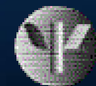
Interventions I: Guiding Principles and Integrated Framework

- Principles identified by SAMHSA's National Consensus Conference:
  - Recovery emerges from hope
  - Recovery is person-driven
  - Recovery occurs via many pathways
  - Recovery pathways are highly personalized
  - Recovery is non-linear
  - Recovery is holistic
  - Recovery is supported by peers and allies
  - Recovery is supported through relationship and social networks
  - Recovery is culturally-based and influenced
  - Recovery is supported by addressing trauma
  - Recovery involves individual, family, and community strengths and responsibility
  - Recovery is based on respect

Substance Abuse and Mental Health Services Administration. (2006). National Consensus Conference



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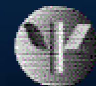
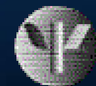
Interventions I: Guiding Principles and Integrated Framework

- Culture
  - Mental health problems among non-white, minority cultural groups can be great
  - Cultural discontinuity and oppression have been linked to high rates of depression, alcoholism, suicide, and violence in many communities
  - Lack of culturally and linguistically appropriate services has been reported as a reason for the failure to access services by non-majority groups
  - Many culturally distinct groups do not speak frankly about problems and may speak in metaphors or use less descriptive words to describe their life situation or problem



Interventions I: Guiding Principles and Integrated Framework

- Women
  - Service needs of women are often very different than those of men
  - Most women with serious mental illness have experienced severe abuse and trauma
    - Specially trained professionals are required
    - Trauma services must be provided in a safe environment and in women only groups
  - Homeless women are more vulnerable than homeless men and often have children to care for and worry about



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8. Interventions II

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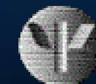
Interventions II: Evidence Based Practices

- Psychosocial Rehabilitation (PSR) Services: What are they?
  - From a scientific viewpoint (what works), there are three categories of PSR services:
    - Evidence Based Practices (EBP)
    - Promising Practices
    - Supporting Services

- While distinct as far as the evidence that supports them, components of the practices and services are sometimes present across the categories

Interventions II: Evidence Based Practices

- Before We Begin
  - People with serious mental illnesses want the same as you and I want:
    - Work, friends, home, family, leisure activities, to be accepted
  - Research has determined that certain interventions work, i.e., help people achieve the things they want for themselves – substantial body of research evidence
  - When delivered as designed and researched – fidelity is extremely important!
- These interventions are now the gold standard for helping people with serious mental illnesses to recover from the effects of their illness and regain their maximum functional capability



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Interventions II: Evidence Based Practices

- EBPs Build Skills & Resources to Achieve Goals
  - Assertive community treatment
  - Supported employment
  - Cognitive behavioral therapy
  - Family-based services
  - Token economy
  - Skills training
  - Concurrent disorders interventions
  - Psychosocial interventions for weight management
- EBPs must be implemented with fidelity to the researched practice!

(Dixon, L. et al. (2010). The 2009 Schizophrenia PORT Psychosocial Treatment Recommendations and Summary Statements. Schizophrenia Bulletin, 36, 1, 48-70)

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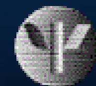
Interventions II – EBPs: Assertive Community Treatment

- Assertive Community Treatment (ACT)
  - The most well known and researched EBP
  - The model has been tested in countries all over the world and found to be effective
  - ACT is the most intensive case management service for those with serious mental illness
  - Cornerstone of effective community services for people who need support to remain out of hospital
  - Requires multidisciplinary team: 10 – 12 staff for 100 clients
  - Team members pool knowledge - no professional hierarchy
  - Staff respond in community 24/7 and adjust services as needed
  - Team meets daily to discuss each person & responds accordingly
  - Services adjusted quickly when necessary
  - Types and length of service depend on needs of client
  - Reduced recidivism is the outcome



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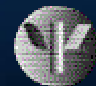
Interventions II – EBPs: Supported Employment

- Supported Employment (SE)
  - One of the most researched EBPs
  - Focus on competitive employment
  - Rapid job searches
  - Jobs tailored to individuals
  - Case load 1 vocational specialist / 25 persons
  - On-going support
  - Time-unlimited follow-along supports
  - Integration of vocational and mental health services
  - Real world jobs
  - Zero exclusion criteria (that is, no one is screened out because they are not thought to be ready)



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Interventions II – EBPs: Family Psychoeducation

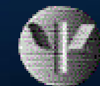
- Family Psychoeducation
  - Family psychoeducation is one of the most researched EBPs
  - Essential elements:
    - Provide information about clinical treatment
    - Teach coping skills that family members can use as needed
    - Consumer and family are partners in provision of services
    - Provide educational workshops
    - Teach skills building for community re-entry
    - Provide social and vocational skills training
    - Should be at least 6 – 9 months in duration
  - Outcomes include:
    - Reduced hospitalization rates
    - Higher rates of employment among those who participated
    - Improved family member well-being, decreases in negative symptoms, and decreased costs of general medical care

Interventions II – EBPs: Cognitive Behavioral Therapy

- Cognitive Behavioral Therapy (CBT)
  - CBT is a combination of:
    - Cognitive therapy (teaches rational thinking)
    - Behavior therapy (teaches skills)
  - Can be offered individually or in groups
  - Goals:
    - Help people think more rationally, and
    - Act differently based on more rational thinking
  - CBT is not aimed at eliminating symptoms
    - CBT helps people manage symptoms by learning to challenge their irrational thoughts and act differently. Rather than "making the demons go away", it helps people learn to "manage the demons"
  - Should be 4 – 9 months in duration
  - Like other EBPs, often improves symptomatology
  - A form of psychotherapy, must be provided by trained clinicians

Interventions II – EBPs: Skills Training

- Skills Training
  - An application of behavior therapy
  - Not aimed at reducing symptoms but at helping people live with their illness and its symptoms in a more functionally adaptive way
  - Applicable to any area of life where better skill performance will help a person function more effectively
  - Can include any area where better skill performance is desired:
    - Social interactions
    - Educational settings, work settings
    - Communication and assertiveness
    - Skills for personal care, independent living, community integration
  - Behavior shaping involves:
    - Didactic instruction
    - Modeling of behavior
    - Systematic practice & reinforcement of desired behavior until criteria is met



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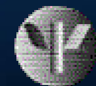
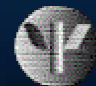
Interventions II – EBPs: Token Economy

- Token Economy
  - Token economy interventions are <u>only</u> appropriate for long term care or residential settings
    - Used when behavioral improvement in daily living skills is needed, i.e., for specific problem behaviors
    - Based on social learning principles where an intermediate reinforcement (something that can be redeemed later for a desired object, such as a token) is provided contingent on performance of an identified behavior
  - Behaviors that token economy interventions are often designed to improve include:
    - Personal hygiene
    - Social interaction
    - Behaviors adaptive for living in a long term care / residential setting



Interventions II – EBPs: Token Economy

- Token economies have been used successfully in institutional settings for several decades and there are many studies that support the efficacy of this highly effective intervention
- Must be provided in a safe treatment environment
- Fidelity to the EBP is essential and includes:
  - Substantial investment in staff training prior to initiation of the program
  - Careful and sustained supervision of all staff throughout the full duration of the intervention
- Punishment is NEVER employed



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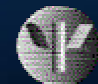
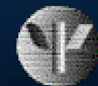
Interventions II – EBPs: Integrated Dual Diagnosis/Concurrent Disorders Treatment

- Co-occurring Disorders
  - Substance use disorders frequently co-occur with serious mental health disorders
  - Range is from 27% to more than 60% (much higher in forensic populations)
  - Use of psychoactive substances exacerbates the symptoms of mental illness and can impede treatment
  - Treatment is most effective when the treatment for both disorders is integrated and offered by one provider who is knowledgeable about both disorders
  - Motivational Interviewing (MI), a specific form of psychotherapy, has been identified as a helpful component of concurrent disorders treatment



Interventions II – EBPs: Integrated Dual Diagnosis/Concurrent Disorders Treatment

- Key Elements of Integrated Dual Diagnosis Treatment Are:
  - Knowledge about the effects of alcohol and drugs and their interactions with mental illness and the medications that are used to treat mental illnesses
  - Integrated services provided by the same clinician / clinical team
  - Stage-wise treatment provided as individuals progress over time through different stages of recovery
  - An individualized treatment plan that addresses both the substance use disorder and the person's mental illness
  - Motivational Interviewing to help the individual develop awareness, hopefulness, and motivation
  - Coping skills training
  - Strategies to maintain engagement in treatment
  - Relapse prevention



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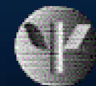
Interventions II – EBPs: Weight Management Interventions

- Weight Management and Serious Mental Illness
  - Many newer anti-psychotic medications, especially Olanzapine and Clozapine, cause weight gain and an increase in body mass index (BMI)
  - Due to effects of medications, controlling appetite and losing weight are very difficult
  - Substantial weight gain can lead to serious health problems:
    - Musculoskeletal disorders
    - Arthritis
    - Insulin resistance
    - Metabolic syndrome
  - Metabolic syndrome – very serious condition:
    - Much more prevalent in people using anti-psychotic medications
    - Can lead to increased risk of type 2 diabetes, heart attack and stroke

Interventions II – EBPs: Weight Management Interventions

- Weight Management and Serious Mental Illness
  - Interventions appear to have greatest chance of success when delivered at the beginning of medication treatment
  - Goal setting, regular monitoring of results, ongoing support, and provision of feedback are important
  - Maintenance of weight loss and reduced BMI have not been consistently shown – very difficult for people on psychotropic medications!
  - Due to the critical importance of maintaining normal weight, interventions for weight management should be an essential component of the PSR continuum of services available to all clients

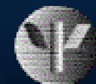


Interventions II: Essential Provisions for Evidence Based Practices

- Fidelity
  - When providing a service that has been shown to be effective, it is extremely important to provide the service exactly as it was developed and researched
  - When the service is not provided with fidelity, the provider is not providing the same service
  - The provider is essentially providing a new, untested service
  - There is no reason to believe that the new, untested service will work
  - However, because providers and service delivery systems often call the new, untested intervention by the same name as the one that has evidence to support it, a serious dis-service is done to clients and to the field because in most cases, the revised (often limited) intervention fails to provide any benefit to the client, i.e., it has no effect
  - This causes distrust among clients and administrators and often leads to a future unwillingness to provide researched services

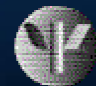
Interventions II: Essential Provisions for Evidence Based Practices

- Appropriately Trained Staff
  - Many EBPs and promising practices require certain clinical skill sets for the service to be provided appropriately
  - Without this knowledge and expertise, the service will not be provided as it was intended to be and as it was researched, i.e., determined to be effective
  - Although many clinicians are trained in some components of each of the practices, many are not trained thoroughly in all of the components of any practice
  - On-going continuing education and supervision are essential for all staff who provide clinical services



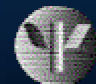
Interventions II: Essential Provisions for Evidence Based Practices

- Integration and Coordination of Services
  - Ideally, one person or one team is responsible for providing *all* services to any given individual
  - Most often this is not the case. The classic example is mental health services which are almost universally separate from substance abuse services
  - When services are not integrated and coordinated by one provider or one team, they are usually fragmented, often work against each other, sometimes have conflicting goals, and many times become a destructive force which impedes rather than facilitates, recovery for the individual
  - Although a systems issue, it impacts directly on the effectiveness of individual services



Interventions II: Essential Provisions for Evidence Based Practices

- Services Tailored to the Wishes and Goals of Each Person
  - Services should only be provided when:
    - The person expresses a desire for services
    - The person has set one or more goals for him/her self
    - A comprehensive rehabilitation assessment of capabilities and resources has been completed
    - The person has indicated a willingness to begin the rehabilitation process
    - Services should be tailored to the wishes and goals the person has set for him/her self and based on the rehabilitation assessment



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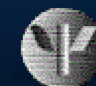

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9. Interventions III

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Interventions III: Promising Practices

- Those practices or services that have a body of research to support them but not sufficient evidence to be designated an EBP
  - The PORT study designated four interventions as promising:
    - Medication Management or Adherence
    - Cognitive Remediation
    - Psychosocial Treatments for Recent Onset Schizophrenia
    - Peer Support/Peer-delivered Services

**Dixon, L. et al. (2010). The 2009 Schizophrenia PORT Psychosocial Treatment Recommendations and Summary Statements. Schizophrenia Bulletin, 36, 1, 48-70*

Interventions III: Promising Practices

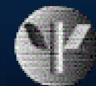
- Important New Findings
  - An integrated approach combining multiple interventions within a recovery oriented context, targeted to the unique needs of each individual including those in the justice system, may be the most effective approach
  - Increasingly clear - cognitive impairment is at the heart of functional skill deficits
  - Social cognition approaches needed for improving community functioning
  - Integrated approaches should include cognitive enhancement approaches as a fundamental component
- Including cognitive remediation "may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone" *(Pinkham & Harvey, 2013)*

Interventions III – Promising Practices: Medication/Illness Management

- Medication/Illness Management
  - Programs combine teaching people how to manage their illness to achieve their own recovery goals
  - The strategies taught are a subset of those in several EBPs and promising practices
  - Client concerns and preferences must be an integral part of the process
  - Common Elements:
    - Education about mental illness, treatment, and wellness strategies
    - Management of medication dosage and side effects
    - Strategies to increase medication adherence
    - Building social support (family, friends, peers)
    - Relapse prevention/frequency reduction
    - Coping with stress
    - Coping with symptoms (cognitive behavioral strategies)
    - Getting one's needs met in the mental health system

Interventions III – Promising Practices: Cognitive Remediation

- Cognitive Remediation
  - Neuropsychological functioning is often negatively affected, resulting in impaired thinking ability and an inability to function well in social, educational, and work settings
  - Cognitive remediation can improve neuropsychological functioning and life skills outcomes especially when delivered in conjunction with other PSR interventions
  - Programs generally provide computer assisted training sessions aimed at improving learning, memory, attention, concentration, and executive functioning
  - Behavioral shaping is used, targeting the following neuropsychological functions:
    - Attention and concentration
    - Memory
    - Planning
    - Monitoring one's work & making adjustments based on feedback



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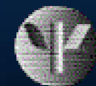
Interventions III – Promising Practices: Early Psychosis Interventions (EPI)

- Early Psychosis Intervention
  - Most frequent onset of serious mental illness: between 15 and 26 years of age
  - Warning signs can appear as early as 6 or 7 – prevalence of warning signs increases with age
  - Age of typical onset is during a critical developmental period for learning social and vocational skills and for educational progress and attainment
  - Suicide risk is much higher:
    - During first episode
    - Immediately following release from hospital
    - Especially for those not receiving treatment

Interventions III – Promising Practices: Early Psychosis Interventions (EPI)

- Increasing Evidence
  - There is a critical period which occurs soon after manifestation of symptoms where intervention is important to minimize the effects of the illness
  - Young people with psychotic symptoms often experience delays in assessment and treatment
  - Treatment effects are not sustained beyond the intervention period and continued intervention may be needed especially during what is considered the five year critical period from onset of symptoms
  - The longer an individual remains without treatment after evidencing psychosis, the poorer the long term outcome
  - Reducing treatment lag leads to better long term outcomes
  - Early intervention improves overall outcomes



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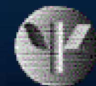
Interventions III – Promising Practices: Early Psychosis Interventions (EPI)

- Early Intervention Programs Generally Include Multimodal PSR Interventions
  - CBT
  - Family based psychoeducation
  - Illness management
  - Educational and vocational interventions
  - Case management
  - Pharmacotherapy
  - An assertive approach to treatment



Interventions III – Promising Practices: Peer Delivered Services

- Peer Delivered Services
  - Participation of consumers in the design, delivery, and evaluation of mental health services is a hallmark of a mental health system that truly supports recovery
  - People with serious mental illness consistently say support of others who have gone through what they are going through is one of the most important & helpful services - focus of considerable research to determine if there is enough evidence to include it as an EBP
  - Peer services are provided by individuals with serious mental illness who have recovered sufficiently to help others who have similar illnesses
  - Peers listen, share their own experiences, offer support, hope, encouragement, and practical suggestions

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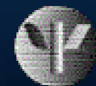
Interventions III – Promising Practices: Peer Delivered Services

- Types of Peer Delivered Services:
  - Peer led self help interventions, may include telephone lines
  - Peer operated and managed services
  - Traditional services, i.e., case management by peer providers in the mental health system
  - Peer support, individually or groups, in or outside the system
- Despite the many benefits of peer delivered services, some potential challenges exist including:
  - Role conflict and confusion
  - Potential for dual relationships
  - Risk of violation of confidentiality
- Training & resolution of personnel issues is crucial



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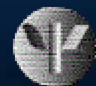
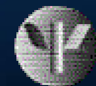
Interventions III: Important Provisions for Delivering Promising Practices

- Services Designated as Promising Should be Delivered:
  - With fidelity
  - By appropriately trained staff
  - Integrated and coordinated with other services
  - Tailored to the wishes and goals of each person



Interventions III: Supporting Services

- In addition to the EBPs and promising practices, there are several services that support people with SMI and help them achieve a healthy and satisfying life. These are often called supporting services and are part of a comprehensive system of services for people with serious mental illness
- Supporting services are those that have achieved some consensus among people with lived experience and service providers as helpful for achieving recovery
- These services are sometimes the subject of research to determine their effectiveness
- Provision of EBPs, promising practices, and supporting services in an integrated PSR model has been shown to improve the functional capability of individuals with serious mental illnesses and improve outcomes across a broad spectrum of domains when compared with standard care



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Interventions III: Supporting Services

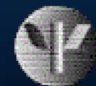
- Services Generally Agreed as Helpful and Supporting Are
  - Motivational Interviewing*
  - Supported Housing
  - Supported Education
  - Trauma Informed Care**
  - Smoking Cessation
  - Health Education
  - Clubhouse and Drop-in Center Models
  - Leisure Services
  - Personal/Daily Life Services
  - Gender Specific and Culturally Informed Services

** Evidence based for addictions work*

*** Trauma services are critically important especially for women, require adequate training, and often must be provided in women only groups*

Interventions III – Supporting Services: Motivational Interviewing

- Motivational Interviewing (MI)
  - MI focuses on empathy, an interpersonal relationship, and reinforcing talk of change in each client
  - MI is non-confrontational and non-judgmental
  - Highly effective in helping people make difficult behavioral changes, especially those associated with addictive disorders
  - Uses a stages of change model
  - MI is a form of psychotherapy and requires specific training in MI strategies

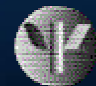


Interventions III – Supporting Services: Interventions for Trauma

- Trauma Interventions
  - Factors influencing development of a trauma related disorder:
    - Include age at which the trauma occurred with children being most vulnerable
    - Emotional resilience
    - Socio-economic status
    - Severity of the traumatic event
  - Estimates of those who have experienced or witnessed trauma and develop a traumatic reaction range from 27 to 74%
  - Alcohol and drug abuse commonly occur with a trauma related disorder – concurrent treatment is important
  - Pharmacotherapy can be an important component to reduce the anxiety, depression, & insomnia often experienced with trauma reactions & PTSD, making it possible for individuals to participate in treatment
  - Trauma interventions are specialized psychotherapeutic interventions & require specialized clinical expertise, provided in a safe environment.

Interventions III – Supporting Services: Interventions for Trauma

- The Most Effective Interventions for People who Have Experienced Trauma Utilize:
  - Exploration of feelings in a safe environment
  - Education
  - CBT
  - Exposure
  - Coping skills for anxiety - breathing retraining, biofeedback, cognitive restructuring
  - Managing anger
  - Preparing for stress reactions - stress inoculation
  - Handling future trauma symptoms
  - Addressing urges to use alcohol or drugs when trauma symptoms occur - relapse prevention
  - Communicating and relating effectively with people - social skills/family relationships



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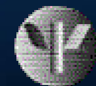
Interventions III – Supporting Services: Interventions for Trauma

- Serious Mental Illness and Trauma
  - Many individuals with serious mental illness have experienced severe trauma
  - Trauma can be from prior events unrelated to the illness, BUT
  - Many individuals also experience significant trauma at the hands of the treatment system
  - Experiencing a psychotic episode for the first time can be highly traumatic and can lead to full PTSD or to PTSD symptoms. The trauma can be from terror experienced as a result of the psychotic symptoms or from experiences encountered in the treatment system, or both
  - People with serious mental illness who are homeless, especially homeless women, have very high rates of trauma



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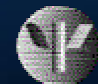
Interventions III – Supporting Services: Interventions for Trauma

- Trauma and Women
  - Up to 97% of homeless women with mental illness experienced severe physical and/or sexual abuse; 87% experienced this abuse both as children and as adults
  - Due to their increased vulnerability and poverty, women are more likely to be unable to control sexual situations and may be more often exposed to HIV/AIDS and other sexually transmitted diseases
- Women - Very Different Treatment Needs than Men
  - Women that have been abused by men will be unable to work through those issues in a mixed group - a mixed trauma group can exacerbate their trauma
  - Services offered in women only groups are essential for women who have been abused both to help them recover and to avoid exacerbating their trauma



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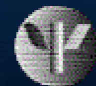
Interventions III – Supporting Services: Supported Housing

- Supported Housing
  - Having decent, stable, affordable housing of one's choice is the first step toward achieving recovery – Housing First
  - Providing stable housing decreases homelessness
  - Supports needed are often provided within an ACT program
  - Case management and treatment for concurrent substance use are important components of supported housing
  - Often individuals need support and skills training:
    - How to avoid losing their home and how to find a new home if needed
    - Skills for managing their home



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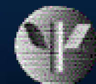
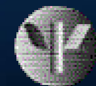
Interventions III – Supporting Services: Supported Education

- Supported Education
  - Assisting people with serious mental illness to continue their education is increasingly recognized as vital to their recovery and ability to resume a normal life:
    - Young people whose education was interrupted
    - Adults wishing to obtain additional education
  - Supported education programs help consumers gain knowledge and confidence
  - Process helps people with serious mental illness return to education to achieve their learning goals and/or become gainfully employed in the career of their choice
  - Communication and collaboration between all stakeholders is vital



Interventions III – Supporting Services: Supported Education

- Supported Education Programs
  - Have a supported education team or specialist designated to work with consumer-students
  - May offer preparatory assistance and options
  - Offer support and assistance to acquire necessary resources for school attendance
  - No non-educational eligibility requirements for entrance into the program
  - Supported education specialist completes educational assessments with consumer-students



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Interventions III – Supporting Services: Smoking Cessation

- People with Serious Mental Illness Have Higher Prevalence Rates of Smoking
  - Smoking rates may be as high as 80 – 90 percent in this population compared to prevalence rates of 20 – 30 percent in the general population
  - People with serious mental illness and concurrent substance use disorders consume 44% of cigarettes sold and smoke more per day
- Recent Nicotine Research Suggests
  - Psychotropic medications and nicotine have interactive effects on cognitive functioning – for people with these illnesses, nicotine appears to normalize the deficits in sensory processing, attention, cognition and mood
  - Nicotine may also offer some relief from the side effects of psychotropic medications because smoking decreases blood levels of these drugs

Interventions III – Supporting Services: Smoking Cessation

- Research Indicates that Several Factors are Common to Successful Smoking Cessation Programs:
  - Advice to quit given by a physician
  - Nicotine pharmacotherapy (both over the counter and by prescription)
  - Counseling that is both long term and intensive
  - A supportive public health environment and approach
- Due to the high prevalence and negative health effects, smoking cessation programs are an essential service for those with serious mental illnesses

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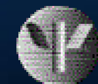
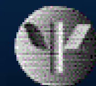
Interventions III – Supporting Services: Health Education

- Health Education
  - People with serious mental illnesses are often vulnerable to sexual exploitation and abuse, with women being most vulnerable
  - Information about safe sex, HIV/AIDS, other STDs, risks of drug injection, safe injection practices, and other more general health information, is considered an essential service
  - Access to general health and dental care is important because many people with serious mental illness do not obtain health and dental care due to stigma, inability to pay, and importance of attending to other priorities before accessing health care



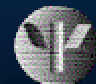
Interventions III – Supporting Services: Clubhouse Model

- Clubhouse Model
  - Fountain House: first PSR intervention developed in New York in 1948 – many others, including ACT and SE, are based on the clubhouse model
  - The model now includes housing supports and links to mental health and substance abuse treatment
  - Essential daily activities include
    - Providing individuals with serious mental illnesses opportunities to participate in the work activities of the clubhouse itself :
      - Administration and outreach
      - Hiring, training and evaluation of staff
      - Research on the effectiveness of the clubhouse



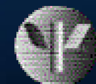
Interventions III – Supporting Services: Clubhouse Model

- Studies Have Found:
  - Clubhouse members are more successful in paid employment
  - Have longer job tenure
  - Move on to employment that is less supported than do those who are similarly ill and in other parts of the mental health treatment system, but not part of a structured clubhouse
- Research on the Model has Consistently Found These Necessary Components:
  - Education for clients and families
  - Skills training for work and community living
  - Case management
  - Medication management
  - Clinical follow up



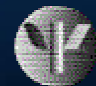
Interventions III – Supporting Services: Drop-in Services

- Drop-in Centers
  - Drop-in centers are often loosely built around the clubhouse model but are generally much less structured
  - Other clubhouses are in operation that do not adhere to the model – sometimes these function more as drop-in centers or with features of both a clubhouse and a drop-in
  - The true Fountain House model is now the subject of considerable research and is showing excellent results. Fidelity to the researched model is important!



Interventions III – Supporting Services: Leisure Services

- Leisure Activities
  - Leisure activities can play a key role in the restoration and maintenance of mental health by helping people:
    - Develop self esteem
    - Build confidence from learning new skills
    - Make connections with others
  - Therapeutic recreation programs including moderate intensity exercise or even rest can reduce some psychological distress including depression, confusion, fatigue, tension, and anger
  - Leisure has benefits for everyone and is part of everyday life – leisure services are considered an important supporting service for people with serious mental illnesses



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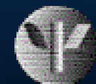
Interventions III – Supporting Services: Personal/Daily Life Services

- Personal and Daily Life Services
  - Due to the developmental stage at which many develop serious mental illness, skills for managing every day activities may not be learned
  - Services focusing on helping people manage aspects inherent in daily living are essential for success in the community
  - All skills should be assessed as part of the functional assessment and training provided where needed
- Services can Include skills training in:
  - Personal care/self management
  - Nutrition
  - Physical health and safety
  - Budgeting and finance
  - Housekeeping
  - Transportation
  - Coping with stress
  - Relationships
  - Use of community resources



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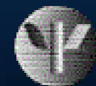
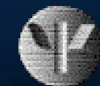
Interventions III – Supporting Services: Services Supporting Gender & Culture

- Culturally Appropriate and Gender Sensitive Services
  - Despite PSR's focus on inclusiveness, PSR services may or may not meet the needs of all cultures or be gender appropriate
  - Those who need services often do not avail themselves of treatment
  - Issues related to gender and culture should be considered:
    - When problems arise that don't have an immediately apparent cause
    - Each time services are discussed with a client
    - During interviews, assessments, and goal setting meetings
    - When clients are participating in services
    - At each service transition point



Interventions III – Supporting Services: Services Supporting Gender & Culture

- Many Times the Issues are Subtle; Other Times Apparent
  - Women are usually responsible for caring for their children but unable to access services with their children
  - Women are more likely to have been abused and may be further traumatized by groups that include men
  - Minority cultural groups may have substantial mental health problems but the reported prevalence is low due to reluctance to report problems, access needed services, and stigma
  - Cultural barriers are often not recognized by service providers, yet appropriate services could make substantial difference to the individual and his or her family
  - Those whose primary language is different from the majority language may need services that are in their primary language
  - Where stigma about mental illness is the norm, people may need to have providers from their culture who offer education, break down barriers, and include traditional providers



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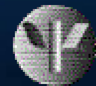
APA Recovery to Practice Curriculum

10. Forensic Issues I



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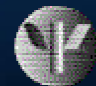
Forensic & Related Issues I: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

- Forensic Issues
  - For people with SMI, the prevalence of containment in prison/forensic system is high: men 15%; women 31%
  - For people exhibiting symptoms: 67 % greater likelihood of arrest
  - African American men especially at risk
  - Multitude of co-occurring problems:
    - Severe trauma
    - Homelessness
    - Substance abuse
    - Victimization
    - Poor health



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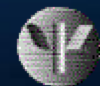
Forensic & Related Issues I: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

- Forensic Issues, cont'd
  - Criminal Justice/Forensic systems antithetical to concept of recovery:
    - Little treatment, emphasis on risk reduction
    - Respect, person centered, cultural considerations, EBPs: not the norm in criminal justice/forensic settings
    - Criminal justice/forensic settings are extremely re-traumatizing
  - Insufficient resources
  - Personnel receive little to no training re people with mental health disorders
  - Extremely stigmatized by dual stigma – serious mental illness & criminality

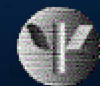
Forensic & Related Issues I: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

- Homelessness
  - Due to double stigma of criminality and mental illness, little housing stock available
- Co-occurring Substance Abuse
  - More hospitalizations
  - Higher suicide rate
  - Poor social functioning
  - Homelessness
  - Violence
  - People often excluded from treatment services



Forensic & Related Issues I: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

- Trauma
  - People with serious mental illnesses twice as likely to be victims of violence as those without illnesses
  - Importance of trauma, especially for women cannot be overstated:
    - Trauma is the norm, especially for women: virtually **all** women in the criminal justice/forensic system have experienced **severe trauma**; most men have as well
  - Criminal justice/forensic systems are universally re-traumatizing
  - Effects of trauma so severe that mental health providers must use extreme care to avoid re-traumatizing people



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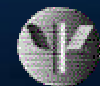
Forensic & Related Issues I: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

- Racial and Cultural Factors
  - Clear differences in treatment for people of color
  - African Americans especially overrepresented in criminal justice & forensic settings
    - Those with mental illnesses often mis-labelled as criminals
  - Immigrants, refugees and people from diverse cultural backgrounds affected by many issues:
    - Language barriers
    - Fear of authoritarian systems
    - Different beliefs about mental illness
    - Different cultural values:
      - Women and children often not allowed to speak for themselves
      - Acceptability of familial abuse



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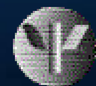
11. Forensic Issues II



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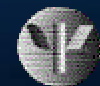
Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Essential Components of Recovery Service Provision are Missing in Most Criminal Justice Settings:
  - Respect
  - Autonomy
  - Person centered
  - Evidence based practices
- To Break the Cycle of Incarceration, Release, Symptom Exacerbation, and Re-incarceration:
  - Mix of services
  - Designed for and with the individual
  - Tailored to his or her complex needs
- Many Complex Dynamics in Such Settings – Requires Resources not Typically Available



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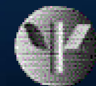
Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Interventions for People with Serious Mental Illnesses in the Criminal Justice/Forensic System
  - Where provided, medication – often too much
  - Currently only provided in the best facilities – social learning programs to improve adaptive behaviors
  - Clinical interventions adapted for justice involved population:
    - Forensic Assertive Community Treatment
    - CBT
    - Concurrent Disorders Treatment
    - Supported Housing
  - Essential & critically needed for this population:
    - Trauma informed & specialized services



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Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Forensic Assertive Community Treatment (FACT)
  - Distinguished from ACT in four ways:
    - Participants have criminal justice histories
    - Preventing arrest and incarceration are explicit outcome goals
    - Majority of referrals come from criminal justice agencies
    - Supervised residential treatment is incorporated into the program
- Supported Housing
  - Usually offered together with FACT
  - Considered important for keeping people connected to treatment and out of the justice system

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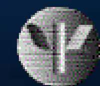
Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Cognitive Behavioral Therapy (CBT)
  - Improves interpersonal functioning & reduces impact of substance misuse
  - Considered essential for those with conduct disorders & antisocial personality disorder
  - Aims:
    - Control anger, reducing aggression
    - Impulsivity , violent behavior
    - Maladaptive patterns of thinking
    - Associations with pro-drug and antisocial peers
    - poor social skills



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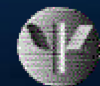
Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

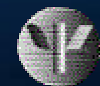
- Concurrent Disorders Treatment
  - Extremely high rate of co-occurring substance abuse and mental health disorders among forensic/criminal justice populations
  - Treatment widely recognized as essential
  - Components include:
    - Psychotropic medication
    - Motivational interviewing
    - CBT interventions
  - Providers must:
    - Engage the person and encourage commitment
    - Take steps to ensure continuity of care from one setting to another
    - Provide comprehensive services
    - Provide on-going assessment and services tailored to the needs of each individual

SAMHSA GAINS Center, Treatment of People with Co-occurring Disorders in the Justice System (undated)



Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Trauma Informed Specialized Care
  - Severe trauma is so prevalent that it is considered the norm for this population – virtually 100% for women
  - Many have developed extreme coping strategies
  - Requires specialized professional training
  - For women, especially important and NOT in mixed group!

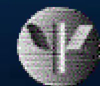


Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Trauma Informed Specialized Care, cont'd
- Components:
  - Learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts (cognitive restructuring)
  - Managing anger
  - Preparing for stress reactions (stress inoculation)
  - Handling future trauma symptoms
  - Addressing urges to use alcohol or drugs when trauma symptoms occur (relapse prevention), and
  - Communicating and relating effectively with people (social skills or marital therapy)
- Trauma Informed Specialized Care is essential for this population!

Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Mental Health Courts
  - Specialized court dockets:
    - Deal exclusively with people with mental health disorders in the criminal justice system
    - Combine community treatment services with criminal justice supervision
    - Provide a range of high intensity interventions needed by this population
  - Mental health courts hold promise of helping individuals remain out of the forensic/criminal justice system and achieve a stable and satisfying life in the community



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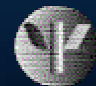
Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- Transition Planning and Follow up - Essential but Usually Lacking
  - Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis
  - The period immediately after release is critical – the first hour, day or week can determine success or failure - high intensity interventions that support the person during this time are essential
  - Without immediate monitoring and follow up many miss the first crucial health and social service appointments:
    - Do not have medications
    - End up on the street
    - Quickly return to the criminal justice/forensic system



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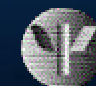
Forensic & Related Issues II: Interventions, Transition Planning, Follow Up

- If People with Serious Mental Illness in the Criminal Justice and Forensic Systems are to Succeed
- **WE MUST PROVIDE:**
  - Complete range of clinical and justice related interventions aimed at ensuring best psychological treatment, proper housing, and successful employment for those who can work
  - Superior transition planning
  - Help with medical and mental health follow up
  - Community integration that diminishes stigmatization



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12. Community Inclusion

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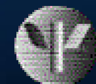
Community Inclusion

- STIGMATISM REDUCES OPPORTUNITIES FOR COMMUNITY INCLUSION AND PARTICIPATION



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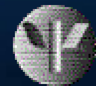
Community Inclusion

- People with Serious Mental Illnesses:
  - Among the poorest and most vulnerable in society
  - Consistently excluded from participation
  - Often discriminated against – in a national study:
    - 73% reported discrimination due to psychiatric disability
    - 51% reported discrimination in employment
    - 30% reported discrimination in housing (Corrigan, et al., 2003)
  - Fear, misunderstanding and stigma are huge problems for people with serious mental illnesses



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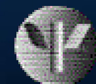
Community Inclusion

- Intrinsic and Extrinsic Sources of Stigma
  - Intrinsic Factors:
    - Odd behavior
    - Poor hygiene
    - Fear of rejection
    - Uncomfortable around others
  - Extrinsic Factors:
    - Media that portrays people with serious mental illness as dangerous
    - Mental health system that encourages segregation and stigma
    - Community advocates for segregation
    - Community rules for acceptable behavior
    - General intolerance



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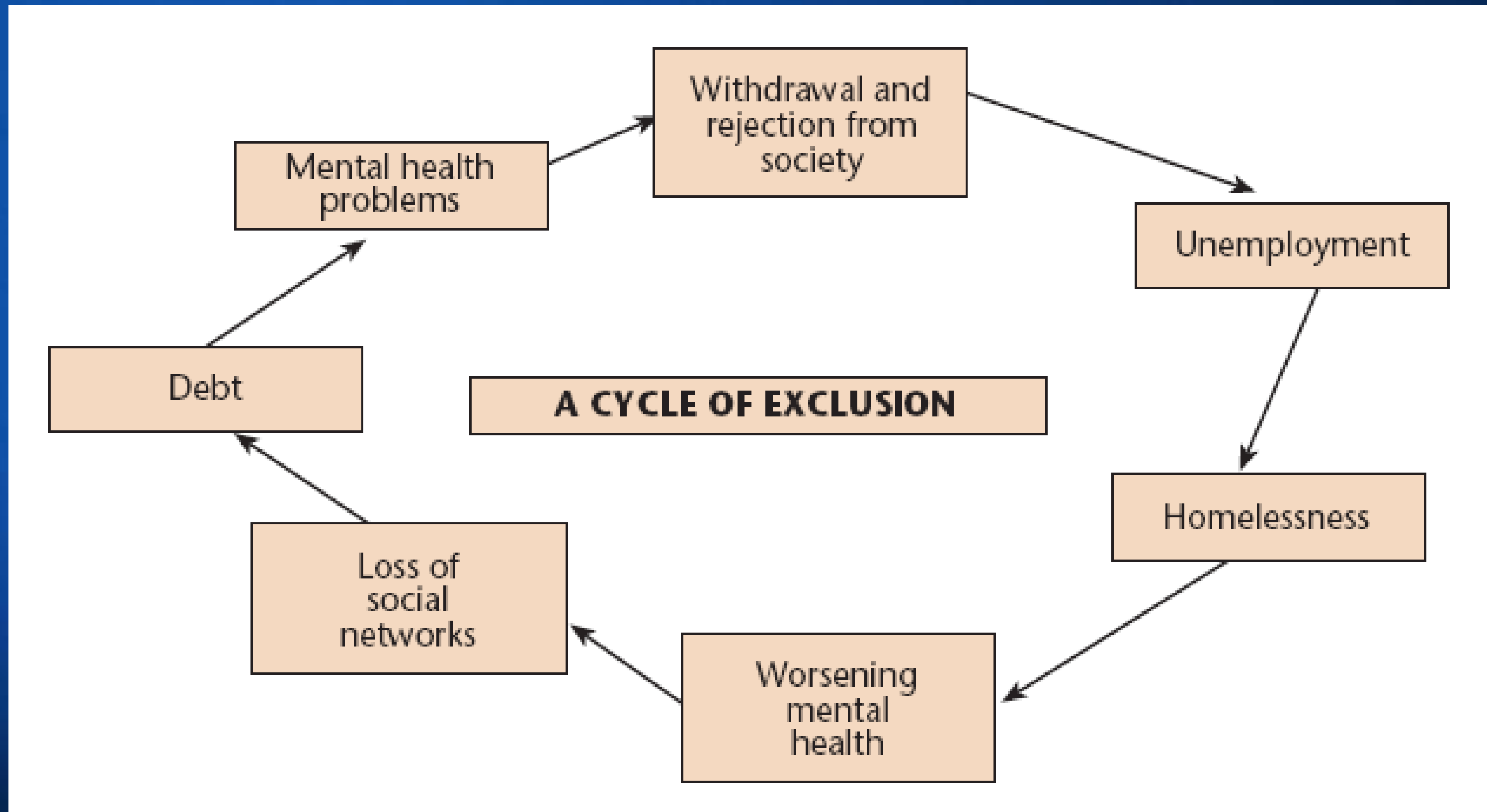
Community Inclusion

- Downward Spiral of Marginalization



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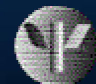
Community Inclusion

- Persons Most at Risk for Social Exclusion:
  - Racial and ethnic minority groups
  - People who are unemployed
  - Those considered by the general public as undesirable: prostitutes, individuals who use alcohol or other drugs, etc.
  - Immigrants and refugees
  - People with physical and mental impairments
  - People who are homeless



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Community Inclusion

- Culture and Gender – Important Considerations

Ethnicity

Religion

Gender/
Gender Identity

Etiology and/or Accept-ability

Trauma Adversities

Language Capabilities

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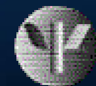
Community Inclusion

- Domains of Inclusion for Both General and Serious Mental Illness Populations
  - Community Inclusion Implies Full Participation in Every Domain:
    - Leisure and recreational activities
    - Friendship and intimate relationships
    - Employment
    - Education
    - Housing
    - Religion and spiritual activities
    - Medical services, choices, and confidentiality
    - Protection of legal rights
    - Freedom from discrimination and granting of dignity
    - Right to free speech



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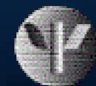
Community Inclusion

- The Ecological Framework
  - Social inclusion shapes both the individual and the environment
    - Individuals shape their own behavior to live within the social environment (culture)
    - Environment is shaped by the interaction of individuals
  - Sometimes people are excluded because those around them are afraid the person will fail or be hurt or humiliated, but:
  - *"Many of our best achievements came the hard way: We took risks, fell flat, suffered, picked ourselves up, and tried again. Sometimes we made it and sometimes we did not. Even so, we were given the chance to try. Persons living with disabilities need these chances, too."*

Perske, R. (1981). Hope For The Families – New Directions for Parents of Persons with Retardation and Other Disabilities



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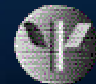
Community Inclusion

- Ways the Mental Health System Can Help to Promote Inclusion:
  - Ensure Environment Quality
  - Raise Self Esteem
  - Encourage Emotional Processing
  - Develop Self-Management Skills
  - Reduce Stress
  - Make a broad-spectrum of individualized supports readily available
  - Reduce and eliminate environmental barriers
  - Encourage Social Participation
  - Eradicate Emotional Abuse
  - Diminish Emotional Negligence
  - Eradicate Emotional Abuse
  - Reduce and eliminate environmental barriers



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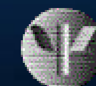

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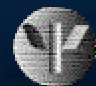
13. Peer Delivered Services



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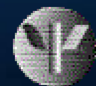
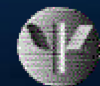
Peer Delivered Services

- Value of Peer Delivered Services
  - People with Serious Mental Illnesses consistently report that receiving services from others with similar illnesses is one of the most helpful services they receive
- Characteristics
  - Peer providers can be current or former users of mental health services
  - Peer providers have recovered sufficiently to be able to help others with similar issues



Peer Delivered Services

- Models of Peer Delivered Services
  - Peer led self help interventions that can involve sharing experiences, offering information, e.g., in a mutual support education group, or teaching others how to develop a recovery plan
  - Telephone services such as a “warm” line
  - Peer operated and managed services
  - Traditional mental health services such as case management delivered by peer providers within the mental health system
  - Peer support programs, either in a traditional mental health service, or in an agency outside the mental health system – <u>this is the most common</u>



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Peer Delivered Services

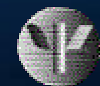
- What do Peer Support Providers Do?
  - Anything that can help! Examples include:
    - Listening
    - Sharing own experiences and offering support, hope, encouragement, mentoring
    - Providing information and education about how to stay well, recognize signs of distress
    - Modeling behaviors to take responsibility for wellness and stay healthy
    - Practical advice about housing, medications, schooling, employment, government entitlement programs

Peer Delivered Services

- Benefits for Recipients of Peer Services
  - More engaged and more involved in treatment
  - Longer community tenure between hospitalization and fewer days in hospital
  - Symptom stability, self-esteem, empowerment, coping skills, social support
  - Facilitation of community integration
- Benefits for Peer Providers
  - Increased confidence in their abilities
  - Increased ability to cope with their own illness
  - Increased self esteem, sense of empowerment and hope

Peer Delivered Services

- Implementation Considerations
  - Personal Concerns
    - Confidentiality
    - Role Identity and Boundaries
    - Dual Relationships
  - Administrative Concerns
    - Not Standard
    - Adequate Compensation
    - Cultural and Gender Issues
    - Environment of Acceptance
    - Adequate Supervision



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14. System Transformation

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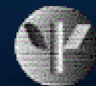
Systems Transformation

- Why should we care about providing a system dedicated to actually helping people recovery and achieve the life they want to live?
  - "Most people with schizophrenia get no or virtually no care, little of the care is delivered consistent with the best evidence, and people with schizophrenia are overrepresented in most of life's worst circumstances: Incarcerated, homeless, disabled, or dying early."

Hogan, M. (2010). Updated schizophrenia PORT treatment recommendations: A commentary. Schizophrenia Bulletin, 36, 1, 104 – 106.



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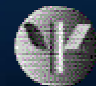
Systems Transformation

- What's Involved?
  - Systems transformation: Not just about services!
  - Requires a fundamental shift in thinking – a paradigm shift/changing the organizational culture:

- Recovery environment
- Commitment & leadership by all
- Careful hiring
- Collaboration with all stakeholders
- Allocation of sufficient resources
- Appropriate services
- Data collection
- Sustainability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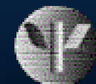
Systems Transformation

- Recovery Environment
  - True partnership with person and family
  - Believing that people will choose services they need to achieve a satisfying life
  - Overcoming provider resistance
- Commitment and Leadership
  - All must be committed
  - Change must be implemented in total - not piecemeal
  - Long term process – will not take hold overnight
  - There are frequent changes in leadership - Processes must be put in place that will continue when leaders change
- Careful Hiring
  - Must ensure the right personnel are in place and receive on going supervision



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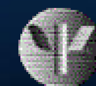
Systems Transformation

- Collaboration with All Stakeholders
  - Genuine partnership with recipients, families, professionals
  - Development of recipient and family leadership
  - Ongoing monitoring of process
  - Ongoing training and supervision
  - **ALL OF THE ABOVE WILL MEET WITH PROVIDER RESISTANCE!!**
- Allocation of Sufficient Resources
  - Follows from commitment
  - Shifting of priorities may be necessary
  - **MORE PROVIDER RESISTANCE!!**

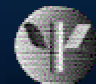


Systems Transformation

- Appropriate Services
  - A comprehensive system to meet the needs and wishes of people with serious mental illnesses:
    - Evidence based practices (EBPs) WITH FIDELITY!!!
    - Promising practices
    - Supporting services
- Data Collection
  - Requires a system to gather information and data IMMEDIATELY
  - Assess attitudes, vision, concerns of moving to a system that truly promotes recovery
  - Willingness to make changes based on data and feedback

Systems Transformation

- Sustainability
  - Requires diligence!
  - Frequent changes in mental health leadership are a continual threat
  - Need:
    - Processes that will transcend leadership changes
    - Active partnerships
    - DATA, DATA, AND MORE DATA!!
- The job isn't finished when new services are in place
  - Sustainability requires careful attention to all of the components and an ongoing commitment!



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15. Scientific Foundations

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Scientific Foundations

- Research Designs for Recovery Oriented Mental Health Services
  - Quantitative Studies:
    - Experimental designs
    - Quasi-experimental designs
    - Non-experimental quantitative designs
  - Qualitative Studies
- All of the above have limitations!
- What is the solution?
  - Mixed methods designs:
    - Solves many of the problems inherent in single approaches

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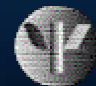
Scientific Foundations

- Guidance from the NIH Office of Behavioral and Social Sciences Research defines Mixed Methods Designs as:
  - "...a research approach or methodology:
    - focusing on research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences;
    - employing rigorous quantitative research assessing magnitude and frequency of constructs and rigorous qualitative research exploring the meaning and understanding of constructs;
    - utilizing multiple methods (e.g., intervention trials and in-depth interviews);
    - intentionally integrating or combining these methods to draw on the strengths of each; and
    - framing the investigation within philosophical and theoretical positions."

Creswell, Klassen, Plano Clark & Smith, 2011

Scientific Foundations

- Research Methods: Mixed Methods Designs
  - Traditional research methods (quantitative & qualitative) have advantages and challenges; neither captures effects of community interventions well
  - True mixed method research combines quantitative and qualitative data collection and analysis in the same study – *not in sequential processes, but as part of one overall research design*
  - This method broadens the questions that can be asked and answered, and offers the possibility to do so *all within the same study*
  - Possible to answer both exploratory & confirmatory questions in the *same study*. Permits verification & generation of theory in the same study



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