

We hope you enjoyed the training!

SUPERVISING TO OUTCOMES

Tuesday, September 25 and Wednesday, September 26, 2007
Sonoma County Adult & Youth Development (SCAYD) Family Resource Center
7345 Burton Avenue • Rohnert Park, CA 94928

Post-Training Resource

Table of Contents

Participants Introductions	1
Parking Lot List	2



DAY 1 INTRODUCTIONS

Participants were asked to introduce themselves and tell the others how they initially got started in the Mental Health field.

Joyce Abrams, Santa Clara County Mental Health Department, joyce.abrams@hhs.sccgov.org
Joyce started her career in the business world of the textile and fashion industry in New York City. Her interest in Psychology evolved from a Management course in Understanding Motivation of Employees. She returned to Graduate School and earned a Clinical Psychology degree, worked in Private Practice for twenty years, retired and, joined the County of Santa Clara County's Department of Alcohol and Drug Services, as Psychotherapist for the Dependency Drug Treatment Court for two years and, most recently, joined the Department of Mental Health as Program Specialist II - FSP Coordinator for Adult/Older Adult Services.

Debra Brasher, Inspired at Work, consulting@inspiredatwork.net
Debra began with interest in developmental disabilities until she was introduced to mental health by a community mental health agency. Realizing the challenges and successes of working in the mental health field inspired a change in her career path.

Karen Brockopp (Day 1), Sonoma County, ksellite@sonoma-county.org
Karen began her career in mental health working with the homeless; she continues to work to improve lives of the homeless today.

Lucinda Dei Rossi, Inspired at Work, consulting@inspiredatwork.net
Lucinda began her career in mental health when she took a summer job at a residential treatment facility.

Patty Lions, Marin County, plyons@co.marin.ca.us
Patty recently started with Marin County; she runs a FSP – HOPE program. Patty has been in the field for 16 years, having spent a majority of her time doing hospice work. Patty honed in to her natural draw to social services with a love of helping people and working with those with the same passion.

Amy Lovell, El Dorado County, amy.lovell@edcgov.us
Amy began her career in law enforcement working for a maximum security prison in Nevada. Her interest in dealing with people and mental health steered her focus to the mental health side.

Lyle Keller, Sonoma County, lkeller@sonoma-county.org
Lyle currently supervises an MHSA program for kids. Originally from Florida, Lyle's interest in mental health was born when his family move to New York when he was 10-11 years old. On his own, he decided to interview a homeless person living on a park bench.

Nancy Mast, Santa Cruz County, nmast@health.co.santa-cruz.ca.us
Nancy's first job in the mental health field was after graduate school, she worked for Community Companions in San Jose working with adults with mental illness.

Teresa (Sid) McColley, Sonoma County Mental Health, tmccolle@sonoma-county.org
Sid currently manages an adult program, but is preparing to embark on a MHSA IDDT team. Her interest in the mental health field began when she was trying to finish her thesis and holding a managers position at a restaurant and pondering a future in social services. She befriended a woman at work with who had been living with Schizophrenia and after getting to know her, this woman (probably appreciating Sid's friendship and listening skills) suggested Sid work in mental health.

Steve Ruzicka, Santa Cruz County Mental Health, steve.ruzicka@health.co.santa.cruz.ca.us
Steve supervises two programs for Older Adults and Transition Age Youths. Steve began his work in mental health as a camp counselor when he was in high school and then for group homes.

Peggy Schneider, City of Berkeley, nmast@health.co.santa-cruz.ca.us

Karin Sellite, Sonoma County, ksellite@sonoma-county.org

Tim Tuscany, Santa Rosa County, ttuscany@sonoma-county.org
Tim works for the Forensic division as a supervisor. Tim's interest in mental health was peaked in nursing school when a client inspired him to think about how mental health work can really change the lives of those living with mental illness.

PARKING LOT & INFORMATION REQUESTS

- ☑ FIDELITY SCALE
- ☑ (Brief) PSYCHO-SOCIAL SUMMARY (for group supervision)
- ☑ Link to electronic copy of PARTICIPANT'S MANUAL online
http://cimh.networkofcare.org/downloads/handouts/ParticipantManual_onlinedwnld.pdf
- ☑ Sample curriculum for ENGAGING CLIENTS, found on the CiMH website under Handouts From Previous Conferences
- ☑ Sample WORK-SCHEDULE (from Shannon Mong)

Still working on finding information on the following items/topic:

- 1) List of examples for CLIENT-CENTERED MANAGEMENT
- 2) How to apply EXTERNAL AGENCIES
- 3) How to report EMPLOYMENT FLEX to HUD
- 4) Will Rick and Diane offer CASE-MANAGEMENT MHSA program managers?
2-Day Basic Case Management Training
<http://www.socwel.ku.edu/mentalhealth/str/Trainings/viewTraining.asp?ID=65>

Strengths-Based Case Management Fidelity Scale

University of Kansas
School of Social Welfare
Office Of Mental Health Research and Training

07-31-07

CM responsibilities

Item #1. Case Managers' Job Responsibilities are fully devoted to case management.

Rating 1a: $\frac{1a + 1b}{2} =$	1	2	3	4	5
1a) What percentage of time do case managers spend providing case management and performing related case management responsibilities?	Less than 70%	Between 70% to 79%	Between 80% to 89%	Between 90% to 94%	95-100%
1b) What percentage of case managers have mixed responsibilities?	90% or more	Between 70% and 89%	Between 51% and 69%	Between 26% and 50%	25% or less

Caseload Ratios

Item #2. Case managers have low caseload ratios (this varies depending on intensity of caseload, but no more than 20:1)

Rating 2: _____	1	2	3	4	5
2) What is the average weighted caseload size for the CM team?	More than 30	26 to 30	21 to 25	17 to 20	16 or less

Integrated MH Services					
Item #3: Integrated Supported Employment Services					
Rating 3: $\frac{3a+3b+3c}{3}$	1	2	3	4	5
3a) The employment specialist attends in all group supervision meetings.	The agency doesn't have an SE program.	The agency has an employment specialist but doesn't attend group supervision meetings.	An employment specialist attends 50% or less of group supervision meetings	An employment specialist attends 51-99% of group supervision meetings	An employment specialist attends all group supervision meetings
3b) The employment specialist attends group supervision for the entire meeting.	The agency doesn't have an SE program		The employment specialist attends group supervision meetings but does not stay for entire meeting		The employment specialist attends group supervision for the entire meeting.
3c) The employment specialist accepts referrals exclusively from the team.	The agency doesn't have a SE program	An employment specialist accepts referrals from more than 2 teams		An employment specialist is assigned to two CM teams & accepts referrals exclusively from those teams.	An employment specialist is assigned to one CM team, & accepts referrals exclusively from the team.

Group Supervision					
Item #4: Strengths-Based Group Supervision					
Rating 4 = $\frac{(4a + 4b + 4c)}{3}$ = OR $\frac{(4a + 4b + 4c + 4d^*)}{4}$ =					
*4d = sum of 6 sub-items/ 6	1	2	3	4	5
4a) The group supervision focuses primary on discussion of clients rather than administrative tasks	40% or less of the meeting is focused on discussion of clients	41-50% of the meeting is focused on discussion of clients	51-69% of the meeting is focused on discussion of clients	70-79% of the meeting is focused on discussion of clients	80% or more of the meeting is focused on discussion of clients
4b) Number of case managers that attend each group supervision meeting.	9 or more case managers	8 case managers	7 case managers	6 case managers	5 or fewer case managers
4c) A specific set of clients are presented using the formal group supervision process	Team does not use the formal group supervision process		One client is presented using the formal group supervision process	Two clients are presented using the formal group supervision process	Three or more clients are presented using the formal group supervision process
* Only rate items in 4d if the team uses a formal group supervision process; was rated 3, 4, 5 for 4c.					
4d) Group supervision presentation quality:					
➤ Sub-item 1: Strengths assessments are handed out to each team member for all presentations.	No SA's were given to team members in any of the presentations	SAs were given to team members in 25% or less of the presentations	SAs were given to team members in 26-50% of the presentations	SAs were given to team members in 51-99% of the presentations	SAs were given to team members in all of the presentations.
➤ Sub-item 2: The case manager clearly states what they want help with from the group during the presentation.	What the CM wants help with is not clearly stated in any of the presentations	What the CM wants help with is clearly stated in less than 25% of the presentations	What the CM wants help with is clearly stated in 26-50% of the presentations	What the CM wants help with is clearly stated in 51-99% of the presentations	What the CM wants help with is clearly stated in all of the presentations

➤ Sub-item 3: The case manager clearly states what the client's goal(s) are	The client's goals are not clearly stated in any of the presentations	The client's goals are clearly stated in less than 25% of the presentations	The client's goals are clearly stated in 26-50% of the presentations	The client's goals are clearly stated in 51-99% of the presentations	The clients goals are clearly stated in all of the presentations
➤ Sub-item 4: The team asks constructive questions based on the strengths assessment (SA)	None of the presentations questions pertaining to the SA are asked	..	A few questions based on the SA are asked	..	Team asks a majority of questions based on the SA.
➤ Sub-item 5: The team brainstorms constructive suggestions related to the strengths assessment to help the client achieve their goal or help the CM engage with person or develop goal. An average of 10 suggestions is generated per review.	Brainstorming results in 3 or less ideas per review	..	Brainstorming results in 4 to 9 ideas per review	--	Brainstorming results in 10 or more ideas per review
➤ Sub-item 6: An clear plan/strategy is stated for each presentation. The CM states the next steps.	No clear plan or next steps are stated in any of the presentations	A clear plan or next steps are stated in less than 25% of the presentations	A clear plan or next steps are stated in 26-50% of the presentations	A clear plan or next steps are stated in 51-99% of the presentations	A clear plan or next steps are clearly stated in all of the presentations.

Supervisor Item #5. Supervisor's duties					
Rating 5 = $\frac{(5a+ 5b+ 5c+ 5d)}{4}$ =	1	2	3	4	5
5a) Supervisor spends at least 2 hours per week providing a quality review of tools related to Strengths Model of Case Management (i.e. Strengths Assessments and Recovery Goal Worksheets) and integration of these tools into actual practice.	Supervisor spends less than 30 minutes reviewing Strengths Assessments and Recovery Goal Worksheets	Supervisor spends 30-59 minutes per week reviewing Strengths Assessments and Recovery Goal Worksheets	Supervisor spends 60-89 minutes per week reviewing Strengths Assessments and Recovery Goal Worksheets	Supervisor spends 90-119 minutes per week reviewing Strengths Assessments and Recovery Goal Worksheets	Supervisor spends at least 2 hours per week reviewing Strengths Assessments and Recovery Goal Worksheets

<p>5b) Supervisor spends at least 2 hours a week giving case managers specific feedback on skills/tools related to the Strengths Model of Case Management.</p>	<p>Supervisor spends less than 30 minutes case managers giving them specific feedback on skills/tools related to the model</p>	<p>Supervisor spends 30-59 minutes per week giving case managers specific feedback on skills/tools related to the model</p>	<p>Supervisor spends 60-89 minutes per week giving case managers specific feedback on skills/tools related to the model</p>	<p>Supervisor spends 90-119 minutes per week giving case managers specific feedback on skills/tools related to the model</p>	<p>Supervisor spends at least 2 hours per week giving case managers specific feedback on skills/tools related to the model</p>
<p>5c) Supervisor spends at least 2 hours per week providing field mentoring for case managers</p>	<p>Supervisor spends less than 30 minutes per week providing field mentoring for case managers</p>	<p>Supervisor spends 30-59 minutes per week providing field mentoring for case managers</p>	<p>Supervisor spends 60-89 minutes per week providing field mentoring for case managers</p>	<p>Supervisor spends 90-119 minutes per week providing field mentoring for case managers</p>	<p>Supervisor spends at least 2 hours per week providing field mentoring for case managers</p>
<p>5d) What is the ratio of case managers to supervisors?</p>	<p>1 supervisor to 9 or more case managers</p>	<p>1 supervisor to 8 case managers</p>	<p>1 supervisor to 7 case managers</p>	<p>1 supervisor to 6 case managers</p>	<p>1 supervisor to 5 or less case managers</p>

<p>Strengths Assessment Item #6: Strengths Assessment is a stand-alone tool used according to the strengths model of case management.</p>					
<p>Rating 6 = $\frac{(6a+ 6b+ 6c+ 6d + 6e)}{5}$</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	<p>5</p>
<p>6a) The SA is regularly updated.</p>	<p>44% or less SA's are updated quarterly.</p>	<p>45% to 59% of the SA's are updated quarterly.</p>	<p>60% to 74% of the SA's are updated quarterly.</p>	<p>75% to 89% of the SA's are updated quarterly.</p>	<p>90% or more of the SA's are updated more than quarterly.</p>
<p>6b) Client interests and/or aspirations are identified in some detail and with specificity.</p>	<p>33% or less of SA's reviewed identified client interests / aspirations</p>	<p>--</p>	<p>34% to 66% of SA's reviewed identified client interests / aspirations</p>	<p>--</p>	<p>67% or more of SA's reviewed identified client interests / aspirations</p>

6c) Consumer language is used, e.g. "I want more friends" rather than "increase socialization skills"	33% or less of SA's reviewed use consumer language	--	34% to 66% of SA's reviewed use consumer language	--	67% or more of SA's reviewed use consumer language
6d) Talents and / or skills are listed on the SA in some detail and specificity.	33% or less of SA's reviewed list talents / skills.	--	34% to 66% of SA's reviewed list talents / skills.	--	67% or more of SA's reviewed list talents / skills.
6e) Environmental strengths are listed on the SA in some detail and specificity.	33% or less of SA's reviewed list environmental strengths	--	34% to 66% of SA's reviewed list environmental strengths	--	67% or more of SA's reviewed list environmental strengths

Integration of Strengths Assessment Item #7: Integration of Strengths Assessment into Practice					
Rating 7: _____	1	2	3	4	5
7) Strengths Assessment is used to help clients develop treatment plan goals	60% or below	61-70%	71 -80%	81-90%	91-100%

<p>Recovery Goal Worksheet (Personal Plan) Item #8: The Recovery Goal Worksheet is integrated into CM practice.</p>					
<p>Rating 8: 8a _____ Or $\frac{(8a+8b+8c+8d+8e)}{5} =$</p>	1	2	3	4	5
<p>8a) Agency uses the Recovery Goal Worksheet as a stand-alone tool for helping clients achieve goals</p>	<p>Agency does not use Recovery Goal Worksheet</p>		<p>Agency uses Recovery Goal Worksheet, but not in any systematic way with all client's who have recovery goals.</p>		<p>Agency uses Recovery Goal Worksheet in a systematic manner with all client's who have recovery goals.</p>
<p>* Only rate items 8b through 8e if the agency has stated they use the Recovery Goal Worksheet; otherwise the rating for 8a will serve as the final rating for this item.</p>					
<p>8b) Goals on the recovery goal worksheet should use the client's own language and reflect something they are passionate about.</p>	<p>Less than 25% of goals on the goal worksheet use client's own language</p>	<p>Between 26-50% of the goals on the goal worksheet use the client's own language</p>		<p>Between 51-99% of the goals on the goal worksheet use the client's own language.</p>	<p>All the goals on the goal worksheet use the client's own language</p>
<p>8c) Long-term goal on the Recovery Goal Worksheet is broken down into smaller, measurable steps.</p>	<p>Less than 25% of goals on the goal worksheet are broken down into smaller, measurable steps</p>	<p>Between 26% and 50% of goals on the goal worksheet are broken down into smaller, measurable steps</p>		<p>Between 51% and 99% of goals on the goal worksheet are broken down into smaller, measurable steps</p>	<p>All goals on the goal worksheet are broken down into smaller, measurable steps</p>
<p>8d) Specific and varying target dates are set for each step on the Recovery Goal Worksheet.</p>	<p>Less than 25% of steps on the goal worksheet are specific and have variation</p>	<p>Between 26% and 50% of steps on the goal worksheet are specific and have variation</p>		<p>Between 51% and 99% of steps on the goal worksheet are specific and have variation</p>	<p>All steps on the goal worksheet are specific and have variation</p>
<p>8e) Goal worksheets are updated during nearly every contact with the client.</p>	<p>Less than 25% of goal worksheets are frequently updated</p>	<p>Between 25% and 50% of goal worksheets are frequently updated</p>		<p>Between 51% and 99% of goal worksheets are frequently updated</p>	<p>All goal worksheets are frequently updated</p>

Community Contact Item #9: The majority of consumer contact occurs in the community					
Rating 9: _____	1	2	3	4	5
9a) What percentage of consumer contact occurs in the community? Note: include time spent in consumers' homes.	Less than 49% of CM contact is spent in the community with clients or information is not able to be determined.	50 - 64% of CM contact is spent in the community with clients.	65 - 74% of CM contact is spent in the community with clients.	75 - 84% of CM contact is spent in the community with clients.	85% or more of CM contact is spent in the community with clients.

Naturally Occurring Resources Item #10: Case managers make use of more naturally occurring resources than formal mental health resources in the helping relationship					
Rating 10: $\frac{10a + 10b}{2}$	1	2	3	4	5
10a) During the past 3 months, what percentage of goals worked on did the case manager specifically help the client access a naturally occurring resource to help achieve this goal.	Less than 25% of goals have evidence of the case manager helping to access at least one naturally occurring resource.	26-39% of goals have evidence of the case manager helping to access at least one naturally occurring resource.	40-59% of goals have evidence of the case manager helping to access at least one naturally occurring resource.	60-74% of goals have evidence of the case manager helping to access at least one naturally occurring resource.	More than 75% of goals have evidence of the case manager helping to access at least one naturally occurring resource.

<p>10b) During the past 3 months, what percentage of goals clearly reflected a trend toward the use of formal mental health services.</p>	<p>More than 75% of goals clearly reflect a trend toward the use of formal mental health services</p>	<p>41-75% of goals clearly reflect a trend toward the use of formal mental health services</p>	<p>26-40% of goals clearly reflect a trend toward the use of formal mental health services</p>	<p>11-25% of goals clearly reflect a trend toward the use of formal mental health services</p>	<p>Less than 10% of goals clearly reflect a trend toward the use of formal mental health services</p>
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<p>Hope Inducing Behaviors Item #11: Case Managers exhibit hope inducing behaviors when interacting with people receiving services or other staff.</p>					
<p>Rating 11 = $\frac{(11a + 11b + 11c)}{3} = \underline{\hspace{2cm}}$</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	<p>5</p>
<p>11a) Case managers exhibit hope-inducing behaviors in the following areas:</p> <ul style="list-style-type: none"> ➤ Interactions at group supervision. ➤ Interactions with clients in the field. ➤ Language in progress notes ➤ Responses to interview questions 	<p>None of the case manager behaviors clearly reflect hope inducing behaviors</p>	<p>The minority of case manager behaviors clearly reflect hope inducing behaviors</p>		<p>The majority of case manager behaviors clearly reflect hope inducing behaviors.</p>	<p>All of the case manager behaviors reflect hope inducing behaviors.</p>
<p>11b) Supervisor exhibits hope-inducing behavior in the following areas:</p> <ul style="list-style-type: none"> ➤ Interactions at group supervision ➤ Interactions with staff and clients during field mentoring ➤ Responses to interview questions 	<p>None of the supervisor's behaviors clearly reflect hope inducing behaviors</p>	<p>The minority of the supervisor's behaviors clearly reflect hope inducing behaviors</p>		<p>The majority of the supervisor's behaviors clearly reflect hope inducing behaviors.</p>	<p>All of the supervisor's behaviors reflect hope inducing behaviors.</p>
<p>11c) People receiving services state that case managers exhibit hope-inducing behaviors.</p>	<p>None of the responses reflected hope-inducing behaviors</p>	<p>A minority of the responses reflected hope-inducing behaviors</p>		<p>A majority of the responses reflected hope-inducing behaviors</p>	<p>All of the responses reflected hope-inducing behaviors</p>

Group Supervision Presentation – Psychosocial Summary

What I'm asking for from the Group: _____

"Snapshot" of the individual. Summarize descriptive information that may or may not be captured in strengths assessment.

Name	
Age, Gender, Sexual orientation	
Dual dx ?	
Race and/or Culture	
Living Situation	_____ _____
Psychiatric History	_____ _____ _____
Vocational & Educational History	_____ _____ _____
Family of Origin (for example, biological and/or adoptive parents, siblings, living/dead)	_____ _____ _____
Other Psychosocial History (optional)	_____ _____
Financial	
Medical	



OUTREACH AND ENGAGEMENT

Annette Mugrditchian

Anthony Delgado

Anthony Hawthorne

Clayton Chau

IMPLICATIONS

- Life has a profoundly relational character
- It is not whether one can establish a relationship with another, but rather how will any given relationship develop and take shape from moment to moment over time
- O & E seeks to build a relationship of trust and care with those who present unusual challenges and are the most difficult to serve
- It is a complex but ultimately hopeful process

THE CONSUMER

- Economic refugees
- Isolation and distance characterize the relational field of the consumer without care
- The consumer has few and minimal interactions with others
- The consumer is the most difficult to serve
- Chronic persistent mental illness
- Co-occurring disorders – substance misuse, HIV, chronic physical illnesses
- Long history of trauma → distrust of society (war veteran, childhood abuse, present victimization, G/L/B/T, etc)

STREET OUTREACH

WHAT IS IT ANYWAY??



OVER VIEW

- Outreach – the initial and most crucial step in connecting or reconnecting a homeless individual to needed health, mental health, recovery, social services and housing services; a process rather than outcome; first and foremost a process of relationship-building. Webster's dictionary defines outreach as "the extending of services or activities beyond current or usual limits."
- Engagement – a crucial process for successful outreach; a process by which a trusting relationship between the worker and the consumer is established; can range from a few hours to a few years

VALUES & PRINCIPLES OF OUTREACH

- Person orientation
- Recognizing the consumer's strengths, uniqueness and survival skills
- Empowerment and self-determination
- Respect for the recovery process – recognizes small successes
- Consumer driven goals
- Respect – culture, privacy, lifestyle (consumer as expert and worker as consultant)
- Hope
- Kindness
- Advocacy

OUTREACH WORKER'S STANCES/CHARACTERISTICS

- Good judgment, intuition and street sense (dress code, travel light, travel equipped)
- Non-judgmental attitude
- Team player – know when to ask for help
- Flexible
- Realistic expectations
- Commitment to consistency and persistence (no emptied promises)
- Less is more – at the outset of intervention, less application of intensive and costly treatment, less professional distancing, less rigid, less intrusiveness, less directiveness

(Con't)

- Altruism – finds rewards in the work
- Sense of humor
- Creative
- Resourceful
- Cultural competency across ethnicity, gender, transgender, lifestyle and age spectrum
- Resilient – patient, enduring difficulty without personalizing them

Disqualification of an outreach worker

Someone who is:

- A know it all attitude and unwilling to learn
- Un willing to listen
- Playing God
- Liable to compromise on principles – drug use/trafficking; discrimination; exploitation; mis-utilization of resources
- Talking down and inflexible
- Not recommended by peers

GOALS OF OUTREACH

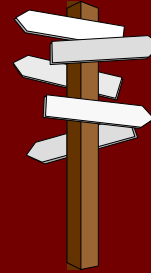
- Four main goals: care for immediate needs (ensuring safety, providing crisis intervention, helping with food, clothing, shelter needs); develop a trusting relationship; provide services and resources for as long as it takes; and, connect the consumer to mainstream services
- Phase from the street to outreach services to the community

ENGAGEMENT

- A crucial, on-going, long-term process necessary for successful outreach
- Reduces fear, builds trust and sets a stage for “the real work” to begin
- Morse (1991) defines 4 stages:
 - *Setting the stage – establish presence & credibility
 - *Initial engagement tactics – engage conversation, provide incentives
 - *On-going engagement tactics – providing services based on needs, i.e. transportation, linkage to medical care
 - *Proceeding with the outreach/maintaining the relationship – define service goals and activities, which may include pursuit of housing, income, medications, negotiating service settings

Crisis Intervention

- Many outreach workers will be “crisis managers”. A role that will require identifying immediate problems to be solved and the most appropriate person to do this.
- Workers must learn:
 - time management skills
 - strategy development
 - where to find adequate resources
 - how to help someone in a crisis situation
 - determine if it is a crisis or an attempt to sidetrack



SERVICE STRUCTURE

- Three ways of classifying outreach models:
- Linkage vs continuous relationship – “find and link” vs “find and serve”
 - Mobile vs fixed model
 - Individual vs team approach

LINKAGE MODEL

FOUR PHASES

- Approach, companionship, partnership and mutuality
- Each phase is marked by a predominant quality in the emerging relationship as seen from the perspective of the outreach worker and the experience of the consumer
- The model is based on relational theory
- The process is not a linear progression
- The phases are not discrete
- The phases have no clear bounded stages

APPROACH

- The worker honors the tentativeness of the relationship
- The intention of the worker is to be present and to weave the fabric of connection
- The role of the worker is at its most diffuse – a neighbor, a caring observer, a passerby willing to stop and listen
- Specific activities are minimal; no to little agenda
- Setbacks and pauses are parts of the process

COMPANIONSHIP

- Begin when the worker offers and is permitted to share the consumer's journey
- The worker is recognized, greeted and welcomed
- Provide a reliable presence, listen, offer empathy and act with knowledge and proper timing to the consumer's issues and concerns
- Attune to the consumer's current situation, self identity, perception of the world and ability to meet needs
- Benchmarks: time spent together, agreement on a regular meeting place and sharing hospitality moments
- Small task shared, minor helps, check out shelter/drop-in center, etc

PARTNERSHIP

- Begin with the capacity of the worker and the consumer to open their relationship of trust to include a significant third party – a social worker, case manager, nurse, doctor or individuals who provide specific support
- Benchmarked by the consumer's acceptance of a growing circle of care
- The worker's companioning role continues to be critical, providing a trustworthy presence, information and encouragement

MUTUALITY

- The worker celebrates with the consumer such basic experiences as making a home, developing a daily routine, discovering meaningful activities toward community integration
- In this context of a real and growing life with others, the worker prepares for separation and eventually to an appropriate termination
- This complete the Outreach and Engagement process

CONTINUOUS MODEL

MORSE'S FOUR STAGES

- Setting the stage – establish presence & credibility = *Approach*
- Initial engagement tactics – engage conversation, provide incentives = *Companionship*
- On-going engagement tactics – providing services based on needs, i.e. transportation, linkage to medical care = *Partnership*
- Proceeding with the outreach/maintaining the relationship – define service goals and activities, which may include pursuit of housing, income, medications, negotiating service settings = *Partnership*

SUCCESSFUL O & E

- Fully engaged in services
- Beginning of the active treatment phase
- Begin the recovery journey
- Ultimate hope is community re-integration

STAGES of CHANGE MODEL — Prochaska and DiClemente (1982)

- Precontemplation – engagement
- Contemplation – aware but keep using for having good reasons, begin to consider but no commitment
- Preparation – intention, making plans
- Action – active treatment
- Maintenance – relapse prevention (hard work in changing one's life in order to support the change in drug use)
- *Termination* – exits the addictive process to abstinence or minimum

INSTITUTIONAL ISSUES

VULNERABILITY OF OUTREACH STAFF

Psychosocial processes and environmental factors:

- Nature of work – attract independent and adventurous people
- Constant access to drugs
- Isolation of outreach workers from other agency staff
- Often go to absurd lengths to share commonality with the clients
- Undervalued – underpaid – disempowered - isolated

VULNERABILITY OF OUTREACH STAFF (Con't)

Psychosocial processes and environmental factors:

- Outreach workers are often accountable to management with conflicting views
- Glamorized by media/others → envy from agency staff
- Isolation often results in missing out on professional development opportunities
- Anti drug use attitudes at work leads to concealment of drug use – fear, shame and guilt
- Insufficient training and skills to cope with such stressors
- Often insufficient monitoring/accountability

MINIMIZING BURNOUT

Organizational level:

- Involve outreach staff to develop strategies to minimize burnout (and relapse if utilize consumers as outreach workers)
- A clear friendly policy to protect the work integrity and health/well being of staff
- Realistic and clearly defined criteria for selection of outreach staff
- Tailored and need based on going training
- Inter departmental shuffling to avoid boredom and burn out and minimize isolation from agency staff

MINIMIZING BURNOUT (Con't)

Organizational level:

- Re-visit salary/incentive structure and should be at par
- Provide support/counseling
- On going on site monitoring and provide feed back
- Involvement of outreach staff in organizational activities/processes – part of the agency team
- Encourage alternative social networks

DISCIPLINARY ACTIONS

Requires a warning:

- Lending money to consumers
- Looking sleepy and incoherent during office hours (not including side effects of prescription medications)
- Failure to attend a shift without calling in advance

DISCIPLINARY ACTIONS (Con't)

Requires a temporary suspension:

- Purchasing drugs from consumers
- Borrowing money from consumers
- Coming to work inebriated
- Being consistently late for work
- Failure to attend work several times without calling in
- Doing drugs with consumers

DISCIPLINARY ACTIONS (Con't)

Requires dismissal:

- Selling drugs to consumers
- Violating confidentiality of consumers
- Helping consumers in injecting drugs
- Failure to deliver services due to a personal outstanding debts with the consumers
- Threatening consumers for not paying their debts
- Consistently being late for work after several warnings
- Consistently being absent from work after several warnings

RECOMMENDATIONS

- Organizational support to outreach staff is crucial in order to minimize burnout and relapse
- Involvement of outreach staff in developing strategies to minimize burnout and relapse is crucial
- Continuous training – Health Belief Model, Social Learning Theory, and Stages of Change Model

BUILD RELATIONSHIP WITH COMMUNITY

In outreaching to the members of the unserved and underserved communities

- The program director/coordinator should build and establish a working relationship with the community leaders
- This relationship should be on-going and informative
- Conduct presentations in the community to introduce the agency, the outreach program, the program's mission and the employees
- The presentations should point out benefits/advantages of conducting outreach in their community and with the target population

COMMUNITY BARRIERS

- Language barriers
- Stigmas, myths, and misconceptions
- Politics
- Lack of communication, support, trust, and funds

Community barriers to effective outreach will always exist
However, outreach workers should take every opportunity to explain in clear, culturally appropriate terms the goals of their outreach efforts



Q & A

New Rules for Staff to Work By (2006)

As I travel around the state conducting recovery based transformation workshops, I'm inevitably faced with an objection from the back of the room, "What you're telling us to do is against the rules. I'd get in trouble with my supervisor for that." Indeed when I looked at the personnel policies for Los Angeles' DMH, I realized I break a dozen rules before lunch. I am an outlaw.

Although it would ultimately involve sitting hour after hour in a workgroup debating every last word, I realized we'd have to rewrite the "rules" if transformation was going to have a chance. We have to bring our policies in line with a recovery based practice if we expect to succeed.

This document is the product of Chad Costello, David Pilon, and me from MHA joining a DMH Medical Director's work group including representation from unions, risk management, human resources, and the Office of Consumer Affairs. This is the final draft. It subsequently went through several layers of administrative approval to become official. I hope it will help guide others as you rewrite your rules.

No one told me when I was sitting in a college dorm room dreaming of changing the world, that to do that you have to sit in long administrative meetings writing beaurocratic parameters, but here they are.

DRAFT

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

4.12 PARAMETERS FOR SERVICE RELATIONSHIPS IN A RECOVERY-BASED MENTAL HEALTH SYSTEM

7-26-06

I. INTRODUCTION

The Department of Mental Health (DMH) has adopted concepts of the Recovery Model for the transformation of its delivery of mental health services. For the purposes of these parameters, recovery refers to both the process individuals go through as they rebuild their lives and to the mental health treatment movement

focused on promoting individuals' recoveries. It includes an underlying belief that every individual can recover substantially, if not entirely, and deserves support to achieve their recovery. Although recovery is a uniquely individual process, each individual's progress can be described and tracked using a variety of descriptive tools. Generally this progress is conceptualized as moving through a series of stages, for example, hope, empowerment, self-responsibility, and attaining meaningful roles. These stages are flexible and fluid. They are fundamentally the same stages all individuals progress through as they recover from serious setbacks.

In adopting this model, DMH recognizes the role effective relationships between our staff (which includes volunteers and contract personnel) and the individuals we serve (individual) will play to accompany them through the stages of recovery. Staff must develop and use all their skill, education and talents to create and maintain caring, positive, and supportive relationships with individuals. DMH also recognizes that there may be new, substantial and complex risks inherent in such relationships.

II. PURPOSE: DMH has created these parameters to:

1. Support staff to manage potential risks successfully;
2. Serve as guidelines to understand recovery model concepts and the relationships essential to assist an individual through the stages of recovery successfully;
3. Clarify standard processes in the event of future legal actions,
4. Avoid misunderstandings for staff and individuals who may be unfamiliar with Recovery Model concepts;
5. Become aware of needs for staff training and performance improvement;
6. State the department's written intentions as a resource and training tool for staff, managers and individuals; and
7. Improve morale by establishing an opportunity for individuals and staff to participate in and review the parameters as they currently exist and may evolve.

III. RELATIONSHIP TO EXISTING POLICY OR REGULATIONS:

These parameters are not to be considered as a substitute for compliance with relevant existing Departmental or Agency Policies and Procedures (P&P,) Codes of Ethics and Conduct from individual licensing boards or regulations. Relevant Departmental or Agency policies include but are not limited to:

1. Ethics (See DMH P&P [100.1. Department of Mental Health Code of Ethics](#))
2. Compliance Policies and Programs (See DMH P&P [112.2 Compliance Program](#))
3. The Health Information Portability and Accountability Act (HIPPA) (See DMH P&P [500.1 to 500.10](#))

HIPAA)

4. [Sexual Harassment Prevention](#) (See DMH P&P [605.2 Sexual Harassment Prevention-Anti-Retaliation](#))
5. Conflict of Interest (See DMH P&P [608.2 Conflict of Interest](#))
6. Organizational Codes of Conduct (See [DMH Code of Organizational Conduct](#))
7. Illness and Injury Prevention Programs (See DMH Illness & Injury Prevention Program)

IV. PERTINENT RECOVERY MODEL CONCEPTS AND COMPONENTS

1. Creating and Establishing a Recovery Milieu
2. Engagement and Understanding
3. Emotional Healing
4. Financial and Work Relationships
5. Medication Support
6. Psychosocial Rehabilitation
7. Substance Use and Abuse
8. Working in the Community
9. Working with Law Enforcement

V. PARAMETERS ESSENTIAL TO THE UNDERSTANDING AND DEVELOPMENT OF SERVICE RELATIONSHIPS IN A RECOVERY MODEL.

1. Creating and Establishing a Recovery Milieu

Individuals need a safe place to recover. This safe place must provide acceptance, understanding, hope, emotional and practical support, treatment and rehabilitation. It must also provide a base for increasing self-responsibility and achieving meaningful roles in the community. DMH expects all staff to work together to insure every program is a safe place in which recovery can occur.

- A. Creating a recovery milieu depends upon all staff, including clinical and non-clinical, creating caring, positive, and supportive relationships with everyone they meet, whether they are on their caseload or not. This creates a web of recovery-based relationships that serve as a powerful environment for all our services and protects both staff and individuals
- B. Program supervisors are responsible for creating and maintaining the recovery milieu in their program. Their leadership should emphasize hope, healthy usage of authority, healing, and community integration. Staff should contribute positively in each of these areas.

2. Engagement and Understanding

Staff are expected to develop enough trust with an individual to be able to engage them in treatment and understand both their mental illnesses and them as individuals.

- A. Trust-building should rely on shared humanity in addition to emphasizing professional authority and expertise. Toward this end, staff are encouraged to use:
 - 1) therapeutic self-disclosure,
 - 2) agency charity, i.e. the giving of resources to individuals to improve their lives without requiring them to do anything in return. Examples of agency charity include providing bus tokens, food, or clothing,
 - 3) "meeting individuals where they are" for example in terms of dress, in order to emphasize attempts to decrease the distance between us,
 - 4) language, cultural competency and spiritual sensitivity, and
 - 5) using personal connections to individuals or places in the individual's life to enhance the original engagement and ongoing relationship. Examples of these connections may include circumstances in which you may already know the person or someone in their family, or have some shared interest or history, e.g. you went to the same high school or came from the same state.

- B. Staff should be careful not to take advantage of this trust by taking over decision-making for an individual. Staff should instead focus on building a collaborative relationship by giving an individual choices and meaningful education about those choices.

- C. When an individual shares their story with staff they place themselves in a vulnerable position. It is imperative that staff protect their story. Staff must respect confidentiality rights and keep information within the confines of the mental health system. However, personal confidentiality or exclusivity between an individual and a staff member is not a right and should be used cautiously and circumspectly. Keeping personal secrets may increase the risk of fragmented care, personal impropriety, and even danger, along with possible losses of staff accountability, documentation, and funding. Staff are expected to work as an integrated part of the entire mental health system, not as an individual practitioner.

3. Emotional Healing

One of the primary goals of mental health services is emotional healing. Individuals with mental illnesses often have substantial emotional distress. This distress can arise as a as a part of their illness, as a consequence of their illness, for example, stigma or the services received, or from other issues in their lives. Emotional healing can be either the direct reduction of the state of emotional distress or the improvement of underlying emotional traits that contribute to ongoing emotional distress.

At our most effective, our services should go beyond impersonal assessment, medication, case management, and placement to incorporate emotional healing. In general, to be healing requires skillful maintenance of relationships of substantial emotional depth. Traditionally, these relationships have been contained and protected within the controlled confines of therapy sessions. Staff are now expected to integrate healing throughout a variety of roles and settings.

A. High levels of personal emotional strength and awareness are a basis for the effective and safe promotion of emotional healing in others.

1) Staff may find themselves challenged by tragedies and traumas, both to an individual and to themselves. At these times, staff should make every possible effort to reestablish their emotional strength and seek personal healing. Both supervisors and team mates have a responsibility to ensure that all staff have personal and professional support in this effort. Supervisors are expected to help staff utilize all internal and external resources at their disposal.

2) Staff should not tolerate being abused, threatened, taken advantage of, or harmed sexually, emotionally or physically by an individual. Supervisors and teammates must act purposefully to protect staff and report such actions to their supervisors.

B. Staff may not demean, emotionally abuse, intentionally wound, or be physically aggressive or threatening to an individual regardless of the circumstances. The risk of these infractions should be reduced by staff knowing their own emotions. Staff can be clearer about the emotions involved by avoiding treating those individuals with whom they have previous or ongoing personal relationships. Supervisors and teammates must act purposefully to protect individuals and report such actions to the manager.

C. Physical contact between staff and an individual may often contribute to emotional healing, but it carries special risks. Staff absolutely must avoid all

inappropriate touching or other sexual contact with an individual. Sexual attraction or "falling in love" by either the staff or an individual dramatically increases the risk of inappropriate and/or unethical behavior on the part of staff. Therefore, these emotions must not be kept private. When confronted with these situations, staff must make their supervisor and teammates aware of them. Therefore, situations in which there is likely potential for inappropriate behavior or allegations of inappropriate behavior, staff should discuss the situation with teammates and with their supervisor. Supervisors shall report these situations immediately to the program manager. The program manager, upon evaluation of the situation, should report when warranted to the DMH Human Resources Bureau (HRB) for possible reporting to the Los Angeles County Office of Affirmative Action Compliance. Decisions regarding further contact between the staff and the individual shall be based upon a consultation with the Manager and DMH HRB.

- D. Persons with mental illnesses are valued by DMH in all staff positions because their life experiences afford them unique abilities to engage with, understand, and emotionally heal an individual. They must meet the same employment standards as staff without mental illnesses.

4. Financial and Work Relationships

Treating mental illness should focus on improving quality of life. As a result, mental health services include a wide range of social activities managing an individual's money, using discretionary mental health funds, and assisting individuals in accessing other funds to improve their quality of life.

Staff control over financial and other resources creates a potentially problematic power differential between staff and an individual. Even when staff believe that they are acting in the best interests of an individual, there are risks of exploitation, withholding, and manipulation.

- A. These risks shall be reduced by establishment and adherence to clear policies, sharing decisions with supervisors and teammates, having clear paths for an individual to air grievances, and by the keeping of transparent and accessible records.
- B. Staff may not get involved in personal financial dealings, e.g. the personal exchange of goods or services with an individual. Staff may not use a program participant's funds, discretionary mental health money or other program related funds for their own use.

- C. Staff who are serving as a representative payees are at particularly high risk for the development of a power differential and therefore may require additional physical protection. The same staff who is serving as a payee for an individual should not also have primary service coordination or emotional healing responsibilities for that same individual. Payees may use physical barriers for additional protection when needed, especially when handling cash. Payees should be in physical proximity of other staff and/or security staff when handling cash and interacting with an individual. Representative payee policies should include procedures for handling cash.

- D. With the approval of the manager, staff may operate in the role of “work supervisor” with an individual. These work experience, day labor, life coach, and peer supportive services jobs should all be temporary, part-time positions designed to promote an individual's growth while they perform needed work. Staff must be conscious of the additional risks inherent in these more complex relationships, and should make it clear to an individual that the true employer is the organization and not the staff person. Fulltime, permanent jobs should be separate from an individual's treatment team.

5. Medication Collaboration and Support

Although taking medications is not a prerequisite for an individual to receive services, medications are an important factor in recovery for many people. Medication collaboration is the process where the prescribing professional and an individual taking the medications work together to find ways of using medications that will benefit the individual. This is in contrast to a definition of medication compliance in which the prescribing professional orders the individual to take medications in the way they think best and an individual is expected to comply with those orders. It is expected that all staff, not just those whose scope of practice includes prescribing or monitoring medications, should be attentive to medication issues which they observe or are raised by an individual and respond within the context of the parameters that follow.

- A. Staff may assist an individual as they learn about their medications and the role medication plays in their lives. They should be able to provide competent guidance about additional credible sources of information about medication. Staff may also assist an individual to improve communication with their prescribing professional, and may use their relationship to increase medication collaboration. They may not, however, forward their own medication instructions or opinions about what an individual should do, unless their scope of practice includes medications.

- B. Staff may assist individuals in taking their medications as prescribed, for example by picking up medication(s) at the pharmacy, or helping them organize medication(s) into reminder boxes. However, they may not hand the medication(s) directly to an individual to take unless their scope of practice permits it. Examples of those with such a scope of practice would be a Medical Doctor, Registered Nurse or Licensed Psychiatric Technician.
- C. Staff may work with an individual to increase medication collaboration by a variety of means including the offering of incentives, or, with the individual's permission, involving other individuals in their support system. However, staff may not use coercive means or otherwise withhold services or funds that may be due to an individual, except when specifically permitted by law or statute.
- D. Staff may not, directly or indirectly, give an individual medication surreptitiously, intentionally mislead or misinform them about medications, or otherwise undermine informed consent, even if they believe they would be acting in an individual's best interests by doing so.

6. Psychosocial Rehabilitation:

The practices of psychosocial rehabilitation are essential components of services that promote recovery. Psychosocial rehabilitation is a service delivery philosophy that focuses on creating meaningful roles apart from the illnesses of an individual. For staff to take on these other roles successfully, they must also take on roles apart from the illnesses. Staff may find these other roles (for example customer, coworker, and house guest) less comfortable than their usual staff roles when they are less practiced in them, but these roles are not inherently more risky. They should continue to work on therapeutic goals including emotional healing while working in these multiple roles.

Among the important staff techniques used are goal setting, motivating, skill building, and applying these skills in the community, classically expressed as the "choose, get, keep" model. They should incorporate these practices into their relationships with an individual. It is preferable to do skill building in the actual community settings where the skill will be used instead of in classroom settings.

- A. Staff should support development of autonomy and independence in all domains, including finances, and refrain from doing things for an individual when they can do it for themselves. Encouraging individuals to provide for themselves and promoting growth are the ongoing underlying goals.

- B. Goal setting should be value-driven and consumer-centered. Goals should reflect the choices of an individual. Goals should also reflect socially promoted values such as increased independence in housing, employment, adherence to laws, responsible child rearing, safety and others. Staff should be culturally competent, sensitive and respectful of personal choice in goal setting. However staff should not support illegal or socially destructive goals. Special sensitivity is needed when working on spiritually-oriented goals to make sure staff is truly supporting choices of an individual and not persuading them to make spiritual choices that staff may personally value. Staff may ask for another staff to work on a particular goal with an individual if it conflicts with their personal spiritual beliefs.

- C. Motivating individuals should be based upon understanding them well enough to promote their core drives and desires rather than upon coercion. Staff should maintain supportive relationships even when an individual makes choices that may result in serious consequences. Staff should help an individual take risks in a more prepared manner and to help them learn from the consequences of their choices.

7. Substance Use and Abuse

DMH is committed to serving individuals living with mental illnesses who are also using or abusing substances. Staff should be competent in the delivery of integrated substance abuse services (Co-occurring Disorders (COD) appropriate to their roles.

- A. To effectively serve individuals with both mental health and substance abuse conditions, staff must have the ability to provide services for each condition separately, the ability to integrate services for the two conditions, and the ability to provide services uniquely designed for dually diagnosed individuals. Staff who are considered to be COD competent have these abilities in all areas of service including engagement, assessment, treatment, rehabilitation, advocacy, and recovery.

- B. Staff must maintain a willingness to actively serve individuals who are using and abusing substances, and accept them wherever they are along the continuum of recovery. However, this does not imply condoning substance use or abuse. Staff should always maintain a goal of freedom from dangerous and addictive substances no matter how remote or unlikely it appears at the time. Staff must maintain relationships and continue to serve individuals who use and abuse substances.

- C. Staff must provide or consult with their supervisor in order to arrange for the provision of a full range of substance abuse interventions appropriate to the stage of recovery of the individual being served.
- D. Staff should assume advocacy roles for individuals when dealing with other groups or agencies that have exclusionary “no tolerance” policies. In these situations staff must pay special attention to individual choice and maintain confidentiality.
- E. Program restrictions and limitations on individuals should be based on the appropriateness of their behavior, rather than on the fact that they are continuing to engage in substance use or abuse. Substance use and abuse increases the risks in relationships, including unlawful behavior, violence, and unsafe sexual practices. There may be increased risk to staff directly involved with individuals using and abusing substances. Therefore, staff should exercise extra caution and discuss any concerns with their supervisor.
- F. Staff may not use any alcohol or illegal drugs or while working, even if they are at an activity where drinking would be appropriate, and even if the individual they are serving is drinking or using drugs. Under no circumstances should staff who are impaired by drugs, legal or illegal, interact with the individuals they serve.
- G. DMH values smoking cessation and supports efforts by both staff and individuals to stop smoking. Nonetheless, both staff and individuals are permitted to smoke during work wherever permitted by law. No staff members or individuals should be in any way coerced or pressured to expose themselves to secondhand tobacco smoke, and every effort should be made to maintain smoke-free environments. However, individuals should be permitted to smoke where lawful and where others are not involuntarily exposed to secondhand smoke.

8. Working in the Community

Working outside of traditional locations and in the community vastly increases staff effectiveness, but also increases a number of risks. For the purpose of these parameters, community is defined as the social, cultural and physical environment in our daily lives. This does not include treatment settings. For individuals with mental illnesses, community is the environment in which they have meaningful roles that are not solely defined by their mental illness and its treatment.

- A. Staff should serve people in the community, not just in crisis situations, but whenever it is likely to increase the effectiveness, intensity, or relevance of their service. Many times this will involve taking on friend, family, mentor, or teacher roles (for example while facilitating hosting a house warming party, attending an AA meeting with them, or attending someone's graduation). However, staff should be mindful that their primary responsibility is not socialization or transportation alone. Depending on each person's needs and choices, staff should be engaging, assessing, supporting charitably, emotionally healing, treating, training, rehabilitating, advocating for, or promoting integration into the community while working in a variety of roles. For example while going out to lunch with someone a staff may be building trust, feeding a hungry person, demonstrating caring and reliability, assessing medication side effects or functional literacy, assisting in vivo practicing of relaxation techniques, modeling social skills, introducing someone to a friendly waitress the staff knows, or working to get the restaurant to serve a strange looking person.
- B. Staff should pay special attention to confidentiality when working in the community and, within constraints of applicable laws, any disclosures should be based upon the personal choice of an individual.
 - 1) Staff should avoid identifying themselves to others as mental health workers until they have reached an agreement with an individual regarding disclosure. This may involve, for example, altering vehicles or clothing or removing identifying badges while working in the community. However, County identification badges must be carried on the person of the staff when providing services in the community.
 - 2) Staff should secure confidential documents until returned to the designated storage site.
- C. When staff are serving an individual in the community and interacting with the individual's family, friends or other community contacts, the staff's role is not necessarily to speak for that person or take responsibility for them. Staff should be prepared to assume different roles when interacting with various agencies and individuals to facilitate attainment of meaningful roles in the community.
- D. Staff working in the community should conceptualize their role as guide or mentor, rather than caretaker or protector of either the community or the

individual. There are exceptions in emergency situations, but even when an individual is placed on an involuntary hold for treatment, relationships should follow these guidelines. Often these emergency contacts are an individual's first contact with the mental health system and therefore should be recognized and approached as important engagement opportunities.

- E. Community work may involve unique safety risks. Staff should not work alone when legitimate safety concerns are identified. In high-risk situations, staff should consult with their supervisor and/or call for police assistance to avoid endangering themselves and others. Staff should avoid physically restraining an individual in the community.
- F. Advocacy is a core component of recovery services. Staff are expected to fight stigma and advocate on behalf of individuals when working with other agencies and community members. Staff should expect support from their supervisors and by DMH in these efforts.

9. Working with Law Enforcement

DMH is making a strong effort to serve people who are struggling to be included in our community. Many of these people also have contact with law enforcement. Staff are encouraged to become directly involved with law enforcement issues when so desired by an individual in supportive, advocacy, and collaborative roles (for example by visiting individuals in jail, collaborating with their probation officer, or providing clinical bases for sentencing determinations).

- A. Law enforcement and mental health systems have different basic missions that effect our collaborations. Mental health is primarily focused on helping individuals with mental illnesses have better lives, while law enforcement is primarily focused on increasing public safety. Sometimes these goals are in alignment, for example, when staff is trying to help someone escape a battering partner, and sometimes they are in conflict, for example, when someone staff is serving is trying to avoid criminal punishment.

- 1) In some situations, for example, the Duty to Warn or Child or Adult Protective Services situations and court ordered treatment for Mentally Disordered Offenders, mental health staff are required to act as agents of public safety and should actively support law enforcement that carries the ultimate authority and responsibility. Staff should strive to provide services collaboratively rather than under court order unless directly required for public safety.

- 2) In some situations, for example, 5150 evaluations or involuntary treatment enforcement, law enforcement is acting as agents of mental health care and should actively support mental health staff that carry the ultimate authority and responsibility. In general, it is not law enforcement's role to directly promote or court order mental health treatment, except as it is reflected in increased public safety.
 - 3) In most situations, mental health and law enforcement are acting relatively independently. In these situations mental health staff's focus should not be on either advocating for individuals to help them avoid legal responsibility and punishment (except in situations of legal insanity, clear diminished capacity, or mental incapacity to stand trial), nor on directly assisting law enforcement's efforts to increase public safety, but on supporting individuals to meet their legal responsibilities in the most constructive way possible, so that they can be included as responsible members of our community. This includes promoting legal responsibility when individuals perpetrate crimes against the mental health staff and programs serving them.
 - 4) The above goals may, at times, run contrary to the desires of an individual. Staff should not support illegal desires, but should instead try to maintain a collaborative, emotionally healing relationship with the individual while promoting legal responsibility even during periods of disagreement or legal coercion.
- B. Because mental illness has specific legal implications there is a tendency for law enforcement to respond to the illness instead of the person. We have a responsibility to advocate for and collaborate directly to promote person-centered law enforcement responses.
- 1) When an individual with mental illness witnesses a crime or is a victim of a crime we should advocate and collaborate directly for them to be taken seriously as a member of our community with full rights.
 - 2) When an individual with mental illness is contacted by law enforcement we should advocate and collaborate directly against a presumption of increased dangerousness or irrationality unless warranted by their behavior.
- C. Law enforcement agencies may have access to specific resources and support for individuals they serve. Being a client of the mental health

system should not relieve law enforcement of their responsibilities to serve individuals themselves. Mental health staff should advocate for and collaborate directly to assist individuals in accessing these resources.

What's most remarkable to me about these policies is that it turned out to be possible to have policies that we believe will promote recovery that met the needs of risk management, human resources, the medical director's office, and even the union representative. They honestly worked hard collaborating with us to make it work.

I want to tell one last story about these meetings. One day the heavy set black woman who was the union representative and who had struggled with many of these policies said that she'd been thinking about what we'd said about hugging clients and that it didn't need to be forbidden. So she'd tried it. She hugged a client for the first time that week and it went pretty well. Maybe we were right. Maybe she'd even try that again.

X X X X X

You may wonder how someone like me ended up trapped in a room with a group of LA County DMH administrators hour after hour writing personnel policy. After all, I don't know how to do that. Strangely enough, thanks to the enormous memory banks of modern computers, I have copies of the e-mails that got me into this mess. It all started when David Pilon sent me a copy of some new personnel policies the county had written to be more recovery oriented. Here's my reply:

“Hi everyone,

This is the first time I have seen these policies and I am absolutely stunned. These are terrible, terrible, terrible. The purpose is wrong. Almost every single one of the statements is wrong, destructive, and needs to be dramatically changed. I don't know where to start. If those are the policies I won't be able to help hardly anyone and I won't be able to work as a consultant. I really can't believe how awful they are. We mine as well just quit right now with any transformation if you can't change this very drastically.

Fortunately, a friend called and interrupted this e-mail. I decided not to delete my tirade so you'd know how I feel, but try to start again more constructively:

When Village staff say we break six rules before lunch, we're not being dramatic. We really do. And it's not because we're rebellious. It's because we have to in order to succeed. In fact, there was a year long study made of the Village by two UCLA anthropologists a couple years ago to see why it's hard to replicate. Their conclusion was that the

Village was willing to fight against the existing rules in order to preserve our recovery culture where “people are treated like people.” They went on at length to describe what made the Village strong enough to be actively resistant and how hard that would be to replicate. The Village doesn’t discard ethics, we emphasize them. We have a long orientation, including the Patricia Deegan trainings. Our supervisors emphasize ethics, attitude, and respect above all for new hires. I’d wager that the Village turns away more interviewees and fires more people during their probation for problems with ethics, attitude, and respect for members than the entire LA County DMH put together. Your job, in my opinion, is to change the rules so that other less rebellious, less insulated, less strong programs can create and maintain recovery cultures. This draft perpetrates recovery destructive rules. It doesn’t promote transformation.

Remember, although all these rules are stated from the staff point of view to define the staff’s behavior and culture, they must also be seen from the consumers’ point of view because they will be also defining the consumers’ behavior and culture.

Let me give some daily examples,

1) Our street outreach staff all smoke. They share cigarettes with the street people they outreach and smoke with them. Forbidding smoking at work would impact them. I read somewhere that 70% of cigarettes in America are smoked by people with mental illnesses. They tend to be just as ashamed of their inability to quit as anyone else.

From the consumers’ side this rule is, “I can’t smoke with you because it’s unprofessional. Even though I would ordinarily smoke with you, I can’t because I need to demonstrate how different I am from you.”

2) I regularly eat at the Village café with whoever sits down, usually a combination of consumers and staff. We generally talk about current events, our families, sports, movies, the usual. Sometimes the conversation is deeper, even therapeutic, and sometimes I use the opportunity to offer someone medications who won’t make an appointment with me. If it does I take on dual roles and even bill for the time. Forbidding eating together without previous supervisor approval and forbidding dual roles would impact me.

From the consumers’ side these rules are, “I can only interact with you as a professional, not a real person. I need permission to eat with you. We can’t share our lives. I can’t interact in any way to make a relationship besides psychiatrist with you.”

3) What is professional attire when we’re at the YMCA playing Volleyball with members and staff together, or kayaking, or when we’re leading a

work crew of members cleaning out a totally trashed apartment, so the landlord will rent to us again? Recovery is not an office based practice. From the consumers' side this rule is, "I'm going to dress different from you to emphasize that I'm a successful helper and you're an unsuccessful person in need. If we try to do something out of the office together, I'm going to wear office clothes, so you remember I don't really belong here. I'm only here because I'm being paid to be with you."

4) I regularly treat people who are family members of someone else I treat. The most common scenario this occurs in is when a mother who I've treated, or am treating, brings in their young adult child, who I've known since childhood, because they desperately need help and I'm the only one they'll talk to, because they don't want to be part of the system. Sometimes I'm referred siblings, spouses, boyfriends, or girl friends too. At this point I've been the doctor for hundreds of mentally ill people in Long Beach. They come up to me all the time everywhere. Also, if you're a new member moving into an apartment, I'm likely to know your landlord and a few of your neighbors and I freely give advice how to fit in and make friends.

From the consumers' side these rules are, "You should be so ashamed of having a mental illness and having to see a psychiatrist that we'll work very hard to keep it a secret from everyone. If you know anyone, especially a family member, who I could help, you'd better send them to someone else because you won't be able to handle sharing me with them."

5) I certainly don't wear a badge to distance myself from members. I do have a Village membership card, the same as the members do, in case we need to distinguish who belongs at the Village and who doesn't, not to differentiate staff from consumers.

From the consumers' side this rule is, "We have badges here so we know who's safe and whose not. When you're done with the business staff have with you, get out. You don't belong here."

6) I see many people without appointments, or when they come at the wrong day or time, without checking with my supervisor for permission. That's one of the reasons people stay on meds and stay in treatment with me, when they've failed elsewhere.

From the consumers' side this rule is, "My time is too important to be flexible for you. If you can't get your act together enough to make appointments, you can forget about seeing me."

7) I hug members, and co-staff, daily. It's an amazingly good way of sharing feelings, being compassionate, and making sure people know I care. It's not sexual on either side. I'm not a particularly sexually attractive person, so if someone is coming on to me, the odds are they're doing it with other people in their life too and having problems as a result,

and I will intentionally use my reactions to them and rejection of their hugs as a therapeutic intervention that I wouldn't have access to without the hugs. Our staff who are more attractive than I am, generally have a lot of personal expertise in how to reject advances in a variety of positive ways.

From the consumers' side this rule is, "When I say I care, it's just because I'm paid to say that. I don't really want you near me and I sure don't want to touch you."

8) Although I've never had members over to my house, other staff have. I remember how thrilled a small group was to go have a BBQ and pool party at their social workers' house in the past. Just because I still have too much internal stigma and rejection to have them to my house, doesn't mean she should be forbidden from it. Rules need to embrace our best staff, not permission give to avoid for our worst staff.

From the consumers' side this rule is, "No matter what you say, you do think I'm a potentially violent crazy person who can't be trusted."

9) We often hire members within our teams, especially in the Outreach and Engagement Team, to give them a first opportunity with work, before we move them on to more official job training or community employment. Most of us got our first jobs through family or friends until we could compete on our own. We need employment engagement services for members not able to compete on their own.

From the consumers' side this rule is, "You don't really think I can work. You won't hire me. Why would anybody else?"

I could go on for virtually every rule, but I think you get the point. These rules cripple recovery.

Please, please, please start over in this effort. The reason you're addressing these rules at all is to facilitate the recovery transformation along with all the other projects we're all working on. In general, we have three strategies available to us: Development, transition, and transformation.

Development means working from where you're at in a gradual progression adding things and taking away things to improve. I suppose that's what David had in mind when he passed on Patricia Deegan's work, but this train is going in entirely the wrong direction. In my opinion, adding trainings is useless until we get turned around first.

Transition means assessing where you're at and where you want to go and making a clear plan to get from here to there. Here's my sample, very rough, of a transition oriented draft of this policy statement:

“We are in a process of transforming our services into a recovery based system. Our transformation goals are:

- 1) Move from an illness based relationship to a broader quality of life based relationship
- 2) Move from an office based, appointment based, individual and group therapy centered approach to a welcoming, recovery based, community integration based, milieu centered approach
- 3) Move from highly structured, artificial, therapeutic relationships to closer, more emotionally real, guiding and mentoring relationships
- 4) Move away from using distancing, strict boundaries and role definition as a way of maintaining trust and safety
- 5) Move towards healing ways of restoring trust and safety when either consumers or staff violate it
- 6) Move from an individual clinician responsibility model to a team shared responsibility model, including moving accountability from supervisors to team mates.
- 7) Move to increase consumer empowerment and increase consumer roles available, especially employment
- 8) Move to decrease our own internal stigma and it's professional indoctrination and maintenance
- 9) Move to increase flow and graduation
- 10) Move to successfully engage challenging consumers and their families and to maintain relationships with them

Here are the policies we have developed to support staff, consumers, and families while we make these changes together...”

Transformation means changing something about our internal values and vision and creating new things based upon those internal changes. I have two suggestions for your group changing internally.

First, each of you could spend a day or two at the Village in a buddy experience where you don't bring your badge, you don't wear professional attire, you don't have appointments or an office or a defined role, you interact with people without being sure who's a staff and who's a consumer, you eat with consumers and smoke with them if you smoke, you disclose personal things about yourself, you take consumers in your car, you have them host you as a visitor in their home, you meet their family and friends, you help clean up, and you give someone a hug. See how it affects you, both positively and negatively, to break all those rules. Don't worry; we'll give you an experienced team mate to watch your back and make sure you don't do anything exploitative, sexual, or aggressive and to help you deal with any feelings that come up and keep you safe.

Second, I don't know who all of you are, but your workgroup itself needs to include people who represent all the various parts of the recovery movement – consumer, family, substance abuse, rehabilitation, civil rights, staff who are in the field because of personal difficulties or recovery, cultural competence, and spiritual inclusion. Your group itself will be transformed if you actively include all these people and you will create a different product. We're not going to create recovery without including the people that created the recovery movement.

I've gone on at length in this e-mail because I think the work you are doing is crucial. (For example, a truly transformational policy statement would help me with line staff in the Big 6 Clinics.) I also have been exceptionally critical and forceful because I think you need to head in a new direction. I hope there is enough room in our process for passionate advocacy and disagreement. On the other hand, I also hope I have not offended or disrespected you."

Aren't you glad you don't get e-mails from me? I calmed down a little a couple weeks later and sent this:

"David,

I know you're not too pleased with some of my more offensive comments in my last e-mail to this policy workgroup.

I also know that you wanted me to work on trying to amend the draft document so I'd like it better, but I've found it surprisingly difficult to do so. I've found that I get very upset every time I begin.

I think after a couple weeks, I've figured out why it's so upsetting: This document makes me into an outlaw again.

I remember when I first came to the Village, one of the most amazing things was that all of the helpful things that I was doing that I was getting in trouble for because they were against "the rules", were actually praised and rewarded at the Village. You loved that I gave shots to people myself if they were too disorganized to show up at the right time or that sometimes I even brought them to someone's home. It was prized that I got involved in people's lives and not just their illnesses, taking on multiple roles and interacting more personally. It was positive that I encouraged my "rehab group" to lead their own group, help each other, and get into each other's cars, including mine, to go to the park or bowling or out to eat together. You liked that I met people "where they were at", encouraged them to have opinions about their meds and followed their advice, saw them without an appointment, or when they were dirty or disruptive, got involved with helping their families too. Martha's key

question at my interview was “Will you play pool with members?” I don’t see that anywhere in these policies.

When, I read through this list of policies, I feel rejected again. Now I’m being made into an outlaw in hiding again.

It’s upsetting and it doesn’t make sense. How are we supposed to transform things to be more like the Village while making up policies that outlaw our helpful practices? I don’t really want to be consulting line staff how to do things that violate their own policies. I’m going to have trouble approving of any policy that I’m not willing to follow.

Mark”

Now it says something important about our county DMH (and how much rope they give me) that the result of this tirade was that David, Chad, and I were invited to join the workgroup to try to create new policies we’d all be happy with. Since I felt guilty for having been so obnoxious and gotten away with it, I worked hard on this project. Fortunately, there were people in the room who are experts on policy writing and so the product is usable.

CFAR

Outreach & Engagement

Getting your foot in the door

Janet Anderson Yang, Ph.D.
Clinical Director

CFAR Outreach & Engagement Phases

1. **Community outreach:** case identification & referral
2. **Clinical engagement:**
 - 1) initial contact
 - 2) assessment
 - 3) crisis management
 - 4) linkage
3. Transition to mental health services
4. Staffing issues

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Community Outreach: “Gatekeepers”

Gatekeepers (Florio & Rauschko)

- People who know the day-to-day lives of older adults
- People with whom elders are familiar
- People with whom you can develop contact

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Community Outreach: Gatekeepers

- Adult Protective Service workers
- Police officers
- Case managers
- Hospital discharge planners
- ER staff
- Apartment managers
- Senior center staff
- Clergy
- Physicians
- In-home supportive services workers (IHSS)
- In-home nurses
- Paramedics
- Postal carriers
- Utility meter readers
- Shelters

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Community Outreach: Networking with Gatekeepers

Develop relationships of trust

Arrange meetings with gatekeepers

Attend or create multi-disciplinary meetings

Educate gatekeepers as to:

- what you can do for their older adults

- what signs to look for suggesting mental illness

- how to contact your system

- how to talk to the elder about meeting the clinician

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Community Outreach:

Signs for gatekeepers to look for:

- Significantly worsened appearance or grooming including clothing, cleanliness, smell, bruises
- Abrupt deterioration in upkeep of home or yard such as more trash, less repaired
- Significant change in elder's usual interactions such as more or less talkative, increased suspiciousness
- Worsened memory
- Indications that elder is seeing or hearing things which are not real

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Community Outreach: Referral from gatekeeper to mental health provider

- Establish a simple, friendly, accessible system for outside individuals to provide information to your agency about elders in need
- Provide specific feedback to the referral source as to case disposition, when appropriate, &/or
- Provide general feedback to referral source as to helpfulness of their collaboration

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Clinical Engagement: Engagement of older adult

1. Initial contact
2. Assessment
3. Crisis management
4. Linkage

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Clinical Engagement: Initial Contact

- Intake coordinator gathers information from referral & assigns case to clinician
- Mental health clinician calls elder
- If telephone contact is ineffective, clinician “drops by”
- Clinician references referring party, or initial meeting is scheduled jointly with referring party, if appropriate

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Clinical Engagement: Initial Contact

- Clinician presents self as “someone to help” or “counselor;” not as someone from the Dept. of Mental Health(!)
- Clinician listens carefully, builds rapport, gathers understanding of client
- Clinician allows client to take the lead with regard to what or how much client is asked to share

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Clinical Engagement: Initial Contact

- Clinician is prepared to move away from threatening topics, to safer ones, as needed
- Clinician empathizes with elder's perceptions of reality
- Clinician identifies and tries to understand elder's affect linked to those perceptions & misperceptions

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Clinical Engagement: Initial Contact

- Rapport building may take many forms:
 - Meeting an immediate need of elder
 - Talking with elder about their interests
 - Taking a walk; playing cards
 - Bringing some thing, e.g., food to share
 - Teaching relaxation skills

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Clinical Engagement: Initial Contact

With very hesitant clients:

- Gradual increase in contact is attempted
- Further contact is gently but persistently encouraged, in person, by phone or by letter
- If client refuses services, client is asked if clinician can “check in” with him/her at some future interval

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Clinical Engagement: Assessment

Older adult is evaluated in a discreet manner:

- Client's stated and implied wishes
- Mental health needs
- Safety needs
- Elder abuse issues, including self-neglect
- Risk of harm to self or other
- Basic needs (food, shelter, etc.)
- Pressing medical needs
- Cognitive level/ability to self-care

CFAR Clinical Engagement:
Crisis Management

Elder abuse – consider calling Adult Protective Services, police

Unable to care for self/self neglect – may need to hospitalize or notify APS

Suicidality – may need to hospitalize

Danger to others – may need to call police

Threats of eviction – may require active advocacy with landlord

Child abuse

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The Center for Aging Resources: Heritage Clinic

www.centerforagingresources.org

(626) 577-8480

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Clinical Engagement: Linkages

In terms of need for linkages:

- What does the elder want?
- What does the elder need?
- What can we help them with?

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Clinical Engagement: Linkages

Case managers

Permanent housing

Advocacy with apt. manager

Legal assistance

Utility bill assistance

Food, meals

Social contacts

Family relationships

Religious connections

Medical treatment/ Meds

Sensory enhancement tools

Money management

Transportation

Public benefits

Substance abuse/detox
facilities

Shelters

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Clinical Engagement: Staffing Issues

Selection

Organization

Training

Supervision

Support

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Staff selection

Clinician selection is crucial

Desire to work in the community, in a nontraditional manner, e.g., adventurous, like challenges, tolerant of wide variety of factors, flexible

Significant prior experience with severely mentally ill persons

Personal maturity to be persistent in the face of ambivalence/rejection

Clinical training

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Staff Organization

Each client is assigned to a primary clinician who trained in a mental health field

Primary clinician initiates contact with elder

Primary clinician provides all/most front line services

Primary clinician meets with team, including supervising licensed mental health professional, case managers, peer advocates, nurses

Other team members will provide consultation and at-the-office help (e.g., case management)

Other team members may or may not provide direct client contact

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Clinician Training

Training in extending services to hesitant,
reluctant individuals

Training in persistence

Training in attention to elder's underlying
messages

Training in crisis assessment & response

Gradual case load development

Expect more case drop-out with new clinicians

CFAR Clinician Supervision

Provide weekly individual supervision

Team meetings several times/week

Supervision to adopt a gentle, non-threatening manner

Supervision in gradual intervention

Group brainstorming in supervision

Supervision in tolerating rejection & small successes

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Clinician Support

Peer & supervisor emotional support

Support to tolerate slow process

Support to tolerate people living in risky situations

Discussion of the tension between safety and autonomy

Case load balance and distribution

CFAR Transition to formal mental health services

Clinician assesses elder's degree of ambivalence about clinician's contacts

Clinician assesses elder's ambivalence about "mental health treatment"

As suspiciousness decreases and trust increases, clinician gently introduces the idea of shift to formal mental health service

If/when willing, elder is asked to sign Consent to Treatment form

Outreaching clinician engages elder within a psychotherapy framework

Reluctance & ambivalence often need to be revisited

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Refusal of services/Informed consent

These older adults often need, but are reluctant to receive services

May refuse services but simultaneously request continued contact with clinician

Must not provide services contrary to older adult's consent

Requires careful judgment as to elder's stronger wish

Progressive consent

Document

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The Center for Aging Resources

www.centerforagingresources.org

(626) 577-8480

In Real Life: The Team

- 3 Licensed Case Managers (full-time)
- 2 Senior Peer Case Managers (full-time)
- 3 Peer Case Aides (full-time)
- 1 Mental Health Nurse Practitioner (full-time)
- 1 Psychiatrist (part-time)
- 1 Employment Specialist (part-time)
- 2 Outreach workers (full-time)
- Psychology Intern therapist (full-time)
- Contracts/Relationships with Shelter Plus Care

In Real Life: A Supervisor's Schedule

Mon 9-11 11-12 3-4:30	Team Meeting Team Drop-Ins Meeting with Admin Staff (data collection coordination, outcome tracking, logistical support)	Thu 9-11 11-12 1-4	Group Supervision Team Drop-Ins Field Mentoring (weekly rotation for six staff with caseloads)
Tue 9:30-10:30 11-11:45 11:45-12:45 1-3	Shelter Plus Care meeting (off-site, biweekly) Team Drop-Ins Psych Intern (individual supervision) Documentation Review	Fri 9-10:30 10:30-12 12-3:30	Team Drop-Ins Evaluations (Potential Members) Evaluation Write-ups
Wed 8:30-9 9-9:30 9:30-10 10-10:30 10:30-11 11-12:30 12:30-1 1-1:30 1:30-3 3:15-3:45 3:45-4:30	Nurse Practitioner (ind. supervision) Substance Abuse Counselor (ind. supervision) Bilingual Case Manager (ind. supervision) <i>Supervision overflow and notewriting</i> Case Manager (individual supervision) <i>Supervision overflow and notewriting</i> Peer Case Manager (ind. supervision) Peer Case Manager (ind. supervision) Adult Services Meeting Case Manager (ind. supervision) <i>Supervision overflow and notewriting</i>		