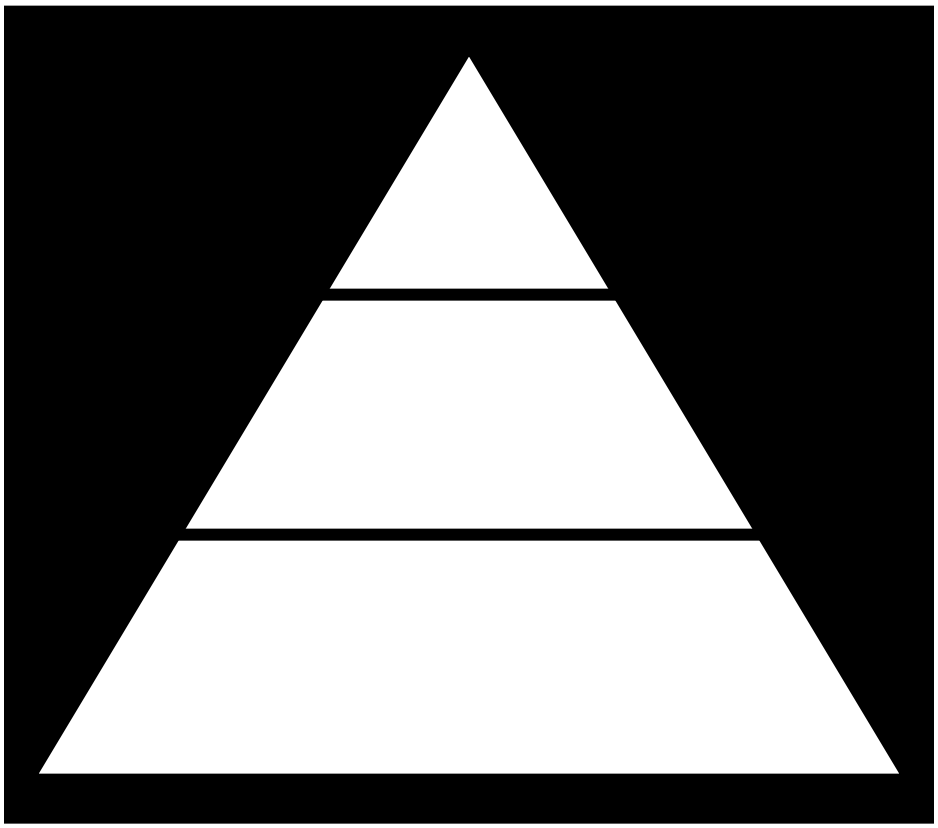


Heartland Alliance

Iraq Torture Treatment Project

Module III

Instructor Curriculum

Revised December 2005

Table of Contents

Introduction

This curriculum was developed as part of Heartland Alliance for Human Needs & Human Rights' training and technical assistance program titled "Integrated Torture Treatment Services in Rural Iraq." The purpose of this curriculum is to train Community Mental Health Workers in Iraq about the assessment of needs and the provision of mental healthcare for individuals who suffer from emotional distress or mental illness.

The content and design of this curriculum were developed, in part, as a result of feedback from trainers and participants. This training curriculum is designed to be a practical, user-friendly and culturally appropriate resource in successfully developing and enhancing the skills of paraprofessional and professional staff in Iraq by helping them to identify their role in the treatment team and practice the skills needed in providing direct service.

Acknowledgments

This curriculum was developed in a collaborative effort between staff at Heartland Alliance for Human Needs & Human Rights — Elizabeth Bowen, Mary Bunn, Juliet Dinkha, Lorna Elam Jackson, Stanley McCracken, and Alice Virgil, with the assistance of several other individuals who offered their technical assistance and support in developing this curriculum — Ari Hasan, Haithem Asedy, Richard Brouillette, Hans Buwalda, Patrick Corrigan, Mary Lynn Everson, Mary Fabri, Salah Hasan, Ahmed Amin, Jonathan Lewis, Sid Mohn, Scott Petersen, and Scott Portman.

In addition, a special acknowledgment and thanks are extended to the people of Iraq who participated in the development and implementation of this project.

About this Curriculum

This curriculum provides an introduction to the knowledge and skills needed to help individuals with mental illness and emotional distress due to trauma. The aim of this curriculum is to help direct service providers learn through a combination of lecture, visual aids, group participation and practice exercises.

The content of this curriculum is intended to provide trainers with insight into the rationale, processes and implications of providing direct service to individuals and their families. The companion participant workbook reinforces the content by reviewing key points covered in the lectures. In addition, several handouts and tip sheets are also provided for the participants' use with their clients.

The design of this curriculum offers specific text explaining the basic concepts of this curriculum, so that the trainer knows what needs to be presented in each lecture. The text is written in an easy-to understand dialogue style, so that the trainer may use the text as a lecture script, if desired. Italicized prompts provide the trainer with teaching tips and presentation notes, along with other helpful information and suggestions.

Trainer Tips

It is important to personalize the training experience by offering or eliciting relative examples or anecdotes regarding the topic areas covered in this curriculum. By doing this you will keep training participants engaged and will help them learn from another.

Throughout the training sessions be sure to continually assess the needs of the training participants and revise the amount of time devoted to each specific topic in this curriculum according to their questions, interests and needs. For example, if some of the participants want to focus on training issues related to a particular problem, you should assess to what degree devoting extra time to discussing these problems would be instructive and helpful for the entire group.

You may also decide to tailor this curriculum in order to meet specific training needs. For example, if your training time is limited, you may choose to conduct several separate training sessions in order to complete one lecture. If so, you may find it helpful to end a training session at the point before a new topic are begins. New topic areas are indicated by bold headers. Also, supplemental reading materials are referenced at the beginning of each lecture and are recommended for individuals seeking a more comprehensive understanding of the topic being covered in the lecture. (We can provide copies of many of these materials written in English, if desired).

Engaging Clients in Services

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to effectively engage their clients in services.

Informational Competencies:
At the end of this training, the CMHW will know…

- The definition of engagement
- The definition of empathy and its uses in engaging clients
- The role of effective communication in engaging clients
- Barriers to effective communication
- Active listening techniques
- The definition of confidentiality and its role in promoting client trust
- The importance of involving clients in identifying strengths and resources and setting their own goals
- Seven domains of mental health or well-being
- The difference between daily, short term, and long term goals

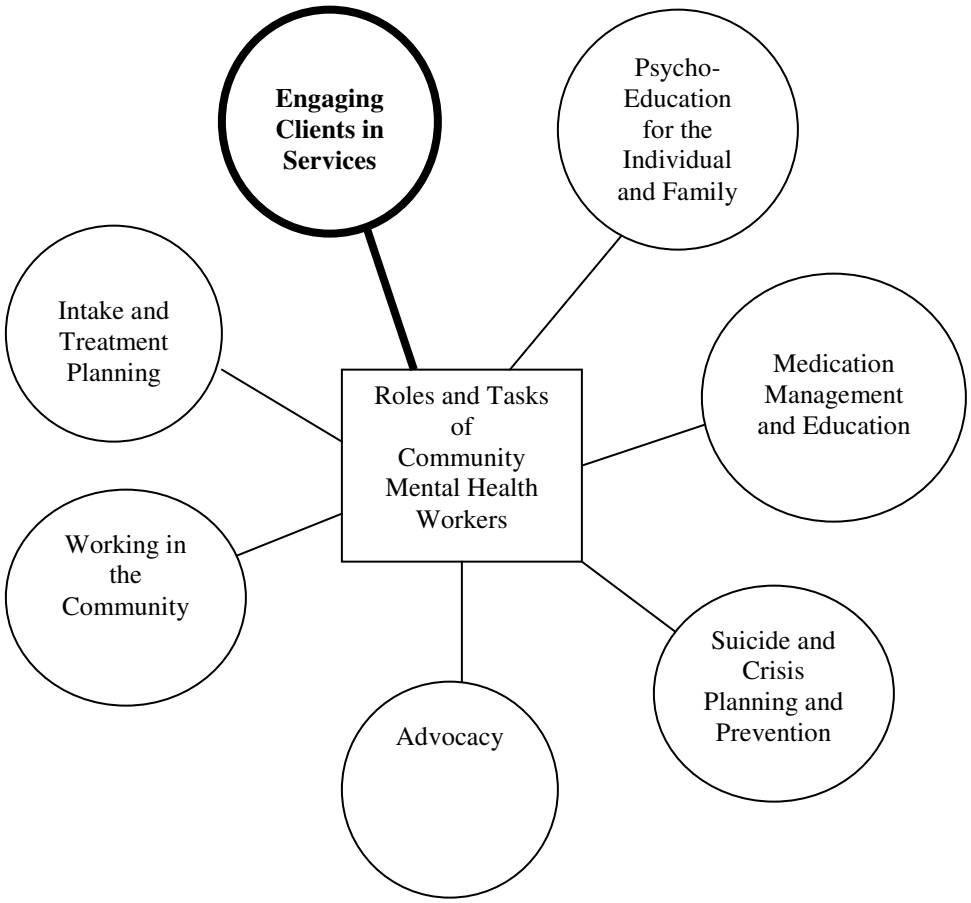
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Discuss engagement and its importance in treatment
- Demonstrate empathy
- Identify and avoid barriers to effective communication
- Perform active listening skills
- Discuss confidentiality with clients and others
- Assist clients in identifying strengths and goals by asking about satisfaction in seven domains of mental health
- Help clients identify daily, short term, and long term goals

Learning objectives:
The goal of this training session is to teach…

- Communication skills
- Goal-setting skills
- Strengths identification skills
- Importance of confidentiality

This training addresses the following CMHW Job Role(s):
Engaging Clients in Services



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:

Egan, G. (1998). *The skilled helper: A problem-management approach to helping*. Pacific Grove, CA: Brooks/Cole.

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing, 2nd ed.* New York, NY: The Guilford Press. Part 2 is highly recommended

Corrigan, P. W., Buican, B., & McCracken, S. (1996). Can severely mentally ill adults reliably report their needs? *The Journal of Nervous and Mental Disease, 184*, pp. 523 – 529.

Corrigan, P. W., & McCracken, S. G. (2005). Interviewing people with serious mental illness. *Clinical and diagnostic interviewing, 2nd ed*. Jason Aronson Publishers: Northvale: NJ.

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

Today, we're are going to talk about how to get people involved and participating in the services that we offer. We refer to this as the process of "engagement" or "engaging a client in services."

II. Understanding Engagement

We would say a person is engaged in services when they are coming regularly to meet with us, have met with the physician, and are able to take the recommended medication. It is someone with whom we have a sustained relationship. We know from experience that the more involved people are in services, the more likely they are to show improvement.

Does anyone have a client that they would describe this way currently? What was it about being involved in services that seemed to help the client?

Elicit responses. Thank participants for their contributions.

III. Exercise 1: Assessing Current Engagement Techniques -- Group Discussion

The purpose of this exercise is to immediately demonstrate the power of shifting attention to the client in order engage the client in participating in a conversation, by similarly engaging training participants in this discussion.

We are going to further explore this topic with a group discussion about your current practice in engaging clients. Think for a moment about the strategies that you use in engaging others to participate in activities. What do you find helpful in getting others to take action? I am going to write your techniques on the board as you share them with the rest of us. Together let us come up with as many ideas as we can.

Elicit responses and write them on the board. Possible responses include: ask clients questions about themselves; let them make decisions for

themselves; improve the quality of client care and their service satisfaction; eliminate barriers to service.

After the exercise, conduct a brief debriefing discussion. Not everyone has the same strategies for engaging others. What works for one person may not work for another person. Some questions you may want to ask during the debriefing include:

- Did you notice a change in your level of attention when this exercise first began?
- Did you remain engaged in the exercise even when you did not have a strategy to share?
- How difficult or easy was it for you to remain engaged? And why?

Some points to bring out during discussion include:

- People are more engaged when they are talking about themselves.
- There are differences in the level of engagement from one person to the next.

Supervision Note
You can increase CMHW competency in this skill during group supervision by asking questions such as:

- On a scale ranging from 1 ("not at all engaged in services") to 5 ("independently and appropriately uses services"), how would you rate this client?
- If this client is not engaged, is this client able to partner with you on some level in order to participate in services with your help?
- What steps could you take to help increase engagement for this client?

There are many strategies that we can use to engage clients in services. They include demonstrating empathy, using effective communication techniques, establishing confidentiality, identifying client strengths, and goal-setting. You may be familiar with some of these strategies from Modules I and II, but this gives us an opportunity to review them.

IV. Using Empathy to Increase Client Engagement

Empathy is often described as placing yourself in the other person's situation in order to understand his or her unique perspective, feelings, and meanings AND to be able to reflect this sensitivity back to the person.

Empathy is not the same as having pity for the other person. It is having an understanding of what that person is experiencing or feeling at the time.

Why is empathy part of engagement?

Elicit responses and discuss.

When clients feel that you understand what they are experiencing and that you are able to accurately reflect their feelings back to them, then they are more likely to want to engage with you. More specifically, demonstrating empathy for a client can help to foster feelings of hope and empowerment. Clients who are hopeful that they can benefit from the treatment process and who believe that they can and will play an active role in their own treatment and healing will be more engaged in services. Demonstrating empathy helps clients feel understood, and this in itself can help clients to have more hope for their futures.

V. Exercise 2: Ways to Demonstrate Empathy -- Group Discussion

Let's review some ways to demonstrate empathy. You may remember some examples from Modules I and II or from your experience in the field.

Write responses on the board. Examples may include:

- *Pay attention to what the speaker is saying and doing*
- *Show a desire to understand the speaker's point of view*
- *Communicate an understanding of the message*
- *Discuss what is important to the speaker*
- *Refer to the speaker's feelings*

VI. Using Effective Communication Techniques to Increase Client Engagement

Effective communication is one of the fundamental skills needed for client engagement. We will start our discussion of communication techniques by describing some things you should try to avoid doing in communicating with clients. Then we will discuss how you can communicate more effectively with clients using active listening.

A. Barriers to Effective Communication

Now we are going to review some common mistakes that people make when they are having conversations with others. These are called barriers to

effective communication, and were introduced in Module I. They can actually decrease client engagement. This is because you will not be able to listen well when you create barriers to your client's ability to speak freely.

There are three categories of barriers to effective communication. Can anyone recall them?

Elicit responses and thank participants for their contributions.

Right, the three categories are judging, giving solutions, and avoiding concern. I'll distribute a handout now that reviews some of the common barriers to effective communication and gives examples of each.

Distribute handout titled "Barriers to Effective Communication." Review each item and elicit questions from participants.

You may have some further questions as to why certain techniques, such as reassuring, are considered barriers to communication. Let's practice using the barriers to communication and after you have observed the effects they have on conversations, we will further discuss the barriers and why some are included on the list.

B. Exercise 3: Identifying Barriers to Effective Communication – Role Play

Now that we have reviewed the barriers to effective communication, let's practice identifying them in an actual conversation. In a few minutes, you will separate into groups of three. One person will be the speaker, one will be the listener, and one will be the observer.

Speakers, you will discuss a decision that you are trying to make. It might be a purchase, a career change, beginning to exercising more frequently, or some other similar issue. You should choose an issue about which you are not personally sensitive. You are approaching the listener to talk over the issue so you can think about it more clearly and come to a decision later.

The speaker will discuss his or her decision with the listener for about three minutes. Meanwhile, the listeners should use as many of the barriers to effective communication as possible. Listeners, you might want to keep the handout in front of you to remind you of the different types of barriers.

Begin the role-play by asking the speaker why he or she came to talk with you today.

Observers will be watching the speakers and listeners for barriers to effective communication. You should note with a checkmark on the handout each time you see an example of one of the barriers.

You will do the role play three times within your groups, so that every person has the opportunity to play each of the three roles. After the role play we will debrief about what you learned and how it felt to play these different roles. Before we begin, do you have any questions?

Help participants separate into groups of three. Circulate around the room to see if participants need any help starting the role play. You might wish to keep track of time and tell participants when three minutes are up and it is time to switch roles. As you walk around the room, pay attention to the kinds of barriers you notice listeners using and how the speakers respond. Call participants back together after everyone has had the chance to play each role. Debrief using the following questions:

- When you were the listener, what was it like to use the barriers to effective communication?
  Possible responses include: felt powerful, frustrating, teasing, in control, etc.
- When you were the speaker, what was it like to experience the barriers?
  Possible responses include: felt frustrating, cut off, was not listened to, felt unimportant, etc.
- When you were the observer, what are some examples you noticed of how people used the barriers?

Now that you are aware of the barriers to effective communication, you can see how they affect conversations, as we just demonstrated. However, you may have noticed that using different barriers results in different effects. After having done this exercise, are there any barriers listed on the handout that you do not agree with (i.e. do not consider to be a barrier)?

Elicit responses. Participants may question why certain acts, such as reassuring or advising, are barriers. Encourage participants to raise these questions or concerns.

One barrier that people often have trouble understanding is reassurance. It's important to understand how reassurance can be a barrier to communication in some circumstances, rather than a method of fostering hope and increasing engagement. Communicating positive messages to the client and providing encouragement can in fact help clients feel more hopeful about their futures, and as we discussed earlier, this can be a powerful engagement tool. Trying to instill hope through encouragement or reassurance becomes a barrier to communication when this is done at the expense of listening to what the client is trying to say. If the client is prevented from voicing his or her problems, concerns or emotions because the worker is interjecting with reassuring statements, then the client will likely not feel hopeful for the future. Rather, he or she will feel frustrated or misunderstood. This is what reassurance can be a barrier to communication in some circumstances.

That said, there are circumstances under which you might purposefully use certain barriers to effective communication. For example, you might find yourself using excessive questioning during the early part of an intake, when you must ask a client several basic questions to gather identifying information. Can anyone think of another example of when you might want to use a barrier to effective communication?

Elicit responses and thank participants for their contributions.

While there may be some circumstances under which you use some of these barriers, it is important to recognize that when you are doing so, you are no longer listening to the client with your full attention. Judging, giving solutions, and avoiding concern all interfere with fully understanding and hearing what the client is trying to express to you. We will next review techniques of active listening, which will help you communicate more effectively.

C. Active Listening

Can anyone define active listening? We first discussed it in Module I.

Elicit responses and thank participants for their contributions.

Active listening is a communication technique that you can use to improve client engagement. There are two important parts of active listening. The first part is receiving a message from the speaker. The second part is

sending a message back to the speaker to tell him or her that you have heard and understood what he or she has said.

Why is active listening an important skill for someone in your profession?

Elicit responses, encouraging participants to give examples from their experience that demonstrate the importance of listening (i.e. to build rapport with the client or gather information).

You will recall from Module I that there are three basic types of active listening skills: attending, following and reflecting skills. Please recall that these skills require attention to both verbal and nonverbal aspects of communication. I'll distribute a handout now that reviews these skills and gives some examples of how you can demonstrate each.

Distribute handout titled "Active Listening Skills." Briefly review each item and elicit questions from participants.

D. Exercise 4: Demonstrating Active Listening – Role Play

Now you will practice using attending, following and reflecting skills by participating in a role play exercise. The structure of the role play will be very similar to the one we did earlier with barriers to effective communication. In a few minutes you will meet again in your groups of three. You will decide who wants to play the roles of speaker, listener and observer.

Speakers, you will talk about a decision that you are trying to make, just as you did in the earlier role play. You can discuss the same decision, or come up with a new one. You will speak for about three minutes.

The biggest difference with this role play is in the role of the listener. This time, listeners will use as many of the active listening skills as possible to let the speaker know that he or she is being heard and understood. You may want to keep the handout in front of you to remind you of the attending, following and reflecting skills that you can use. Remember that while you are using active listening skills, you should also try to avoid using any barriers to effective communication. Begin the role play by asking the speaker why he or she came to talk with you today.

Observers will be observing the conversation to see which active listening skills are used. You should note with a checkmark on the handout each time you see an example of one of the attending, following or reflecting skills. Also, please note if you observe the listener accidentally using a barrier to effective communication.

You will do the role play three times within your groups, so that every person has the opportunity to play each of the three roles. After the role play we will debrief about what you learned and how it felt to play these different roles. Do not worry if you make a mistake, such as using a barrier to effective communication. These barriers are very common and it is natural to make mistakes. Before we begin, do you have any questions?

Participants should separate into groups of three. Circulate around the room to see if participants need any help starting the role play. You might wish to keep track of time and tell participants when it is time to switch roles. As you walk around the room, pay attention to the conversations and note which active listening skills are being used as well as any barriers you hear. Call participants back together after each person has had the chance to play each role. Debrief using the following questions:

- When you were the listener, how did the interaction compare earlier to the first exercise when we were using the barriers?
  Possible responses include: it was more challenging, learned more about the person, etc.
- When you were the speaker, how did this interaction compare to the first exercise when we were using the barriers?
  Possible responses include: it was more helpful, increase in understanding, felt listened to, etc.
- When you were the observer, what are some examples you noticed of how people used active listening skills?
- As the observer, did you notice any instances of listeners using barriers to effective communication?
- What do you think the purpose was of doing this role play and the earlier role play on barriers to effective communication?
  Possible responses include: see how it feels when barriers are used compared with active listening techniques, practice using techniques, become more aware of barriers.

Before we discuss other engagement strategies, do you have any questions about the barriers to communication, active listening, or the role of effective communication in client engagement?

Supervision Note
You can increase CMHW competency in this skill during group supervision by:

- Conducting similar role play exercises to practice active listening skills
- Modeling active listening skills while you listen to group members speak
- Pointing out when you accidentally use a barrier to effective communication
- Reinforcing active listening skills by offering praise to group members who successfully use the skills

VII. Using Confidentiality to Increase Client Engagement

Your client is more likely to be engaged in services if he or she trusts you. People must trust you, or they will not talk to you about things that are important. One way to build trust is to maintain your client's confidentiality. You may recall that we discussed confidentiality in detail in Module I. Can anyone describe what we mean by confidentiality?

Elicit responses and thank participants for their contributions.

At its essence, confidentiality means that the client can have faith or trust in you not to tell anyone what he or she has said to you.

There are only four exceptions to maintaining confidentiality, which we discussed in Module I. To review, they are:

- **Medical emergency**: Confidentially can be broken in a medical emergency to save the life or protect the health of the client.
- **Threat of suicide or homicide**: Confidentiality can be broken if a client threatens to bring harm to self or to others.
- **Permission is granted by the client**: The client can give the helper permission to tell someone else what was said.
- **Part of treatment team**: You are allowed to discuss what your client says with the physician you are partnered with and with your supervisor. Both you and the physician will provide care to your clients, and the physician must know what is going on with the client in order to provide good care. Your supervisor will need to know what you are discussing with your client in order to provide you with useful supervision and recommendations. You should mention this

fact at the first meeting when you discuss confidentiality with your client.

Can you think of any specific examples of how you would have to break confidentiality under any of these exception categories?

Elicit responses and thank participants for their contributions. Possible responses include: client is unconscious and you tell hospital staff that client takes medication for depression; client gives you permission to talk with her family about her diagnosis or progress in treatment; client is threatening to harm someone and you report it to the police.

Do you have any questions about confidentiality or why maintaining confidentiality is so important?

Elicit responses and address any questions that participants raise.

VIII. Exercise 5: Common Confidentiality Questions – Discussion

Now that you understand the importance of confidentiality, let's review some of the confidentiality questions that clients or coworkers might ask you. We'll discuss some of the common questions and how you might answer them.

Write the following questions on the board:

- *What if the client's father or husband asks what the client said to me?*
- *What is meant by a medical emergency?*
- *Can you give me some examples of a medical emergency?*
- *If my client gives me permission to talk with his family, can I tell them anything that the client has told me?*
- *What if the client is an unmarried girl of 18; can I talk with her mother?*

Read these questions aloud and ask participants how they would answer them. As they discuss their answers, emphasize that CMHWs should not discuss anything the client has told them with anyone outside of the treatment team without the client's permission, except in a medical emergency (any situation in which the client's life or health may be in danger and that information that the client has told the CMHW is needed in order to prevent physical harm or death to the client).

Confidentiality should be discussed during your first clinic or hospital meeting with your client. You should discuss what confidentiality means and the conditions under which it will be broken.

IX. Identifying Strengths and Client Engagement

Another way of engaging your clients is to discuss their strengths, resources, skills and future goals. Client strengths and resources come in many forms. Strengths can be personal characteristics, such as having good physical health, a lot of energy, or a curiosity for learning new things. Another type of strength is having positive relationships with friends and family members who can support one in meeting one's goals. Strengths and resources also include things that people possess, such as having a house, a job, or access to a computer.

It can be useful to discuss strengths before asking a client about his or her goals. This is because existing strengths and skills are the basis for many goals. Helping a client identify the strengths and skills he or she currently possesses can lead to a discussion about the goals a client hopes to attain in the future, building upon existing accomplishments.

Discussing strengths can help a client feel more hopeful about treatment and the future. Even in the face of great problems, with your help clients can realize that in many cases, they already possess many of the things they need to find solutions. Even people who are not functioning well or are in great distress have some strengths and resources. The fact that a client had the willpower to survive traumatic events, torture, or serious physical or mental health problems is a tremendous strength in itself.

In many instances clients have difficulty identifying their strengths and skills, particularly when they are feeling overwhelmed by their problems. What are some questions you could ask clients to help them identify personal strengths?

Elicit responses. Possible responses include: ask clients what they like to do for fun, ask what others would say they are good at, have clients describe their top three positive qualities.

Another way to help clients identify areas of strength, as well as future goals, is to ask them about different domains of mental health or well-being.

Domains of mental health go beyond the presence or absence of symptoms of mental illness, and include all areas of life that contribute to a person's wellbeing. More specifically, domains include family life, social life, employment, physical health, emotional health, self care, and religion and spirituality. By asking clients about their satisfaction in each of these areas, you can help them identify strengths and resources, as well as areas in which they want to improve.

X. Exercise 6: Identifying Strengths Using Domains of Mental Health – Role Play

For this exercise, I'm going to distribute a handout with the Domains of Mental Health Satisfaction Scale. You can use this form to help clients identify strengths. For each domain, there is a scale that ranges from "low satisfaction" on one end to "high satisfaction" on the other." Working with a partner, you will practice asking each other about your satisfaction in each of the mental health domains.

Distribute handout "Domains of Mental Health and Well-Being: Satisfaction Scale."

You and your partner will take turns asking one another about your satisfaction in each of the seven domains. When answering questions, you can describe your satisfaction in these areas in your personal life, or if you prefer you can role play a client. The person playing the CMHW should ask their partner how he or she would rate him or herself on each of the domains. For example, the CMHW could say, "Tell me about your level of satisfaction with your family life." After some discussion, the CMHW might ask his or her partner to point to the spot on the line that represents his or her level of satisfaction in this area. The CMHW would mark this spot with a pen. After you have discussed all the domains, the CMHW should ask their partner these questions:

- Based on your satisfaction in each of these areas, what are some strengths or resources that you have?
- What are some areas that you wish to improve upon?

You should spend about ten minutes discussing the domains and these questions. Then we will switch roles, so each person has the chance to play the CMHW. Afterward we will debrief as a group. Before we begin, do you have any questions?

Circulate around the room as participants practice the role play with their partners and address any questions that arise. After about ten minutes, have the partners switch roles. Then debrief as a group using the following questions:

- How did you feel answering the questions on the scale?
- How did you feel using the scale as the CMHW?
- What did you learn from doing this exercise?
- How would you feel about discussing strengths and domains of mental health with actual clients in the future?

XI. Using Goal-Setting to Increase Client Engagement

Another way to improve client engagement is to help clients identify and reach their own goals. As mentioned earlier, conversations about goals often flow naturally from talking about strengths and resources. Goals are important because they help us make plans in life. We use goals to give us direction in life. People who have goals are more likely to be motivated to participate in activities and complete daily tasks that will enable them to reach their goals.

You may recall from Module II that there are three types of goals:

- **Daily goals**, for example attending this training, spending time with your family, or getting a certain amount of sleep.
- **Short-term goals** are those that can be attained over the next few months. Short-term goals may include activities such as enrolling in and starting school, reading a new book, or mastering a new recipe.
- **Long-term goals** are goals that will likely take several months or years to accomplish, such as saving money to purchase a home in three years or becoming a fluent speaker of a foreign language. Long-term goals almost always involve a series of short-term goals for their attainment.

Goal-setting becomes formalized during the intake and treatment planning process. Intake and treatment planning can be important tools of engagement. During the intake process and on the treatment plan, you will help the client to identify problems and specific goals to work on during treatment. You will also help the client determine the skills he or she will need to attain his or her goals, and outline the interventions you will provide to help the client. This process can help to engage clients by giving them a sense of purpose. Intake and treatment planning inform clients as to what is

expected of them during the treatment process, and what they can expect from their CMHWs. However, remember that it is very important for workers to pace intake and treatment planning activities and help clients break larger goals into smaller, more attainable ones. Otherwise, clients might feel overwhelmed and consequently disengage from services.

We will discuss how to set goals with clients on treatment plans in more detail in a later training. In the meantime, keep in mind that you can engage clients by discussing goals in less formal ways throughout treatment. By helping clients identify their goals, and by helping them identify steps in reaching their goals, we can motivate them to increase their participation in services.

Supervision Note
You can increase CMHW competency in this skill during group supervision by asking questions such as:

- What would your client like to accomplish within the next year?
- What steps would your client need to take in order to accomplish this goal?
- If your client could change anything in his or her life, what would that be?
- What does your client identify as some of his or her strengths?
- How can you help the client utilize those strengths to meet his or her goals?

XII. Exercise 7: Goal-Setting and Engagement -- Demonstration

Now we will do an exercise to demonstrate the value of goal-setting in engagement. In a few minutes you will meet again with the partner you worked with on the previous exercise. You and your partner will discuss some questions about your personal goals, strengths, and interests. After your discussions, we will discuss how talking about goals can help people feel engaged.

Please meet with your partner now. Ask each other the following questions, and record the answers:

- Looking back at your responses on the Domains of Mental Health Satisfaction Scale, what are some of your areas of strength?
- What are some of your personal interests?
- Based on the scale, what are some areas in which you would like to improve?
- What is one of your daily goals?
- What is one of your short-term goals?

- What is one of your long-term goals?

Walk around the room to observe what participants are discussing. Allow enough time for both partners to answer all the questions (about 20 minutes). Then call the group back together and debrief using the following questions:

- Describe how you felt when talking about your areas of strength and interests. Were you interested and engaged in the conversation?
- Describe how you felt when talking about your personal goals. Were you interested and engaged in the conversation?
- Did your partner listen to you? How could you tell (i.e. which active listening skills did you notice)?
- How would you feel about asking a client these questions?
- What do you think was the purpose of this exercise?

The purpose of this exercise was to demonstrate how talking about strengths, interests and goals can be a good way of engaging people. Most people are engaged when discussing things that are of interest or value to them, including their strengths and goals.

We will continue to discuss client strengths and goals throughout the course of this training. For now, here are some important points about goal-setting and engagement to keep in mind:

- People are more likely to reach for their goal when they have set the goal for themselves.
- We may need to help clients identify the short-term goals that they need to attain in reaching their long-term goals.
- Success breeds success. A useful strategy in working with clients is to help them choose some easy goals to attain, in addition to the more difficult goals, in order to build motivation and self-efficacy.

XIII. Review

Let's review the key points we learned today about engaging clients in services:

1. Strategies for engaging clients in services include demonstrating empathy, using effective communication techniques, protecting client confidentiality, and helping clients identify strengths and set goals.

2. Effective communication involves avoiding barriers such as judging, giving solutions, or avoiding concerns, while demonstrating active listening skills.
3. Active listening skills include the following: attending skills, following skills, and reflecting skills.
4. Confidentiality means that the client can have faith or trust in you not to tell anyone what he or she has said to you. Maintaining confidentiality is critical in building trust with a client.
5. Clients can become engaged by setting goals for themselves, particularly when those goals are linked to strengths and existing skills.

XIV. Exercise 8: Practicing Client Engagement – Role Play

We will now do a role play that will give you the opportunity to practice all of the strategies for engaging clients that we have discussed. In a few minutes you will select a partner. One person will role play the client, and the other will play the CMHW. Here is the scenario:

Fadeela is a 59 year-old woman. After visiting the physician for treatment for her arthritis, the physician referred Fadeela to a CMHW because she wanted someone to talk to about her problems. Fadeela has had many difficulties in life. Her husband passed away a few years ago, and she now lives with her daughter, son-in-law and their three children. Her youngest son died during a war many years ago. Fadeela still cries when she thinks of her son, which is often. She has never had many friends, and she spends most of her time sitting at home, often remaining in bed. She fears that she is becoming a nuisance to her daughter and son-in-law, although they have not told her this directly.

Fadeela is limited in her ability to help with housework because of her arthritis, although she can do some things. She has always loved children and would like to have more energy to play with her grandchildren and help them with their school work. Fadeela felt hopeful when her physician referred her to a CMHW, but she is not sure what to expect as she has never spoken with a professional before about her personal problems and goals.

You and your partner will now meet to plan your role play. You should pretend that the worker is meeting Fadeela for the first time. The worker's goal is to explain his or her role as a CMHW and begin to engage the client

in services. You do not have to complete the intake form as part of this role play. During your role play, please address the following areas:

- CMHW introducing himself or herself and explaining what a CMHW is and what services can be offered
- CMHW explaining the confidentiality policy to the client
- CMHW asking the client about the problems she is having that prompted her to make the appointment
- CMHW asking the client about some of her interests, strengths and goals
- Remember to use active listening skills and avoid barriers to effective communication throughout the role play

You and your partner will meet for about 20 minutes to practice your role play. Your role play should last about five to ten minutes. Then we will meet again as a group and perform the role plays for each other. I will first model the role play for you with a partner, and then each pair will perform. Afterward we will debrief about what we learned doing this exercise and how it felt to play the client or the CMHW. Before we begin, do you have any questions?

Walk around the room while participants are practicing their role plays and address any questions they have. Call the group back together after about 20 minutes, allowing more time if necessary. First, model the role play using a participant volunteer or co-trainer to play the client. Demonstrate using effective communication techniques as you role play each of the areas of client engagement listed above. Invite participants to describe what you did well in the role play and what they think you should have done differently. After you role play the scenario, invite the participants to perform. Immediately following each pair's performance, debrief by asking the pair the following questions:

- How did you feel playing the role of the client?
- How did you feel playing the role of the CMHW?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief as a group using these questions:

- What are some of the specific strategies that CMHWs used to engage the client?
- What active listening techniques did you notice?
- What barriers to effective communication did you observe?
- If this were a real case, do you think the client would continue coming for services? Why or why not?
- If the client did return, what do you think the CMHW and client might discuss in their next session?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

XV. Conclusion

Today we have discussed several ways you can increase your client's engagement in services:

- Using empathy to connect with your client
- Using effective communication skills in listening to your client
- Using confidentiality to build trust with your client
- Using identification of strengths and goal-setting to motivate your client

Engagement is the starting point for all other services that you will offer the client. A client who is not engaged, motivated, or trusting of the worker is unlikely to continue with treatment or follow up on any recommendation you make. Conversely, when clients are engaged, they begin building a relationship with the worker based on trust and mutual respect that will benefit them throughout the treatment process.

Before we conclude for today, do you have any questions about engaging clients in services?

Address any questions or concerns that participants raise.

I'd like to end the training now by going around the room and having everyone name one thing they will start doing or continue to do to engage clients in services.

Be sure to thank all participants for their contributions and attention. Have them complete the Competency-Based Training Exam.

HANDOUT

Barriers to Effective Communication

JUDGING

- Criticism – "Your house is dirty and you do not care for your children."
- Name-calling – "You are crazy and a bad mother."
- Negative evaluation – "Anyone who does not cook and clean for her husband is a terrible wife."
- Diagnosing – "You act like you are depressed."
- Praising with evaluation – "You are a good cook. Too bad you don't clean the house better."

GIVING SOLUTIONS

- Ordering – "Go to your father and ask for food."
- Threatening – "If you do not stop drinking alcohol I will tell the Imam."
- Moralizing – "Drinking alcohol is haman and brings shame to your family."
- Excessive questions – "What did you do? Who were you with? Who saw you do this? What did they say?"
- Advising – "If I were you I would tell my husband to go to work."

AVOIDING CONCERN

- Diverting – "You think you have problems, well let me tell you about Naima!…"
- Logical argument – "If you consider what it costs to have a wedding, it is good that your son will not marry until after he finishes college."
- Reassuring – "Try not to be so upset about your brother's death. Even though you're sad now, you and your family are going to be fine."

Source: Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

HANDOUT

Active Listening Skills

ATTENDING – Use nonverbal communication to let the speaker know you are listening

- Nod your head
- Smile
- Lean toward the speaker
- Remain silent

FOLLOWING – Use short phrases to let the speaker know that you want the speaker to continue talking

- "Tell me more"
- "I see."
- "What can I help you with"
- "You look like you wish to talk"

REFLECTING – Use reflective statements to let the speaker know that you understand what is being said

- Paraphrasing (restate what the speaker has said in your own words)
- Summarizing (gather together common ideas or statements that the speaker keeps repeating
- Interpreting the speakers feelings by connecting the speaker's verbal and nonverbal communication ("You feel _____ because _____")

Source: Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

Domains of Mental Health and Well-Being: Satisfaction Scale

Family (relationships, support among family members, etc.)

Low satisfaction Moderate satisfaction High satisfaction

Social (friends, activities, interests, etc.)

Low satisfaction Moderate satisfaction High satisfaction

Employment (finding/keeping a job, adequate income to support basic needs)

Low satisfaction Moderate satisfaction High satisfaction

Medical/Physical (medical problems, access to services, money for medicines)

Low satisfaction Moderate satisfaction High satisfaction

Emotional (calmness, not being overly worried, having control over emotions, can express a range of emotions)

Low satisfaction Moderate satisfaction High satisfaction

Self care (sleep/rest, eating, hygiene)

Low satisfaction Moderate satisfaction High satisfaction

Religion/Spirituality (spiritual beliefs/traditions, connection to faith community)

Low satisfaction Moderate satisfaction High satisfaction

Competency-Based Training Exam – CMHW

Name: _____ Date: _____

Answer the following questions to the best of your ability.

1. Why is maintaining the client's confidentiality important?

2. Describe how helping client identify strengths could increase engagement.

3. Name three types of goals and give examples of each.

4. What is empathy?

5. Give an example of a barrier to effective communication.

Psychoeducation for the Individual and Family

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to use psychoeducation as an intervention technique to inform and support their clients.

Informational Competencies:
At the end of this training, the CMHW will know…

- Definition and importance of psychoeducation
- The purpose of normalizing and examples of normalizing statements
- Symptoms of mood and anxiety disorders, including depression and PTSD
- How biological and environmental factors contribute to the development of mental illnesses
- General information on the course and treatment of mental illness
- Ideas for promoting good mental health, based on the seven domains of mental health and wellbeing
- Communication techniques in psychoeducation
- Confidentiality issues in psychoeducation with families

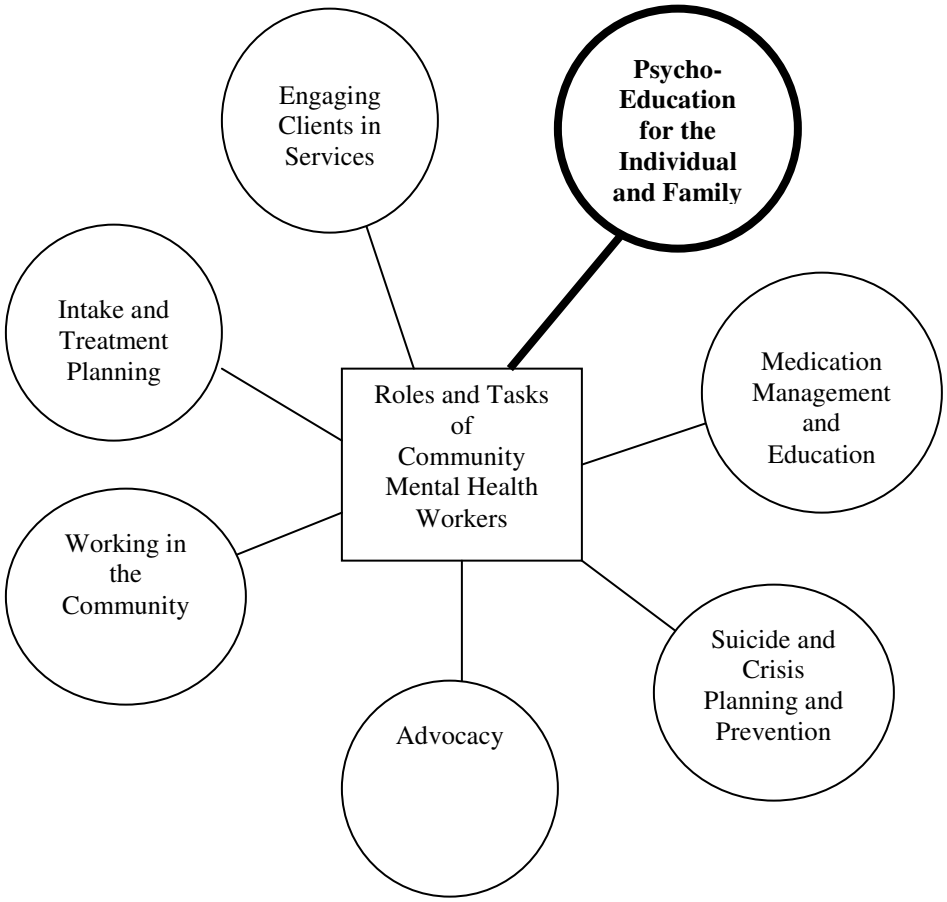
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Define psychoeducation as an intervention technique and describe its importance
- Make statements that convey empathy to clients and normalize client concerns
- Communicate information on symptoms, causes, course and treatment of mood disorders and anxiety disorders to clients
- Communicate information on the seven domains of mental health and how clients can promote good mental health
- Demonstrate effective communication techniques as a psychoeducator, including using active listening and avoiding barriers to communication
- Acknowledge and respect client confidentiality in conducting family psychoeducation sessions

Learning objectives:
The goal of this training session is to teach…

- Information on mental health and mental illness (including common symptoms, contributing factors, course and treatment)
- Communication skills for psychoeducation
- Confidentiality issues and contexts for psychoeducation

This training addresses the following CMHW Job Role(s):
Psychoeducation for the Individual and Family



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*, 4th ed.—text revision. Washington, D.C.: APA.

Corrigan, P.W. & Garman, A.N. (1996). Case management and severe mental illness. In S.S. Blancett & D.L. Flarey (Eds.), *The handbook of nursing case management: Health care delivery in a world of managed care* (pp.334-353). New York: Aspen Publishing.

Pratt, C.W., Gill K.J., N.M. (1999). Chapter 8, Case management strategies. In *Psychiatric rehabilitation*, (pp.122-133). San Diego: Academic Press.

Rothchild, B. (2001). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, W.W. Norton.

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

We will begin this training by defining psychoeducation and describing why it is important in client treatment.

II. Definition of Psychoeducation

Psychoeducation simply means educating clients, families or communities about topics related to mental health such as symptoms, causes, course and treatment of mental illnesses or distress, and the promotion of good mental health and wellbeing. When a person in distress is seeking help, psychoeducation is one of the easiest, most effective intervention techniques that physicians and CMHWs can use, no matter what the person's problem is. Psychoeducation helps to improve a client's understanding of his or her problem, and thereby can increase the client's self-esteem. When people have more information about the nature of their problems and how treatment works, they often regain hope.

III. Exercise 1: Importance of Psychoeducation – Role Play

Let's do a role play to demonstrate how psychoeducation works and why it's important in client treatment. May I have a volunteer?

Select a volunteer and have him or her come to the front of the room.

We're going to imagine that our volunteer has been having severe headaches as well as sharp pain in his left foot. This has been going on for weeks. In great distress, he finally came to see the physician. The physician has just told him that he has orthobrotitis. Let's see how this client is feeling.

Ask the volunteer some questions to probe his concerns and feelings. Elicit questions from the audience. Some things you might want to ask:

- Do you know anything about your condition, orthobrotitis?
- How long do you think your problem will last?
- Do you think orthobrotitis is treatable?

- Do you have any idea what causes orthobrotitis? Do you think it's your fault?
- How are you feeling right now? What concerns are you having?

Our client is experiencing a lot of confusion right now. He knows that he is experiencing pain and he knows the name of his condition. But he does not know what caused the pain, what the expected course of the illness is, or if it can be treated. Now let's say that this client has the opportunity to speak with a CMHW. I will play that role.

Demonstrate the role play. Greet the client and tell him you understand the physician has just given him a diagnosis of orthobrotitis. Ask the client what he knows about this condition. Then, explain that orthobrotitis is a problem that occurs when nerve tissue in the foot becomes infected. The infection reaches to the central nervous system, causing the client's headaches. Tell the client that this infection is often caused by bacteria that people can pick up through bathing or swimming. Assure the client that though it is serious, his condition is treatable with medication that the physician can prescribe. However, the client will have to stay off his feet for a few weeks while the infection heals. Encourage the client to ask questions and discuss his feelings and concerns. Show an empathic response to the client's concerns and use normalizing statements in discussing his feelings.

Now that our client has had the chance to meet with the CMHW to discuss his feelings and learn about his condition, let's see how he's feeling.

Have the audience ask questions, similar to before, about how the client is feeling and what concerns he has. Client should describe feeling some relief now that he feels his concerns are understood and knows what his condition is, what caused it and what to expect from treatment.

You can see what a difference it made for this client to have the chance to talk about his concerns and learn about his condition and how it could be treated. It seemed he was feeling much better as a result of meeting with the CMHW to discuss this.

Orthobrotitis is an imaginary condition. When your clients visit their physicians and receive actual diagnoses, they may be just as confused. Clients may have no idea what the diagnosis means, or may have serious misconceptions about the illness. Psychoeducation helps to empower clients

by giving them the essential information they need to help themselves and recover.

As demonstrated in this role play, the CMHW has a special role in psychoeducation. CMHWs do not make diagnoses. Only physicians can formally diagnosis clients with a condition, such as major depression. As a CMHW, you can recognize symptoms of distress and refer clients to their physicians, who may then make a diagnosis of a mental illness. Psychoeducation continues after a diagnosis has been made. Since physicians often don't have as much time to meet with clients, it's important for CMHWs to take time to provide information to clients about mental health and address clients' questions and concerns, even as the client is receiving different types of treatment or services. In addition, CMHWs can use psychoeducation techniques to inform all clients (as well as family and friends) about ideas for promoting good mental health.

IV. Normalizing in Psychoeducation

In addition to providing information, psychoeducation also gives CMHWs the chance to express empathy for what clients are feeling and normalize their concerns. Normalizing means recognizing someone's concerns and acknowledging that their feelings are not unusual. People who have experienced trauma or distress often feel very isolated. They might believe that they are the only person in the world who struggles with this sort of problem, and might believe their situation is hopeless. Normalizing is one way of demonstrating empathy. Normalizing in psychoeducation shows clients that you acknowledge and understand what they are feeling.

There are many ways in which CMHWs can use normalizing. Often normalizing will be paired with another type of intervention. For example, a client comes to see a CMHW feeling very anxious and upset after experiencing a crisis, such as the death of a family member or running out of food. In this case the CMHW might use normalizing to let the client know that her feelings and anxiety are normal, and also talk with the client about coping skills and resources to help the client work through the crisis. Thus, normalizing is just technique that CMHWs can use to help clients, along with psychoeducation and other treatment interventions.

Let's try to think of some more examples of how you can use normalizing with clients. What are some statements or expressions you could use with clients to convey that the feelings and concerns they are describing are

normal? You can look at the first part of your handout, "Normalizing," for some ideas, but let's also try to come up with some of our own.

Distribute the handout "Normalizing" to participants. Elicit ideas from participants and write all responses on the board.

Using normalizing effectively can be a delicate matter. The second half of your handout has some pointers on how not to normalize. One important thing to remember is that when you use normalizing, be sure to do it in such a way that does not disregard a client's distress or problems. Remember that avoiding concern is one of the barriers to effective communication. Before making a normalizing statement, you should take care to use your active listening skills to fully understand what the client is trying to tell you about his or her problem. Normalizing is powerful because it can help clients feel less anxious or isolated, but it is useful only if the client believes you understand and can empathize with just how distressed or upset he or she is feeling.

Another important distinction is that you are seeking to normalize the client's feelings, and not their experiences. Although traumatic events such as rape, torture, abuse, or the violent deaths of loved ones may happen more often than we would like, these events are not a part of the normal human experience. These are extraordinary events that one wishes would not happen to anybody. When a client describes a traumatic event, he or she may feel ignored, misunderstood, depressed, or angry if the worker reflects that such a terrible event is normal or commonplace. Rather, the worker should try to convey that feeling distressed—in a variety of physical, emotional, or social ways—is a normal response to an abnormal traumatic experience.

Review the examples of "how not to normalize" on the "Normalizing" handout.

V. Exercise 2: Practicing Normalizing – Role Play

Now we will do a brief role play to practice using empathizing and normalizing statements. In a few moments we will separate into groups of three. One person will be the speaker, one will be the listener and one will be the observer.

Speakers, you should discuss your feelings and concerns about a problem you are experiencing. You can choose a personal problem, i.e. "I'm concerned that I will not be selected for a promotion at work," or you can role play a client and select a problem one of your clients might present. Explain to the speaker what the problem is, and describe your feelings, worries and fears in relation to the problem. You are not coming to the speaker to solve your problem, but just to get him or her understand what you are feeling or experiencing. You will speak for about three minutes.

Listeners, focus on using normalizing statements to show the speaker that you understand and support him or her. Use normalizing statements to let the speaker know that you empathize with his or her feelings and his or her feelings and concerns are normal. Also remember to use your active listening skills.

Observers, you will watch the listeners for examples of normalizing statements. Please jot it down when you hear the listener making a normalizing statement. Also pay attention to the speakers' reactions to such statements.

You will do the role play three times within your groups, so that every person has the opportunity to play each of the three roles. After the role play we will debrief about what you learned and how it felt to play these different roles. Before we begin, do you have any questions?

Help participants separate into groups of three. Circulate around the room to see if participants need any help starting the role play. You might wish to keep track of time and tell participants when three minutes are up and it is time to switch roles. As you walk around the room, pay attention to the empathizing and normalizing statements that you notice listeners using and how the speakers' reactions. Call participants back together after everyone has had the chance to play each role. Debrief using the following questions:

- How did it feel to use normalizing statements as the listener?
- As the speaker, how did you feel when the listener used normalizing to respond to you?
- What are some examples of normalizing that you noticed as the observer?
- As the observer, did you notice any instances of listeners trying to normalize the speaker's experiences, instead of the speaker's feelings? How did the speaker respond when this occurred?

Supervision Note
You can increase CMHW competency in this area during group supervision by:

- Doing role plays similar to the one above to have CMHWs practice using normalizing statements
- During case reviews, asking questions such as "How did you use normalizing to address the client's concerns?" or "What did you do to convey empathy to the client?"

VI. Using Psychoeducation to Convey Information

In addition to normalizing, the other main function of psychoeducation is conveying information about mental health. Many clients will come to you before or after receiving a diagnosis for a mental illness from a physician. In this training we will discuss symptoms, contributing factors, course and treatment of mental illness, so you can give this information to your clients. We will also discuss more general information about promoting mental health and wellbeing.

A. Using Psychoeducation When Discussing Symptoms

Mental illness can be experienced in a number of different ways. Symptoms of mental illness and emotional distress can be divided into different groups. Many of your clients' symptoms and problems may fall into the categories of mood disorders or anxiety disorders. I'll distribute two handouts now, one with symptoms of mood disorders and the other with symptoms of anxiety disorders. Some clients may have problems in both of these areas.

Distribute handouts on mood disorders and anxiety disorders. Review each symptom and ask participants if they have any questions.

You can use this information on symptoms to provide psychoeducation to clients. For example, a client comes to see you and describes having low energy, although she sleeps many hours each night; intense feelings of sadness and emptiness; and lack of interest in activities she used to enjoy. How might you respond to this client, based on the information you have about symptoms of mood disorders and anxiety disorders?

Elicit responses and thank participants for their contributions. Possible responses may include: review list of mood disorder symptoms with client, tell client it sounds as if she may have some symptoms of a mood disorder and refer her to a physician.

Supervision Note
You can increase CMHW competency in this area during group supervision by asking questions such as:

- Is the client able to identify the symptoms he or she is experiencing? If not, can you assist him or her in doing this?
- How did you normalize the client's feelings and experience of the symptoms?

You may also wish to routinely review the symptoms of mood disorders and anxiety disorders in supervision as a refresher.

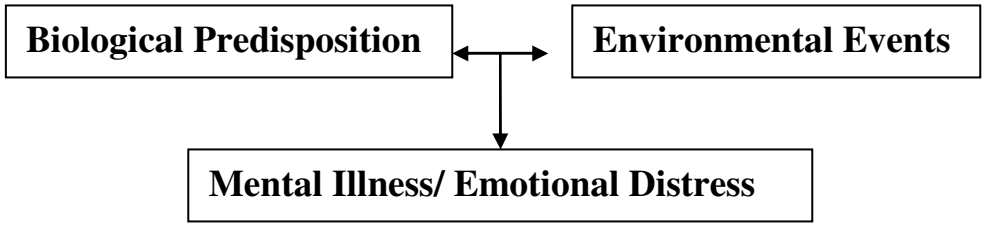
B. Understanding Mental Illness

Many clients may want to know why they are feeling the way they do. Why do you think some people develop mental illness?

Elicit responses and write participants' ideas on the board.

There are many possible sources of mental illness or emotional distress. A great body of research supports the idea that mental illness is best explained as an interaction of biological and environmental factors. We first discussed this idea in Module I. Let's review it now.

Draw the following diagram on the board or paper:



An individual may be born with a certain biological predisposition to illness. Can you give me an example of a biological predisposition? *Example: inherited gene for a certain disease, such as diabetes or breast cancer*

Can you give me an example of environmental events that can lead to illness? *Example: if an infant's mother were malnourished or infected with illness prior to birth; cigarette smoking and lung cancer*

This model of understanding mental illness is important for our discussion of psychoeducation because it is something that we can explain to our clients. The model emphasizes that the symptoms clients experience are most likely the result of complex interactions among biological and environmental

factors and events. You might even draw the diagram here for your clients. It's important to stress the following points:

- Mental illness is real. It involves changes in the biological structure and functioning of the nervous system. A person cannot will it away.
- The client and his or her parents or family did not cause the illness or "bring it upon themselves." One does not have a choice in developing mental illness, just as one does not choose to develop cancer.
- Mental illness and emotional distress are common, particularly for people who have experienced traumatic events such as rape, abuse or torture.

Supervision Note
You can increase CMHW competency in educating clients on this topic by asking questions during supervision such as:

- What explanations do your clients have for why mental illness occurs?
- How do you tactfully explain that research supports the idea of biological predispositions and environmental events causing mental illness, without offending clients with other beliefs?

C. Trauma and Distress

Trauma is one of the best-known types of environmental events that can change an individual's biological predisposition. You'll recall that we discussed trauma and its effects in Modules I and II. Can anyone describe what a traumatic event is or give an example?

Elicit responses and thank participants for their contributions.

Right, a traumatic event is an extraordinarily stressful experience, during which a person fears that their own safety or the safety of those around them is threatened. Traumatic events include the types of things one sees in a war, the death of someone close to you, or rape.

It is widely believed that experiencing a trauma can change the biological structure and functioning of a person's nervous system. These changes can increase a person's predisposition to experiencing symptoms of mental illness. Some people who experience traumatic events develop Post Traumatic Stress Disorder (PTSD), which we discussed in Module II. Recall that a person with PTSD may experience a variety of responses as a result of the trauma, such as reoccurring nightmares or memories of the traumatic event, panic, and being easily startled. Please keep in mind that these responses are normal. It is important to assure clients of this, even

though the traumas they experienced that caused these responses were outside of normal human experience.

So, in the case of PTSD, when we look back at that model of mental illness, we emphasize the "stressful life event" over biological predisposition.

D. Course of Mental Illness

The course of a disease is how long it typically lasts, and the impact it is expected to have on a person's functioning over time. The courses of mental illnesses vary widely, based on the person, his or her environment, and the diagnosis. Clients should be referred to their physicians to discuss the details of the expected course of their particular conditions. However, you can relay the following general information to clients:

- The courses of mental illness vary widely, though generally mental illness affects people over a long period of time.
- Treatment can vastly shorten and change the course of mental illness. Though individual responses vary, almost all mental illnesses are responsive to some type of treatment.

E. Treatment of Mental Illness

You will be working closely with physicians to coordinate a treatment plan for each client. The interventions and goals specified in the treatment plan will vary from client to client, based on the person's goals, skills, strengths and needs. Your discussions about treatment with clients will be ongoing, as you develop and implement the treatment plan. Early in treatment, however, you may wish to educate clients and their families on some basic facts about mental health treatment:

- Numerous treatment approaches have been researched and developed for practically all mental illnesses. In particular, many treatments have been developed for anxiety and depression.
- Although many treatments have been developed, clients should also recognize that even when a treatment exists, it may not always be accessible for them, due to cost or availability. However, many people with mental health problems can helped through the services offered by physicians and CMHWs at your hospital, as well as by their own resources and coping skills, which will be explored on the treatment plan.
- You might wish to tell clients about the specific treatment services available at your facility. For example, you could say, "As part of our

program we offer medical services (including psychotropic medication) and support." You might further describe that the support you can provide includes helping people identify their problems, goals, and strengths and resources they can use to meet their goals.

- Everyone responds to treatment differently, and it takes time. Medications for symptoms of mental illness, for example, typically take a few weeks to take effect. Clients should try to be patient, but communicate honestly with physicians and workers about what is or is not working for them.

F. Promoting Good Mental Health

We've just discussed several different aspects of mental illness, including symptoms, contributing factors, course, and treatment. However, not every client you see will be diagnosed with a mental illness. Recall that there are seven domains of mental health and wellbeing: family life, social life, employment, physical health, emotional health, self care, and religion and spirituality. People may have different levels of satisfaction in each of these areas, regardless of whether or not they have been diagnosed with a mental illness. When a client feels satisfied in each of these areas, he or she is said to be in good mental health.

Psychoeducation should include educating clients about these seven domains of mental health, and exploring things that people can do to promote good mental health and wellbeing.

G. Exercise 3: Ideas for Promoting Good Mental Health – Group Activity

Let's do an exercise to come up with some specific ideas for how people can promote good mental health. You're probably familiar with some general tips for promoting good physical health, such as eating a healthy diet or not smoking. Now we're going to think of some tips we can pass on to our clients for promoting good mental health.

Please divide into groups of three or four. Your group should come up with at least five ideas for promoting good mental health. Consider things you could do to increase satisfaction or functioning in any of the seven domains of mental health. For example, regularly talking about one's feelings with a trusted friend or family member is a general way to promote emotional health. Please write down your ideas. Your group will have 15 minutes to

generate ideas and then we will share them with one another. Do you have any questions before we begin?

Assist participants in separating into groups of three or four. Circulate around the room as groups generate ideas. Call participants back together after about 15 minutes. Have a volunteer from each group read their ideas, and write ideas on the board. Thanks the groups for their contributions. After all groups have presented, lead a discussion using questions such as:

- Which of these tips can you see yourself sharing with clients and why?
- How will you convey information on promoting good mental health to clients? For example, would it be useful to give clients a tip sheet on promoting good mental health? (*If so, you may encourage participants to write down all of the tips and have a volunteer type them up and distribute to other CMHWs*)

VII. Review: Areas of Psychoeducation

We've just covered a lot of information about different aspects of mental health, which you can pass on to your clients. Let's quickly review the areas we've discussed:

- Symptoms of mental illnesses, focusing on mood and anxiety disorders
- Contributing factors to mental illness and emotional distress, stressing the interaction of biological and environmental factors
- Course of mental illness
- Treatment of mental illness
- Promoting good mental health using the seven domains of wellbeing

Do you have any questions about any of these areas?

VIII. Communicating as a Psychoeducator

Now that you have information on different aspects of mental health, let's discuss <u>how</u> you can communicate effectively as a psychoeducator. Think back to the role play we did at the beginning of the training. Let's say that you are a new client who has just been diagnosed with a condition you do not know anything about. Or you might be experiencing some distressing feelings, but not even know what is wrong with you. How would you want to be treated by a CMHW?

Elicit responses and write ideas on the board. Possible responses include: worker should listen without passing judgment, worker should let me ask questions, worker should be patient, worker should make appointments to follow up with me.

Let's keep all of these things in mind when we think about how to communicate in psychoeducation. Here are some important things to remember:

- Use active listening skills. Remember that the first step in psychoeducation is always listening to the questions and concerns that a client has. If a client is not initially forthcoming in voicing his or her feelings and concerns, you may want to ask him or her some questions, such as:
    - How are you feeling right now?
    - Do you understand the information the physician gave you?
    - Do you have any other questions? Any other concerns you'd like to talk about?

- Remember to look out for the barriers to effective communication, which we reviewed in our training on engagement. These barriers include judging, giving solutions or avoiding a client's concerns. In psychoeducation, it is critical to remember to listen to clients first before you try to give them information.

- Recognize that psychoeducation is ongoing. A great deal of psychoeducation may be needed when a client first comes to see you or after he or she receives a diagnosis from a physician. However, many clients will continue to need psychoeducation on how to manage their symptoms and cope with their illness or distress, as well as on promoting good mental health, long after they have started treatment. Even if you have been seeing a client for a long time, check in with him or her periodically about how he or she is feeling and see if he or she has any new questions about mental health.

Supervision Note
While CMHWs may find it easy to use psychoeducation in the beginning of treatment, some may not remember to use this intervention on an ongoing basis. Check during supervision to see if CMHWs are using psychoeducation and addressing clients' questions throughout the course of treatment.

IX. Confidentiality and Psychoeducation

There are many contexts for psychoeducation. You can use psychoeducation with individual clients and families, or in community forums, a topic that we will discuss in another training. Confidentiality is an issue when using psychoeducation with a client's family.

When clients choose to involve their families in treatment, it can often be beneficial, as the family can provide support. However, some clients may not want to involve their families in treatment. They may not even want their family to know that they are having certain problems or going to the hospital. You can ask a client if he or she wishes to involve his or her family in treatment or inform them of his or her problems. If the client says no, you must respect the request and protect the client's confidentiality. In this case, all of the psychoeducation will be directed toward the client and your interactions with the family will be minimal.

Psychoeducation can be a useful intervention with families when the client permits it. For example, after discussing diagnosis and treatment individually with the client, you and the client might choose to organize a family session. What are some of the topics you might want to address?

Elicit responses. Possible responses include: tell family about client's diagnosis and what it means; ask family what questions they have; discuss treatment plan and how family can support the client.

Before you initiate a family session, make sure you and the client are clear on what will be covered. For example, a client might be comfortable talking with her family about the medication she will take, but not want to tell them her actual diagnosis. Once confidentiality is breached, it can be difficult to restore trust in your relationship with your client. Therefore, it is very important to make sure that the client is aware of and comfortable with <u>all</u> of the information you plan to present to the family in a session.

Supervision Note
Conducting a family psychoeducation session is a difficult skill. It requires the worker to attend to the needs of the client while also addressing the family's questions and concerns. The worker is put in a difficult position if family conflict arises during the session. Use group supervision to role play a family psychoeducation session, modeling the role of the CMHW. The role play should demonstrate that the session should always focus on psychoeducation topics as previously agreed upon by the client (i.e. client's diagnosis, symptoms or treatment). The worker should not attempt to mediate or discuss other family issues that may arise, since CMHWs are not adequately trained to do this.

X. Review

Let's review the key points we learned today about psychoeducation:

1. Psychoeducation is the process of educating clients, families or communities about mental health.
2. Psychoeducation can help clients by normalizing their concerns and giving them the information they need to better understand their problems and help themselves.
3. Mood disorders and anxiety disorders are two common types of mental illness.
4. Mental illness and emotional distress are generally caused by the interactions of biological predispositions to illness and environmental events, such as trauma.
5. Courses and treatment of mental illness vary, and a variety of treatment approaches exist for different mental illnesses.
6. Using active listening skills and eliminating barriers to communication are important aspects of communicating as a psychoeducator.
7. It is critical to respect a client's confidentiality and limits when using psychoeducation with families.

Do you have any questions?

XI. Practicing Psychoeducation

Now we'll do some more extensive role plays to practice what we've learned about psychoeducation.

A. Exercise 4: Experiencing Tripsymenia – Role Play

For the first set of role plays, we'll be using an imaginary condition, like we did in one of the earlier role plays. Let's call this condition tripsymenia. The purpose of using an imaginary condition is to give you a sense of how it would feel to be a client who has just been diagnosed with an illness that he or she knows very little about.

In a few minutes you will choose a partner to work with. One of you will be the client and one will be the CMHW. The person playing the client will pretend that he or she has just received a diagnosis of tripsymenia from the physician. Together you and your partner can decide what the symptoms, course, causes and treatment of tripsymenia are. However, the person playing the client should act as though they have very little information about the disease when they are first diagnosed. Try to make your role plays

as realistic as possible. The client will likely have questions or fears about the illness, such as believing it is his or her fault or that it will never get better. Your role play should show the CMHW using psychoeducation in an early session with the client. You may wish to pretend that the client is coming to see the CMHW immediately after talking with his or her physician and receiving the diagnosis.

You will have 30 minutes to practice the role play. The role play itself should last about five minutes. You and your partner may leave the room to practice if you wish. When you return I will model the role play for you with a partner. Then each pair will demonstrate their role play for the entire group. We'll quickly debrief after each performance, and then have a group discussion after all pairs have performed. Before you begin, do you have any questions?

Call participants back together after they have had at least 30 minutes to practice. Demonstrate the role play first, using a co-trainer or volunteer to play the client. You should show the CMHW using active listening skills and making empathizing and normalizing statements, as well as giving the client information about tripsymenia. Invite participants to describe what you did well in the role play and what they think you should have done differently. After you role play the scenario, invite the participants to perform. Immediately following each pair's performance, debrief by asking the pair the following questions:

- How did you feel playing the role of the client?
- How did you feel playing the role of the CMHW?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief as a group using these questions:

- How did you see the workers using psychoeducation? For example, did you see workers using normalizing statements or educating clients on the symptoms, course, and causes of tripsymenia?
- How would you describe the CMHWs' communication techniques—for example, did you notice anyone using active listening skills?
- How did the clients seem to respond to psychoeducation?

- What are some of the challenges of doing psychoeducation that you think you will encounter with actual clients?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

B. Exercise 5: Fareed – Role Play

Our next role play will involve mental health and trauma. You and your partner should switch roles, so that whoever did not play the client last time should play him this time. Here is the scenario:

Fareed is a 28 year-old man. Two years ago Fareed witnessed some police officers beating up a man in the street. Fareed tried to help the man after the officers left, but the man died due to his injuries. For the past few months, Fareed has been having terrifying nightmares about this incident. He often sees the faces of the police officers and the dying man in his mind, even when he is trying to concentrate on other things. Fareed has become quite anxious as a result. He is easily startled. He notices that his heart starts racing with panic and he breaks into a sweat if anything surprises him, such as hearing a loud noise. Fareed has started to avoid leaving his house and socializing with others because of these problems. He finally decides to see a physician, who diagnoses him with Post Traumatic Stress Disorder. Fareed has never heard of this. He goes to talk to a CMHW, fearing that the diagnosis he received means that he is crazy.

You and your partner can decide how the worker should use psychoeducation to help Fareed. Use the information you have on PTSD and trauma to help the client understand his diagnosis. If you are unsure about treatment for PTSD, make some guesses about what kinds of treatment you think would be appropriate (i.e. medication, referral to psychiatrist, helping the client go out more in the community). For this role play you can show how the CMHW would use psychoeducation with Fareed immediately following his diagnosis, or if you prefer you can role play the CMHW using psychoeducation after Fareed has been receiving services for a few weeks.

You will have 30 minutes to practice the role play. The role play itself should last about five to ten minutes. You and your partner may leave the room to practice if you wish. When you return each pair will demonstrate their role play for the entire group. We'll quickly debrief after each

performance, and then have a group discussion after all pairs have performed. Before you begin, do you have any questions?

Call participants back together after they have had at least 30 minutes to practice. Ask participants if they would like you to model this role play before they perform. If so, demonstrate the role play, using a co-trainer or volunteer to play the client. Then invite the participants to perform. Immediately following each pair's performance, debrief by asking the pair the following questions:

- How did you feel playing the role of the client?
- How did you feel playing the role of the CMHW?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief as a group using these questions:

- How did the CMHWs use psychoeducation techniques in this role play?
- What examples did you see of CMHWs using normalizing or empathizing statements?
- How would you describe the CMHWs' communication techniques—for example, did you notice any examples of active listening or barriers to communication?
- Did any workers use psychoeducation on promoting good mental health, as well as on PTSD and trauma?
- Can you think of other ways to use psychoeducation in a case such as this?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

XII. Conclusion

Psychoeducation is a very useful tool for addressing clients' concerns by helping them to better understand their problems. When using psychoeducation, you may want to address symptoms of mental illness or distress that a client is experiencing, questions they have about the causes of their distress, the expected course and treatment for their problem, and how

they can get in the habit of promoting good mental health. As the role plays demonstrated, providing this information to clients is a very powerful thing. Psychoeducation can change a client's outlook, helping to restore hope and increasing engagement in the treatment process. Before we end for today, do you have any remaining questions about psychoeducation?

Address any questions or concerns that participants raise.

I'd like to end now by going around the room and having everyone name one new thing they learned about psychoeducation, or one way that they will use psychoeducation with clients.

Be sure to thank participants for their contributions and attention. Have them complete the Competency-Based Training Exam.

HANDOUT

Normalizing

What to do

Normalizing means recognizing someone's concerns and acknowledging that their feelings are "normal" and not unusual. It is one way of expressing empathy for a person's feelings. When we normalize, we want to do it in a way that acknowledges and validates the person's feelings:

- "I understand that you are very distressed, but feeling that way is quite normal considering what you've been through."
- "I think most people would feel the way you are describing if they had had the same experiences."
- "Although depression can be quite debilitating, many people suffer from this problem, and many can be helped through treatment."

What not to do

When normalizing, take care that you do not…

- Avoid the client's concern.
  - Example: "Everyone is concerned about security these days, but there's not much we can do about it. Try not to worry so much about the safety of your kids every time they leave the house."
- Normalize the client's experiences, instead of the client's feelings.
  - Example: "Lots of women have difficulty with their husbands. Most husbands don't treat their wives very well."
- Normalize a traumatic event as a commonplace experience.
  - Example: "It is an unfortunate fact that many women are raped. You should realize that your situation is not unique."

HANDOUT

Mood Disorders

Mood disorders are characterized by emotional disturbances that affect the way that a person acts and thinks. Examples of mood disorders include Major Depression and Bipolar Disorder.

Symptoms of mood disorders include:

- Depression - sadness, emptiness, tearfulness, apathy, loss of hope, loss of faith, pessimism, a sense of loneliness, and feeling helplessness
- Mania - an elevated mood, out of control with happiness
- Irritability - sudden or unexpected anger for no reason, homicidal rage, out of control anger
- Apathy - a lack of feeling, emotion and interest
- Fatigue/loss of drive - low energy levels and/or the inability to start a task
- Hypersomnia - an increase in time spent sleeping; sleeping too much
- Insomnia - the inability to sleep restfully or not sleeping enough
- Suicidal ideation - thoughts of death and killing oneself
- Psychomotor retardation - a slowing of activity or movement
- Psychomotor agitation - an increased level of activity and jitteriness
- Anhedonia - the loss of pleasure in things that used to be enjoyable
- Impaired memory - problem with attention and concentration, and ability to make decisions

HANDOUT

Anxiety Disorders

Anxiety disorders are characterized by feelings of excessive worry that are not attributable to real danger, and occur either in panic attacks or a constant state of worry. Examples of anxiety disorders include General Anxiety Disorder and Post Traumatic Stress Disorder (PTSD).

Symptoms of anxiety disorders include:

- Phobia - an unnatural, irrational fear of an item or situation, which the person realizes is not really dangerous, but still takes steps to avoid
- Compulsion - an irresistible impulse, urge or desire to perform an irrational act that relieves worry for the person, such as repeatedly washing hands
- Obsession - a repetitive or unwelcome thought, idea, emotion or impulse that provokes worry, such as a constant urge to wash hands or count objects
- Panic - a sudden, overwhelming worry that produces terror and/or fear of death, and results in physiological and psychological changes
- Agoraphobia - the fear and panic of leaving home, or being in public places, crowded spaces, or locations where help cannot be reached

Competency-Based Training Exam – CMHW

Name: _____ Date: _____

Answer the following questions to the best of your ability.

1. What is normalizing? Give an example of a normalizing statement.

2. Describe two symptoms of mood disorders and two symptoms of anxiety disorders.

3. Describe how you would explain the cause of depression to a client, addressing biological and environmental factors.

4. Why is it important to use psychoeducation with clients on an ongoing basis (as opposed to only using it at the beginning of treatment)?

5. Describe when confidentiality is an issue in psychoeducation, and how you should handle this with a client.

Medication Management and Education

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to support clients' use of medication.

Informational Competencies:
At the end of this training, the CMHW will know…

- The role of medication in client treatment
- The CMHW's role in medication management
- Steps for obtaining and self-administering medication
- Side effects of common psychotropic medications
- How to read and use the medication chart
- How to help clients relieve common side effects
- Common challenges clients experience in taking medication and ideas for enhancing medication adherence
- Communication issues in medication management

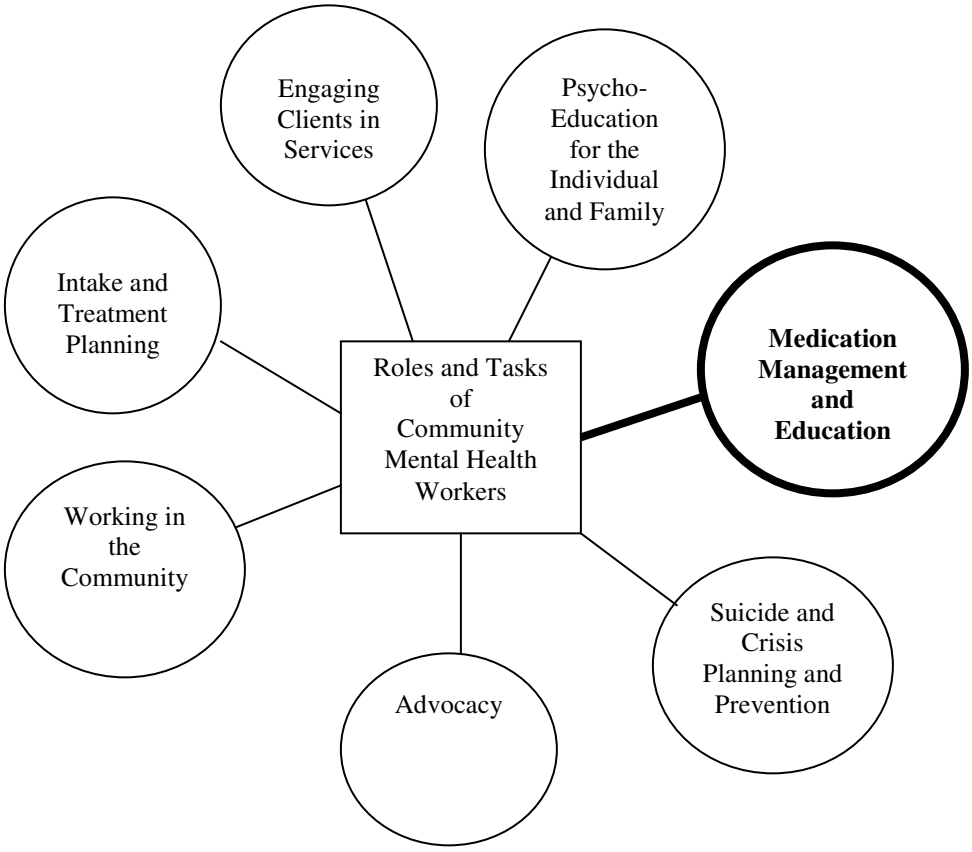
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Define the role of medication and psychosocial support in client treatment
- Identify the role of the CMHW in supporting clients' use of medication
- Explore client options for obtaining medication
- Describe the side effects of common psychotropic medications to clients, using the medication chart
- Discuss suggestions for relieving side effects with clients
- Identify adherence issues and help clients resolve them
- Communicate effectively with clients on an ongoing basis about their experiences with medication use

Learning objectives:
The goal of this training session is to teach…

- Role of psychotropic medications in client treatment
- Purpose and use of the medication chart
- Ideas for relieving side effects
- Adherence issues in medication
- Communication skills for medication management

This training addresses the following CMHW Job Role(s):
Medication Management and Education



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:
Corrigan, P.W. & Garman, A.N. (1996). Case management and severe mental illness. In S.S. Blancett & D.L. Flarey (Eds.), *The handbook of nursing case management: Health care delivery in a world of managed care* (pp.334-353). New York: Aspen Publishing.

Pratt, C.W., Gill K.J., N.M. (1999). Chapter 8, Case management strategies. In *Psychiatric rehabilitation* (pp.122-133). San Diego: Academic Press.

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

The purpose of this section of the training is to emphasize the many roles that CMHWs play in supporting their clients' use of medication. We will begin this by clarifying the role of medication in overall client treatment, and your role as a CMHW in medication management.

II. The Role of Medication in Client Treatment

Let's think for a moment about the role of medication in client treatment. Imagine a client comes to see her physician complaining of a torn muscle in her back, causing her severe pain. What are some of the things that the physician is likely to do for her?

Elicit suggestions from the audience. Possible responses include: tell client to stop doing activities that strain her back; give client prescription for pain medication; teach client exercises to strengthen her muscles.

When a client sees a physician for a physical health problem, medication is often one part of the treatment plan. In this example, medication will not fix the client's torn muscle, though it might help her cope with the pain. It is not much different for people who see a physician because of problems related to trauma or mental health. Medication is often an important part of the treatment plan, but it is only one of several components. This is because medication does not actually cure or prevent a mental illness. Unlike the CMHW, medication cannot teach someone new skills or ways of coping with their problems.

In sum, here are some important points to keep in mind about what medications for mental health problems can and cannot do:

- Medications relieve symptoms and reduce distress and impairment. They do not cure the illness.
- Medications reduce the distress caused by the illness and the symptoms associated with the illness by addressing the biological and psychological components of the illness. Unfortunately, medications

can produce side effects which may also cause distress or embarrassment.
- Medications may reduce some impairment which can interfere with a person learning skills. However, medications do not actually teach someone new skills or provide incentive to use skills.

Psychotropic medication is the term for those medications that are prescribed for symptoms of mental illness, such as anxiety, difficulty sleeping or feeling depressed. We will discuss some common psychotropic medications later in the training.

III. CMHWs and Medication Management

As a CMHW, your role is NOT to prescribe medication. Physicians prescribe medication. Psychotropic medications can be prescribed by primary care physicians or psychiatrists. If the primary care physician is not sure which psychotropic medication to prescribe for a client, he or she may refer the client to a psychiatrist, who has more knowledge in this area.

Although you cannot prescribe medication, you still play an important role in clients' use of medication.

We know from experience that many of the physicians working on this project have very little time to see clients. That means that clients may still have questions or concerns about their medication after visiting the physician. CMHWs can support clients by helping them understand the function of the medicine and what they can expect.

Supervision Note
Some clients may expect the CMHWs to give them medication. Check in supervision to see if this is happening. Workers may have to use psychoeducation to inform clients that only physicians should prescribe medication.

IV. Exercise 1: Identifying CMHW Tasks in Medication Management – Group Activity

For this exercise we will separate into groups of three or four. Your group should come up with as many ways as possible for CMHWs to support clients' use of medication as part of their treatment plans. An example would be discussing the role of medication in client treatment. Please take ten minutes to come up with as many ideas as you can. Write your ideas down and then your group will present them.

After about ten minutes, call the groups back together. Have a representative from each group present the group's ideas. Write all ideas on the board. Thank participants for their responses.

This is a great start. Let's review the different aspects of a CMHW's role in medication management:

1. Educate the client about the role of medication in treatment. Many people think that medication alone is enough to "fix" their problem or make them feel better. As we said in the beginning of this lesson, it is only one small part. It is important to first ask clients about their expectations regarding the medication and then clarify the role of medication in treatment.
2. After the physician has prescribed a particular medication, help the client understand how to obtain it and how it is to be administered.
3. Review the side effects of the medication with the client.
4. Educate the client about tips to relieve uncomfortable side effects.
5. Use engagement and active listening skills to elicit updates or concerns about the medication throughout the course of treatment. If a client has a concern or question about the medication, encourage him or her to speak with the physician about it.
6. Explore adherence issues with the client. Identify difficulties that the client is experiencing taking their medication. Problem solve with the client to help him or her manage adherence issues.

We'll spend the rest of the training discussing the skills and information you will need to perform these tasks with your clients.

V. Obtaining and Administering Medication

After a client has been prescribed medication by the physician and understands the general role of medication in treatment, usually the next step in medication management is determining how the client can obtain the medication. The cost of the medication and the client's financial resources are very important factors. If the client does not have adequate financial resources to pay for the medication, you might encourage him or her to check with the physician to see if there are any less expensive alternatives. You and the client might also explore if there are any NGOs or other community resources that could assist the client in paying for medication.

Once the client has obtained the medication, make sure that he or she understands how it is administered. Most clients will understand how to measure doses and take their own medication, but if the client is illiterate, has never taken any kind of medication before or has some type of severe disability, he or she may have some difficulty self-administering medication.

Although it seems quite simple, there are actually many small steps involved in properly taking a medication. Here are the steps of proper medication self-administration, which you may wish to review with the client if he or she appears to be having any difficulty in this area:

1. Review the instructions for taking the medication. These should be printed on the label. The instructions should tell the client how many pills to take and how often to take them. Make sure the client can read and understand these instructions. Ask the client if the physician gave the client any additional instructions, such as advising him or her to take the medication with meals or before bed.
2. The client should open the bottle and pour the prescribed number of pills, one at a time, onto a saucer or napkin. Then close the bottle tightly to keep the medication fresh and prevent spilling.
3. Have the client check the label again to ensure that the correct amount of pills were removed from the bottle, and that it is the correct time to take the medication.
4. The client should take the medication with a large glass of water or juice to aid the swallowing or absorption of the medication.

After reviewing these steps, you might role play how to properly take the medication with the client if he or she is still experiencing some confusion about this.

Supervision Note
You can increase CMHW competency in this area during group supervision by asking questions such as:

- How are you helping the client to obtain the medication?
- Could your client read and understand the instructions on how to take the medication? If not, how did you help him or her?

VI. Using the CMHW Medication Chart

One important task for CMHWs in medication management is to explain the side effects of medications to clients. Many psychotropic medications have been developed to target various symptoms of mental illness. For our

project, we will focus on a limited number of medications mostly for treating depression and symptoms of post traumatic stress disorder (PTSD). We have prepared a chart that will be used by both CMHWs and the primary care physicians working with you at the hospital. I'll distribute the chart to you now so we can review it.

Distribute CMHW medication chart to participants.

Six categories of drugs are included: antidepressants, non-selective cyclics, anticonvulsants, antiadrenergic agents, antipsychotics and benzodiazepines. These categories are based on the effects that the drug is intended to have (i.e. antipsychotics reduce psychotic symptoms such as delusions or hallucinations) or how the drug works in the brain. If you or a client want to learn more about how a particular medication affects a person's brain chemistry, you should ask the primary care physician prescribing the medication for an explanation.

Drug names are listed in the left column under each category.
The right column lists common side effects. Side effects are unintended, usually negative effects of the medication. When a client has been prescribed a medication, you'll want to check this chart to see if the medication is listed here. The physician may not have had much time to discuss the medication with the client, so the client might have some basic questions. It is particularly important to review the side effects with clients. While not all people taking a particular medication will develop all the side effects listed on the chart, it is important to review them so the client knows what to watch for. There may be things the client can do to relieve the side effects, which we will discuss next, or the client may need to talk to the physician to get a different dosage or prescription.

Supervision Note
If your facility commonly prescribes psychotropic medications other than those listed on this chart, be sure to review these in supervision with CMHWs. You might revise or update this chart to include the information.

VII. Relieving Side Effects

As is evident on the medication chart, side effects are part of taking many medications. Sometimes side effects are so severe or uncomfortable that people may stop taking the medication, even if it is helping their condition.

Learning how to identify and manage these side effects can help people stay on their medication and can make their lives more enjoyable.

I'll distribute a handout now that lists some common side effects for psychotropic medications and describes some ideas for relieving these effects. These side effects are considered less serious, but may still cause considerable discomfort. You may wish to review this list periodically with your clients to see which side effects they are experiencing and give them some ideas for how they can feel better. You might also give clients a copy of the list to take home. Remember that it is important for clients to discuss all side effects with their physicians. The physician may be able to adjust the dosage or change the prescription to reduce the side effects.

Distribute handout titled, "Less Serious Side Effects" (note that it is two pages long). Review each side effect and the ideas for relieving side effects. Ask participants if they have additional ideas about relieving side effects to add to the list.

In addition to these side effects, there are others that are considered to be more severe. I'll distribute another handout that lists serious side effects of psychotropic medications. Please inform your clients that if they experience any of these severe side effects, they should report it to their physician immediately. Keep in mind that these lists are not comprehensive. If a client experiences any type of pain or discomfort after taking medication, he or she should discuss it as soon as possible with the physician.

Distribute handout titled "Serious Side Effects." Review each side effect and answer any questions that participants raise.

Supervision Note
You can increase CMHW competency in this area during group supervision by:

- Asking questions such as "How did the client describe her side effects?" or "Has the client mentioned that problem to her physician?" during case reviews
- Conducting role plays to give CMHWs the opportunity to practice discussing side effects and ideas for relieving them

VIII. Exercise 2: Addressing Side Effects – Role Play

Now we will do a role play to practice using the medication chart and discussing side effects with clients. Please select a partner to work with. One person will role play the client and one will role play the CMHW. The

client should choose any medication from the chart. Pretend you have just been prescribed this medication. You know from the physician that it is supposed to help your symptoms, but you are not sure of what the side effects will be. Using the chart, the CMHW should review the side effects with the client. Then discuss some ideas for reliving the side effects. Be sure to tell the client what to do if he or she experiences any serious side effects. If you like, you can also ask the client if he or she understands how to administer the medication, and if not you can also review the steps of proper medication self-administration. Switch roles after about ten minutes. Afterward we will debrief as a group.

Circulate around the room as participants practice using the chart. Give participants about ten minutes for the role play; then ask them to switch roles. After all participants have had the chance to play the CMHW, call the group back together. Debrief using the following questions:

- How did you feel role playing the client?
- How did you feel role playing the CMHW?
- As the CMHW, what did you do that you liked?
- As the CMHW, what would you do differently when discussing medications and side effects with actual clients?
- Is there anything else we could do now to help you feel more comfortable using this chart with actual clients? (*If so, follow up on this—i.e. give participants more practice time, have participants discuss each medication on the chart in small groups, etc*.)

IX. Medication Adherence

When a client is not taking a medication regularly, as the physician prescribed, they are said to be having a problem with adherence. Adherence issues are very common. Many of us can probably recall a time when we were prescribed a medication and did not take it exactly as the physician ordered us. Someone might take the medication too often, not often enough, at the wrong times, or not at all. What are some reasons why people might have these problems with adherence?

Elicit suggestions from the audience. Possible responses include: person does not understand physician's instructions, person forgets, person does not want family members seeing them take the medication, person does not like the side effects, person does not think medication is working.

In fact there are many factors that contribute to adherence issues. Perceived costs and benefits of the treatment, the client's perception of his or her problem and expectations about treatment, and the client's relationship with the treatment team are among the factors influencing how a person adheres to treatment. Specifically, some of the reasons why people have problems with adherence include:

- The client does not understand the physician's instructions, i.e. when to take the medication, how much to take, etc.
- The medication does not appear to be helping the client's symptoms
- The side effects are causing discomfort
- Client does not have enough money for the medication
- Client is embarrassed or does not want family members to know that he or she is taking the medication
- Client forgets to take the medication

Do not assume adherence or lack of adherence based on whether or not the person's symptoms respond to treatment. Sometimes people are fully adherent with the treatment regimen but do not improve, and sometimes people improve without being fully adherent.

Adherence is not an "all or nothing" issue. When you discuss adherence with a client, you want to find out about his or her specific pattern of adherence. What are some questions you could ask to learn about this?

Elicit responses and encourage participants to be specific. Possible responses include: Describe your routine for taking the medication. How many pills do you take in the morning? How many do you take at bedtime? Are you taking the pills at other times of the day?

One you establish the client's pattern for taking the medication, there are many possible reasons why they may be taking the medication in a different pattern from what the physician prescribed. We'll do an exercise now to explore some of these reasons and find solutions.

Supervision Note
Inquiring about adherence without interrogating the client or lecturing him or her on how to take the medication is a sophisticated skill. Model how participants can inquire about adherence in a manner that emphasizes active listening and normalizing, rather than scolding clients for their non-adherence or telling clients how they should be taking their medication.

X. Exercise 3: Identifying and Resolving Adherence Issues – Group Activity

Earlier we discussed some of the reasons why people may have problems with adherence. Six of the most common reasons, which we reviewed, are listed in your workbook. You will separate now into groups of three or four to think of some recommendations for resolving each of these adherence issues. For each of the factors that can contribute to adherence problems, your group should think of at least one thing the CMHW could help the client do that might resolve the problem. An example would be discussing the client's side effects and telling him or her about some tips for relieving side effects. Your group will have 15 minutes to complete this activity. Remember to list at least one specific recommendation for each factor. Afterward your group will present your ideas to the entire group. Do you have any questions?

Circulate around the room as groups discuss their ideas. Call the entire group back together after about 15 minutes. Write the six types of adherence issues on the board. Then have each group present their recommendations and write these next to the issues on the board. Thank all groups for their contributions.

We've come up with a lot of good ideas for helping clients resolve adherence issues. I'm going to give you a handout now that summarizes some of these ideas. There may be ideas that you've come up with today that aren't listed on the handout, so you might want to take a moment to jot those down.

Distribute handout titled, "Adherence Issues and Recommendations." Briefly review and ask participants if they have any questions.

While we are discussing medication adherence, it is worth mentioning that some psychotropic medications can be abused. Medication abuse is when a person starts taking medication for a purpose other than the treatment of a diagnosed medical problem, such as to get high, relax or have fun. Medication abuse will be discussed in detail in a later training. In the meantime, if you have any questions or concerns about medication abuse, please discuss them with your supervisor.

XI. Communication and Medication Management

One of the most important tasks of medication management is to communicate with clients about their experiences with medication. This is an ongoing process. After completing an intake with the client, you may suggest that he or she talks with the physician about medication options for their symptoms. In some cases, the client will have been referred to you by the physician so he or she may already have a prescription when you meet for the first time

After the physician has prescribed medication, you should continue communicating with the client about their experience with the medication on an ongoing basis. What are some of the questions that you could ask clients to inquire about their experiences with medication?

Elicit responses and write them on the board. Thank participants for their ideas.

We've generated a lot of great questions. For a review of questions to ask clients on this topic, please take a look at your handout, "Questions for Inquiring about Clients' Experiences with Medication."

Briefly review the handout with participants. Participants should write additional questions that they have generated on the handout.

Based on the client's responses to these questions, you may need to assist the client in obtaining the medication, review tips for relieving side effects, explore adherence issues, or refer the client back to the physician.

When communicating with clients about medication, it is important to use your active listening skills. Active listening helps to establish trust with a client, which is essential for honest communication about sensitive issues such as medication and symptoms. Remember to listen without giving the client advice or criticism, or judging him or her.

Another essential communication task is to demonstrate empathy and use normalizing statements. In our training on psychoeducation, we discussed how showing empathy for a person's feelings and reflecting that their feelings and concerns are normal can help that person feel validated and engaged. Showing empathy through normalizing is a good way to engage

clients in talking about their medication concerns and questions. In particular, clients should know that it is normal:

- To have fears or concerns about taking psychotropic medication
- To feel frustrated or angry when a medication does not have its intended effects, or because of negative side effects
- To be prescribed several different medications before the most effective one is found

Supervision Note
You can increase CMHW competency in this area during group supervision by asking questions such as:

- How can you help your client prepare to discuss medication with the physician?
- What questions are you asking to check in with the client about his or her experiences with the medication?
- Give me an example of how you normalized your client's concerns.

XII. Review

Here are some of the key points to remember from today's lecture:

1. Medication can help with symptoms, but it does not teach someone new skills for coping with problems.
2. Although you cannot prescribe medication, there are several things you can do to support your clients' use of medication as part of treatment.
3. CMHWs can educate clients about obtaining medication, the effects of medications, and ideas for relieving side effects.
4. Exploring adherence issues is another part of medication management. Adherence issues are very common and many factors can contribute, including a client not understanding how to take the medication, side effects, and the client's financial resources.
5. Using active listening and making normalizing statements are important aspects of communicating with clients about their experiences with medication on an ongoing basis.

Do you have any questions?

XIII. Practicing Medication Management

Now we will do some role plays to practice the different components of medication management that we learned about today.

A. Exercise 4: Reviewing Ali's Prescription – Role Play

Please select a partner to work with. One of you will play the client and one will play the CMHW. Here is the scenario for our first role play:

Ali is a 53 year-old man. When he comes to the hospital to talk with the CMHW, he describes having experienced many hardships in his life. His wife died two years ago when their city was bombed. Ali has personally witnessed many violent acts during wartime in his life, and he is sometimes disturbed by these memories. In addition, Ali works as a manual laborer, and he is concerned that he is getting too old to perform this strenuous work. After discussing some symptoms of anxiety that he is experiencing, such as excessive worrying and difficulty sleeping, his CMHW encourages him to speak with his physician.

Ali talks to the physician, and returns to his CMHW with a prescription for Lorazepam. Ali says he has not taken any prescribed medication in his life. Instead, he has always used traditional or home remedies to relieve illness. Ali says he is willing to try the medication because he wants to feel better, but he is apprehensive because he doesn't know what it will do to him. No one in his family takes medication for anything, and his children don't understand why Ali should start using medication at this time in his life. In addition, Ali admits that his memory isn't as sharp as it used to be and he is concerned he will not remember to take the medication in the proper amount each day.

In the first role play, you should show the CMHW meeting with Ali immediately after he has received the prescription from his physician. Some of the medication management tasks you'll want to demonstrate in this role play include:

- Discussing the client's general feelings about medication and eliciting questions and concerns
- Explaining the role of medication in client treatment
- Discuss how client will obtain the medication
- Reviewing the side effects of Lorazepam using the medication chart

You and your partner have 20 minutes to practice your role play. The role play itself should last five to ten minutes. You may leave the room to practice if you wish. When you return I'll model the role play for you, and then each pair will demonstrate their role play for the entire group. We'll quickly debrief after each performance, and then have a group discussion

after all pairs have performed. After we've finished these role plays, we'll do another set of role plays, showing Ali interacting with the CMHW at a different point in treatment. Do you have any questions before you begin?

Call participants back together after they have had at least 20 minutes to practice. Demonstrate the role play first, using a co-trainer or volunteer to play the client. Be sure to demonstrate using active listening, empathizing and normalizing as you talk with the client about medication. Invite participants to describe what you did well in the role play and what they think you should have done differently. Then invite the participants to perform. Immediately following each pair's performance, debrief by asking the pair the following questions:

- How did you feel playing the role of the CMHW?
- How did you feel playing the role of the client?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief as a group using these questions:

- How did you see the CMHWs using psychoeducation to discuss medication with the client?
- Did you see any examples of the workers normalizing Ali's concerns?
- How would you describe the CMHWs' style of communication? Did you notice any CMHWs using active listening techniques?
- What are some of the challenges of doing medication management tasks in an early session?
- What are some of the problems in Ali's life that medication likely will not help, and how might the worker help Ali in these areas?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

B. Exercise 5: Ali One Month Later – Role Play

We're going to revisit Ali for our next role play, but at a different point in treatment. You and your partner should switch roles, so that each of you has the chance to play the CMHW. This time you will role play the CMHW meeting with Ali about one month after he has received his prescription.

Some of the medication management tasks you'll want to demonstrate in your role play include:

- Discussing client's experiences with the medication—how he is taking it, client's feelings about taking it, effect on his symptoms, etc.
- Inquiring about side effects that client is experiencing and helping client relieve them
- Inquiring about adherence and problem-solving adherence issues

You and your partner can decide what Ali's side effects, adherence issues and experience with the medication will be. You have 20 minutes to practice your role play. The role play itself should last five to ten minutes. You may leave the room to practice if you wish. When you return each pair will demonstrate their role play for the entire group. We'll quickly debrief after each performance, and then have a group discussion after all pairs have performed. Do you have any questions?

Call participants back together after they have had at least 20 minutes to practice. Ask participants if they would like you to model this role play before they perform. If so, demonstrate the role play, using a co-trainer or volunteer to play the client. Then invite the participants to perform. Immediately following each pair's performance, debrief by asking the pair the following questions:

- How did you feel playing the role of the CMHW?
- How did you feel playing the role of the client?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief using the following questions:

- What medication management tasks or techniques did you notice CMHWs using this time?
- How would you describe CMHWs' communication styles, i.e. did you notice any examples of active listening, empathizing or normalizing?
- If this were an actual case, do you think Ali would continue to take the medication? Why or why not?
- What types of medication management tasks do you think the worker would continue to perform with Ali in the future?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

XIV. Conclusion

We've covered a lot of new information today as we learned about how CMHWs can support clients in medication management. As you saw in the role plays, there are many different things a worker has to think about when discussing medication with clients. Psychoeducation on the role of medication and side effects, listening to and normalizing client concerns, and addressing adherence issues are all important parts of medication management. You are doing a very important job by listening to your clients and helping them understand how medication can be a beneficial part of treatment. Before we wrap up, do you have any remaining questions on medication management?

Address any questions or concerns that participants raise.

As a final activity, I'd like to go around the room and have everyone name one thing they learned today about medication and helping clients.

Be sure to thank participants for their contributions and attention. Have them complete the Competency-Based Training Exam.

HANDOUT

CMHW Medication Chart

ANTIDEPRESSANTS

Drug Name	Side Effects
Fluoxetine	Headaches, nausea, diarrhea, loss of appetite, dizziness, sweating, insomnia, vivid dreams, nervousness/worry, sexual dysfunction, loss of interest in things, weight loss or gain

NON-SELECTIVE CYCLIC

Drug Name	Side Effects
Amitriptyline Clomipramine Imipramine Maprotiline	Tiredness, drowsiness, difficulty sleeping, shakiness, tingly feeling, dry mouth, dry nose, blurred vision, difficulty urinating, sweating, sexual dysfunction, weight gain, menstrual irregularities, sensitivity to light. These medications can be lethal in overdose.

ANTICONVULSANTS

Drug Name	Side Effects
Carbamazapine (Tegretol)	Tiredness, drowsiness, shakiness, skin rash, menstrual irregularities.
Valproate (Depakote)	Sedation, tremors, nausea, weight gain, skin rash, hair loss, menstrual irregularities.

ANTIADRENERGIC AGENTS

Drug Name	Side Effects
Propranolol	Tiredness, drowsiness, dizziness, light-headedness, nausea, wheezing/difficulty breathing, depression.

ANTIPSYCHOTICS

Drug Name	Side Effects
Chlopromazine Trifluoperazine Haloperidol	For many people, these are not well tolerated and there are therefore, many side effects. Stiff muscles, stiffness in the jaw, restlessness. Sedation, slowed cognitive functioning, dry mouth, constipation, urinary retention.

BENZODIAZIPINES

Drug Name	Side Effects
Chlodiazepoxide Clonazepam Lorazepam Diazepam	Tiredness/fatigue, drowsiness, impaired thinking, depression.

HANDOUT

Less Serious Side Effects

This list identifies a number of actions that can be taken to relieve less serious side effects. Be sure to report these side effects to your physician at your next visit.

Symptom	Action to be Taken
Skin dryness	Use mild shampoo and soap; use hand lotion-particularly in the winter, use body lotion after you bathe; wear clothing that protects your skin from the weather.
Dry lips and/or dryness of your mouth	Increase liquid intake, frequently rinse your mouth with water, suck on hard candies or chew gum. If your lips are cracked, rub them with glycerin swabs that may be obtained from your pharmacist.
Occasional upset stomach	Drink small amounts of clear soda water. Eat dry crackers, toast, or hard rolls. Do not take antacids or acid blockers without your physician's permission.
Occasional constipation	Increase liquid intake; increase physical exercise (if approved by your physician); eat leafy green vegetables, fresh or cooked fruit, or bran and other whole grain cereals; drink lemon juice in warm water; occasionally take milk of magnesia, other mild laxative, or a stool softener if suggested by your physician or pharmacist.

Occasional dizziness	Get up slowly from sitting, bending over, or lying-down position. If lying down, sit up--pause--stand up--pause--and then walk.
Tiredness and/or difficulty staying awake after taking your medication	Take a brief rest period or a short nap during the day; consult physician about switching entire daily dosage to bedtime.
Weight gain	Increase exercise (if approved by your physician); discuss your diet with your physician, nurse, or nutritionist; and reduce overeating.
Mild restlessness, mild muscle stiffness, feeling slowed down and lethargic	Exercise (if approved by your physician); take a short walk; stretch your muscles; relax to music.
Sensitivity to heat, sweating	Move desk and chairs away from sunny windows, heat outlets, and radiators.
Eyes bothered by strong sunlight or artificial light	Wear sunglasses, sun visor, hat, or cap with the brim to the front; avoid prolonged exposure to strong sun.

Adapted from Social and Independent Living Skills: Medication-Management Module, UCLA Department of Psychiatry

HANDOUT

Serious Side Effects

The following are serious side effects that can be caused by some medications. These side effects should be reported to your physician immediately:

- Blurred vision
- Difficulty swallowing or drooling
- Extreme difficulty urinating (long wait before starting flow of urine)
- Diarrhea (for more than two days)
- Severe constipation (for more than two days)
- Daytime sleepiness
- Skin rash, including skin eruptions, bumps or pimples on body, around mouth, or in bend of joints
- Skin discoloration or darkening
- Sunburn (quickly or with little exposure to sunlight)
- Sexual difficulties, including delayed ejaculation, impotence (inability to get or maintain an erection), painful erection or erection that lasts for several hours, loss of interest in sex, breast changes
- Menstrual irregularity
- Nervousness, inability to lie or sit still, inner agitation or unrest
- Rigid or stiff muscles, causing slowed movements or difficulty moving, i.e. stiff or expressionless face; turning whole body rather than head when looking to the side
- Body tremors, spasms, neck or back pulled to one side or back
- Tardive dyskinesia — this is a term for slow, involuntary movements of mouth, tongue, hand or other parts of the body

HANDOUT

Adherence Issues and Recommendations

Adherence Issue	Recommendations
Client does not understand physician's instructions	Make sure the client has the physicians' instructions in writing. Review and ask the client to repeat the instructions back to you. Encourage the client to ask the physician questions.
Medication does not appear to help client's symptoms	Encourage client to discuss with physician. Be aware that many medications take a few weeks to take effect.
Side effects are causing discomfort	Review tips for relieving less serious side effects with client. Refer client to physician, especially for serious side effects; dosage may need to be adjusted or prescription changed.
Client does not have enough money for medication	Discuss client's financial resources. Explore community resources that may be able to help. Consult with physician about less expensive alternatives.
Client is embarrassed about taking medication or does not want family members to know	Explore and normalize client's feelings. Provide or help the client provide psychoeducation to the client's family about the client's condition and medication. Or, help client find ways to take the medication discretely.
Client forgets to take medication regularly	Help client establish a routine of taking the medication at the same time every day, per the physician's instructions. Help client create cues to remind them, such as note posted discretely in their home. A client who is supposed to take medication first thing in the morning might want to set it beside their bed the night before.

HANDOUT

Questions for Inquiring about Clients' Experiences with Medication

- How are you taking the medication…
  - How much are you taking?
  - How many times a day do you take it?
  - When do you take it?
  - How many medications are you taking?
  - Are you taking the medication according to any special instructions (i.e. taking it with food)?
- Do you think this medication is helping with your symptoms? Which ones?
- Which symptoms is the medication not helping?
- Have you been experiencing any of the side effects that we talked about?
- What have you done to try to relieve the side effects? Did it help?
- Are you experiencing any challenges to taking the medication?
- How are you obtaining the medication?
- What is your plan for acquiring and paying for the medication for the next month/six months/year?
- How do you feel about taking this medication?
- Is there anything that has surprised you about taking this medication?
- Do you have any questions for the physician about the medication and how it is supposed to help you?

Based on the client's responses to these questions, you may need to review tips for relieving side effects, explore adherence issues, help the client make a plan for continuing to obtain the medication, or refer the client back to the physician.

Remember to always use your active listening skills when discussing medication with clients!

Competency-Based Training Exam – CMHW

Name: _____ Date: _____

Answer the following questions to the best of your ability.

1. Why is medication only one part of a client's treatment plan?

2. List two common side effects of psychotropic medications and give a suggestion for relieving each.

3. List three aspects or tasks of the CMHW's role in medication management.

4. Name two questions you could ask a client to check in about their experience taking a medication.

5. Name one reason why a client might have a problem with adherence, and give an example of how you would intervene to address this.

Suicide and Crisis Planning and Prevention

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to conduct suicide and crisis assessment, practice crisis intervention and planning, and utilize strategies for self care.

Informational Competencies:
At the end of this training, the CMHW will know…

- The definition of crisis and how it relates to stress
- Steps of crisis planning
- Purpose of crisis assessment
- Different aspects of suicidal risk
- Types of aggression and questions to ask to assess violence and aggression
- Typical emotional, behavioral, cognitive and physical responses to crisis
- Basics of crisis intervention
- Ways of providing support to people in crisis
- Purpose of safety plan
- Early warning signs of crisis situations
- The importance of self care in preventing burnout

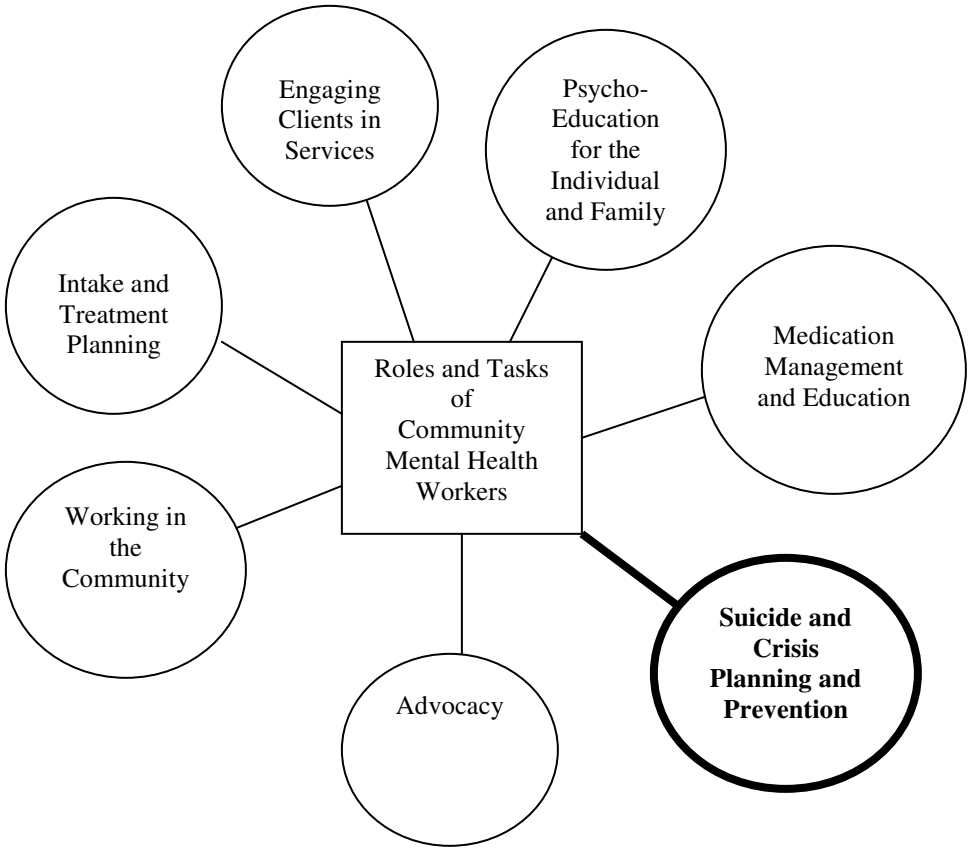
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Explain the definition of crisis
- Assist clients with crisis planning, using crisis assessment, intervention and planning skills
- Complete four areas of crisis assessment
- Observe suicide risk factors and inquire about suicide potential
- Inquire about client potential for violence and aggression
- Discuss typical responses to crisis
- Make appropriate referrals to help resolve a crisis
- Provide support to people in crisis and help foster the use of clients' strengths and coping skills
- Create a safety plan
- Identify early warning signs of crisis
- Discuss and demonstrate the practice of self care

Learning objectives:
The goal of this training session is to teach…

- Crisis planning skills
- Crisis assessment skills
- Crisis intervention skills
- Crisis prevention skills
- Self care skills

This training addresses the following CMHW Job Role(s):
Suicide and Crisis Planning and Prevention



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorder, 4th ed.-text revision*. Washington, D.C.: APA

Bunn, M. (2005). *Training outline: Trauma workshop*. Bangkok, Thailand: Thammasat University.

Buwalda, J., Everson, M.L., & Bunn, M. (2005, January). Discussion on training indigenous peoples to provide treatment for torture and trauma. An informal meeting at Heartland Alliance in Chicago.

Caplan, G. (1964). *Principles of preventive psychiatry.* New York: Basic Books.

The Center for Mental Health Services (2004). After disaster strikes: What you can do. 4therapy.com website at http://www.4therapy.com/consumer/life_topics/article/6946/539/After+Disaster+Strikes--What+You+Can+Do

The Center for Victims of Torture (1997) *Secondary traumatization*. Minneapolis, MN.

Dulmus, C.N. & Hilarski, C. (2003). When stress constitutes trauma and trauma constitutes crisis: The stress-trauma-crisis continuum. *Brief Treatment and Crisis Intervention*, *3*, 27-35.

Eddy, S. & Harris, E. (1998). Risk management with the violent patient. In P.M. Kleespies (Ed.), *Emergencies in mental health practice: Evaluation and management* (pp. 217-231). New York: Guilford.

George Mason University (2005). *Coping with crisis, disaster and the stress of war/terrorism*. http://www.gmu.edu/departments/csdc/disaster.htm

Kono, G. (2004) *Surviving loss, grief and trauma*. 4therapy.com website at http://www.4therapy.com/consumer/life_topics/article/7541/539/Surviving+Loss%2C+Grief%2C+and+Trauma

Lewis, S. & Roberts, A.R. (2001). Crisis assessment tools: The good, the bad, and the available. *Brief Treatment and Crisis Intervention*, 1, 17-28.

McCracken, S.G., Elam, L., Corrigan, P.W., Summerfield, J., & Larson, J. (2004). *Preventive strategies, assessment and treatment planning for aggression and violence*. Tinley Park, IL:

McKenry, P.C. & Price, S.J. (1994). *Families and change: Coping with stressful events.* Thousand Oaks, CA: Sage

National Alliance for the Mentally Ill (Winter 1997-98). *The decade of the brain*. Volume VIII Issue 4.

National Mental Health Information Center: http://www.mentalhealth.org/publications/allpubs/SMA-3717/things.asp

Parad, H.J., & Parad, L.G. (1990). *Crisis intervention, book 2: The practitioner's sourcebook for brief therapy*. Milwaukee, WI: Family Service America.

Parad, H.J. (1965). *Crisis intervention: selected readings*. New York: Family Service Association of America

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

Roberts, A. (Ed.) (1995). *Crisis intervention and time-limited cognitive treatment*. Thousand Oaks, CA: Sage.

Rosen, A. (1998) *Crisis management in the community.* The Medical Journal of Australia website at http://www.mja.com.au/public/mentalhealth/articles/rosen/rosen.html

Rothchild, B. (2001). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, W.W. Norton.

Yeager, K.R. & Roberts, A.R. (2003). Differentiating among stress, acute stress disorder, crisis episodes, trauma, and PTSD: Paradigm and treatment goals. *Brief Treatment and Crisis Intervention*, *3*, 3-25.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

The purpose of today's training is to teach you skills for crisis prevention, assessment, intervention and planning. This will include a discussion of suicide and how to do a safety plan. We will also discuss some of the responses you may have to working with clients in crisis and how to care for yourself when you feel overwhelmed by some of the stories you may hear.

II. Definition of Crisis

When you hear the word crisis, what do you think of?

Elicit responses. Possible responses include: a situation where a person is in need of urgent attention, having overwhelming problems, being in war, being attacked, not having food, water, or housing.

Everyone will probably experience a crisis at some point in life. Crisis situations are NOW, offering little time for thinking or review. As part of your role as a CMHW, you will need to understand how to recognize someone in crisis and what you might be able to do to help.

There are some common components of a crisis that can help us identify when a situation is a crisis. These include:

- Sudden stressful event (e.g., loss of a loved one, home or threat to one's safety)
- Ongoing high risk situations (having several stressful events going on at once and having no end to the stress in the foreseeable future)
- Inability to resolve stressful or ordinary situation with normal coping skills

Now we are going to look at a handout, Zahra's story. We'll be referring to Zahra's story throughout our training today.

Distribute handout and read aloud with participants. Discuss how Zahra's story fits with the description and definition of someone in a crisis situation.

What are some of the signs of crisis that Zahra is experiencing?
What are some signs that the crisis is affecting Zahra's mental health?

Elicit responses and discuss.

III. Stress and Crisis

Stressors are common elements in nearly everyone's life. Most people are able to handle the ordinary stressors, or the daily hassles life brings, such as getting children to and from school, meeting work requirements and schedules, handling household chores and working out differences in relationships. However, the stress experienced as a result of a single significant event, such as the loss of a loved one or loss of a job, may precipitate a crisis. Crises can occur in any setting.

For some individuals, it is the accumulation of small stressors that precipitates a crisis. They may be able to cope with each event as it comes along, but at some point, they reach the breaking point and a crisis ensues. The situation that eventually provokes the crisis may be relatively minor, but when added to the other stressors, it is enough to push the person past a point of feeling in control of the stress.

IV. Crisis Planning

Crisis planning is the synthesis of crisis prevention, assessment and intervention. It involves using your skills in all of these areas to help clients manage their crises and prevent future ones. The steps of crisis planning are:

1. Identifying the current crisis
2. Planning a response to the crisis
3. Confronting and resolving the crisis
4. Forecasting potential crises in the future
5. Developing a strategy to prevent future crises

Crisis planning in the face of a current, real crisis includes identifying the real nature of the current crisis, intervening to minimize damage and recovering from the crisis. Crisis planning also includes a strong focus on predicting other crises that may occur as a result of the current crisis. For example, because of Zahra's electricity problems, she may find herself in a financial crisis because she is unable to pay her bills. If she is unable to get food or medicine, she may soon face a health-related crisis as well.

A proactive crisis management plan includes forecasting potential crises and planning on how to deal with them now in order to prevent them from developing in the future. For example, in order to avoid having a health-related crisis in the future, it would be wise to help Zahra find access to food and medicine now, even though she does not have a steady income. This is going beyond identifying the early warning signs of crisis, because you are trying to solve potential problems before they have the chance to escalate into a crisis state.

V. Crisis Assessment

In situations where you are unable to prevent crisis, the first step in helping someone in crisis is assessing the crisis situation and the person's response to it. This helps us understand the crisis, its impact on the person, and his or her resources and skills for coping with it. There are four main aspects of crisis assessment. I'll list them here and then we will review each one:

1. **Safety** - The most important safety concern for individuals in crisis is whether or not they and those around them are safe from harm. Assessing safety is important to be able to attempt to predict if someone may be suicidal or homicidal.
2. **Client's Perception of the Stressor Event** – Regardless of how we may view the crisis, it is most important to determine how the client perceives the event (or events) that precipitated the crisis.
3. **Resources and Support** - Ask about the person's support system and resources to determine what is currently available to the client.
4. **Coping Skills** – By assessing personal coping skills you will better be able to tell how well the person is functioning and what skill areas you may be able to help the person develop or improve. You will also know what coping skills the person has already tried in an attempt to deal with the crisis.

A. Assessing Safety

As we mentioned earlier, there are two parts to assessing safety:

- Assessing the client's risk of harm to self, or suicidal potential
- Assessing the risk of the client's potential to harm someone else, or likelihood of becoming aggressive or violent

1. Assessing Safety: Risk of Harm to Self

If you identify one of your clients engaging in any behavior that could be risky or dangerous for him or her, please contact the doctor with whom you work as well as your field supervisor. Behaviors that pose a risk of harm to

the self include:

- Suicide attempts
- Self-injury
- Verbally threatening suicide
- Taking a drug or other substance with the intent to cause bodily harm or death

In addition to taking note of these behaviors, you should also determine if any suicide risk factors are present. Research has demonstrated that certain personal characteristics or events are associated with increased suicide risk. I'll distribute a handout now listing these risk factors. Your assessment should note if any of these factors are present. It is very difficult to predict suicide and therefore these risk factors cannot predict the future, but rather, they give us information about the potential for risk.

Distribute handout titled "Suicide Risk Factors." Discuss each item and ask participants if they have any questions.

What risk factors does Zahra have, if any, for potential suicide?

When we identify risks for suicide in clients, we want to follow up with questions to assess the potential for suicide. Remember, even though a person may only try to cause harm and not kill him or herself, any attempt to harm oneself could potentially lead to death.

Now let's think of some of the questions you can ask clients to assess suicide potential. When assessing suicidality, try to use empathy as you ask questions about the following:

- **Thoughts about suicide**. What are some questions you could ask to assess a person's thoughts about suicide?

  Examples: Are you having thoughts of self-harm? Have you been so distressed you thought about suicide? Do you have specific ideas about ending your life or hurting yourself? How many times during the week do you think about killing yourself? How long have you had thoughts to hurt yourself?

- **Lethality**: Try to determine if the plan is likely to lead to death, if carried out. For example, if the person says he is planning to shoot himself in the head, the potential for lethality is high. Also

try to determine if the person has access to the means he or she intends to use for the suicide attempt, like a gun or poison. For example, if she says she intends to shoot herself, but does not have a gun, then the risk is slightly less. If the person is planning to use a very lethal method and has access to it, then help should be sought immediately. What are some questions you could ask to assess a person's lethality or dangerousness?

Examples: Do you have a plan for suicide? How might you hurt yourself? Have you made any preparations to hurt yourself? Do you have access to _____?

- **Intention**: Assess the person's intent for suicide. At this point, if the person has chosen a highly lethal method, has access to it, and has a plan for carrying out the suicide, notify authorities immediately. What are some questions you could ask to assess a person's intention?

  Examples: How close have you come to trying suicide? (If yes, have him or her describe it.) How likely do you feel it will happen? Have you tried to hurt or kill yourself in the past? How close have you come to intentionally hurting yourself?

I'm going to distribute a handout now that summarizes some of the questions you might want to ask clients as you assess safety and crisis. Some of the questions you'd want to ask to assess suicide risk are listed under the first heading. We'll be referring back to this handout as we discuss other areas of crisis assessment.

Distribute handout titled "Questions to Use for Crisis Assessment."

For now, we have covered only how to assess risk for suicide potential. Later we will discuss how to address concerns about suicidality as part of crisis intervention. Before we move on, are there any questions?

Supervision Note
Suicide is an extremely sensitive topic, and many CMHWs may initially feel awkward asking clients direct questions about topics related to suicide. You can role play practicing these questions in group supervision so CMHWs become more comfortable. Furthermore, during case reviews, you might want to ask CMHWs questions such as:

- Did you assess suicide risk for this client?
- What questions did you ask?
- What is your evaluation of the dangerousness of the client's plan and his or her level of intention?
- Does the client have access to instruments that he or she could use to hurt him or herself?

Also, you may wish to remind CMHWs that they can ask clients questions about suicide potential and simply move on when the client says no.

2. Assessing Safety: Risk of Harm to Others

The second part of safety includes assessing a client's risk of harming others. It is very difficult to accurately predict whether or when a particular individual will be aggressive or violent. Also, it is important to recognize that aggression can take many forms. When working with clients, be aware if you observe any of the following types of aggression in the client's behavior:

- Verbal aggression (this can include threatening, shouting and cursing)
- Aggression against oneself
- Aggression toward objects (throwing things, kicking things)
- Aggression toward others, including violence and other aggressive acts toward other people
- Intimidation

When we identify any of these signs in an individual, we will want to follow up with some questions that assess the person's potential for increased aggression or violence. Please take a look at the handout, Questions to Use for Crisis Assessment, as we discuss the risk for aggression and violence.

Discuss each question in the section "Assessing Safety: Risk of Harm to Others (Aggression and Violence)" on the handout. Ask participants if they have any questions.

What risk factors, if any, does Zahra have for becoming aggressive or violent?

As with suicide, inform your supervisor and follow your team's protocol if a person becomes aggressive.

Supervision Note
Be sure CMHWs know and understand the hospital's policy for handling aggressive or violent clients. You may wish to do some role plays in supervision to practice how the CMHW should respond if a client becomes violent or aggressive.

B. Client's Perception of the Stressor Event

If the person perceives the event as a crisis, it is. The event (i.e., the stressful event or high-risk situation) is not necessarily what defines a crisis, but rather it is the individual's level of distress about the situation.

What are some questions you could ask to determine a client's perception of the stressor event?

Elicit suggestions from the audience. Possible responses include: Has anything upsetting happened to you in the past few days? What happened to you before you started feeling this way? What leads you to seek help now? How does this affect your daily life? How does this affect your future?

Remember that you are seeking to determine how the client perceives the stressor event. You are <u>not</u> trying to tell the client whether or not he or she has experienced a crisis.

How do you believe Zahra has perceived each of the events that we know about from the story?

Supervision Note
You can increase CMHW competency in this area during group supervision by asking questions such as:

- How did the client describe the stressor event?
- What does the client identify as her greatest problem?
- Do you think the client regards what happened as a crisis (i.e. extremely stressful and perhaps threatening to the client's sense of safety and well-being)?

1. Typical Responses to Crisis: Ways to Identify a Client in Crisis

The central task of crisis intervention is to help people strengthen their adaptive resources and develop new skills, in order to better cope with the

problem. Before we discuss how you can intervene to enhance clients' coping abilities, it is important to have a sense of how people typically respond to crisis. Responses to crisis occur on emotional, behavioral, cognitive and physical levels.

Each person responds to crisis differently. The unique emotional, behavioral, cognitive and physical responses of a person to the crisis will help shape the way that you intervene to help that person. Although everyone is different, it can be helpful to keep in mind some of the common responses to crisis that people often display.

2. Exercise 1: Zahra's Responses to Crisis – Group Activity

We will now do a group exercise to explore Zahra's response to her crisis. Please divide into groups of four or five people. You will discuss among yourselves the responses and/or symptoms of crisis that the story tells us about, as well as some of the ones you suspect Zahra might be experiencing now that we may not know about. Write down as many possible responses to crisis for Zahra as you can think of and be prepared to share your list with the other groups at the end of this exercise. You will have 15 minutes to meet with your group. Are there any questions?

The point of this exercise is to help participants recognize that there are dozens of possible responses to a crisis and people may respond quite differently than is to be expected.

Give the groups about 15 minutes to create lists; then call the group back together. Once the participants are back into place, ask a spokesperson from each group to read their lists. Write down all responses. Next, point out to participants that people respond to crisis in four main ways: behaviorally, emotionally, cognitively and physically, as was described in Module II. Lead participants in classifying the responses to crisis written on the board as behavioral, emotional, cognitive or physical. Emphasize that when people are in crisis, they respond in many different ways.

C. Assessing Resources and Support

Adaptive resources help people cope with crisis. Adaptive resources include:

- **Personal Resources** – these include an individual's strengths and skills, psychological and physical health, finances and education.

What are some other personal resources that could be resiliency factors to help Zahra cope? *(Example: ability to be resourceful and support herself, good physical health)*

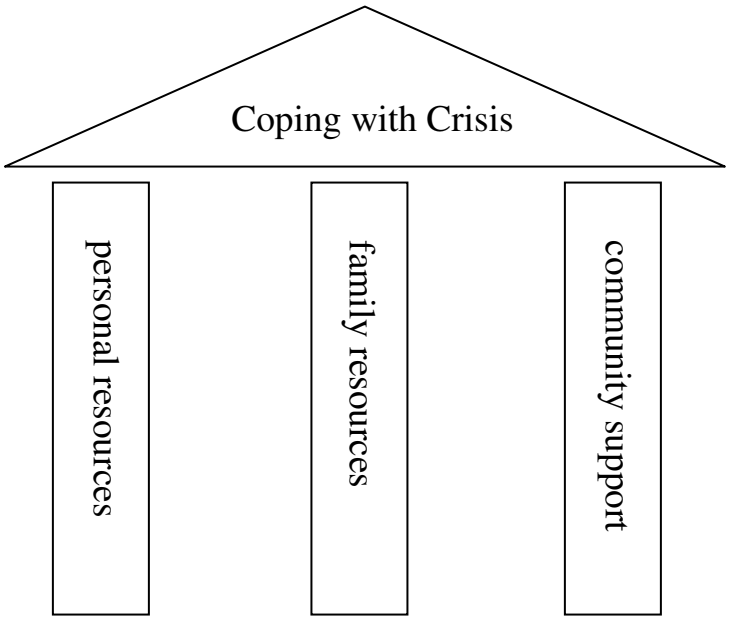
- **Family Resources** – these factors include cohesion/closeness, adaptability and communication.

  What are some of Zahra's family resources?

- **Community Support** - friendship and emotional support from neighbors or coworkers.

  What community supports exist for Zahra?

Draw this diagram on the board to show how the three types of adaptive resources help the person cope with crisis.



You might recall this diagram from Module I. It is a good reminder of how the three types of adaptive resources can help an individual cope with crisis. The three adaptive resources are represented by three pillars that hold the roof on this building. As you can see, even if one pillar becomes cracked or is missing, there are still enough adaptive resources to keep the roof from falling. However, if two of the pillars are missing, the roof will collapse.

What are some questions you can ask a client to assess the level of resources and support that is available to him or her?

Elicit responses. Possible responses include: Do you have a friend or relative that could spend some time with him or her right now? With whom do you live? Who do you talk to when you have problems? Whom can you trust? How did your family respond to the crisis event? What resources are available in your community that might be of help?

As a reminder, some sample questions to use to assess resources and support are listed on your handout "Questions to Use for Crisis Assessment." Also, remember that the Domains of Mental Health and Wellbeing Satisfaction Scale is an excellent tool for assessing strengths.

D. Assessing Coping Skills

Coping skills are a type of personal resource that deserve special attention in an assessment. A person's repertoire of coping skills consists of the behaviors they use to help them solve problems and cope with crises and negative emotions. Assessing coping skills gives you an idea of how well the person is functioning, and skill areas to help the person improve in the future. What is an example of a coping skill?

Elicit responses. Possible responses include: talking to a trusted friend to reduce anxiety, removing oneself from a harmful or stressful situation, confronting the source of a problem.

What do we already know about Zahra's coping skills? What are some questions you could ask Zahra to assess her other coping skills?

Elicit responses. Possible responses include: What do you usually do to feel better? Did you try to do that again this time? Did it work? What helped you through difficult times in the past? What do you think may happen now?

Supervision Note

You can increase CMHW competency in this area during group supervision by asking questions such as:

- What are some the strengths that the client used to cope with problems in the past?
- Do you think those same strengths can be applied in this situation?
- What coping skills does the client have that could be strengthened and how could you help them with this?

E. Exercise 2: Crisis Assessment – Role Play

Now we will do a group activity to practice the different skills involved in crisis assessment. Please meet in groups of three or four. This activity focuses on what the process of crisis assessment would look like with Zahra.

In your groups, please discuss the following:

- How you would assess the safety of Zahra's situation, including risk of harm to self and others
- How you would determine Zahra's perceptions of the stressor events
- What strengths and resources Zahra possesses and how you would assess these with her
- What coping skills Zahra has and how you could assess these

In your groups, discuss the specific questions that you would use to complete this crisis assessment with Zahra. You may wish to practice asking these questions by doing a role play within your groups, taking turns playing the role of Zahra and the CMHW. Remember, you do not need to determine how the worker should intervene to help Zahra; your discussion should focus only on assessment. You have 25 minutes to talk you're your group. Afterward your group will share your ideas with the rest of the class

Call the groups back together after about 25 minutes. Have a spokesperson from each group share their ideas for how they would conduct crisis assessment with Zahra. Write ideas on the board. Then debrief with the entire group using the following questions::

- What do you think would be next step in helping Zahra? (i.e. what might the CMHW want to address in their next session)?
- What are some of the challenges of crisis assessment?
- How would you handle some of these challenges in the future?

Be sure to thank all groups for their contributions.

VI. Crisis Intervention

When people are facing a crisis, they may be experiencing any combination of emotional, behavioral, cognitive and physical responses. In general, crisis intervention should focus on helping people find better ways of coping with the problem, and managing their responses to it. Although the circumstances surrounding each crisis may vary, there are some general things you can do to help anyone who is currently experiencing a crisis.

The overall goal of crisis intervention is to restore the person to his/her pre-crisis level of functioning. This may be accomplished through a number of different strategies:

- **Providing support** - The support and presence of another person is crucial for crisis intervention. It begins with the first encounter, and continues throughout the intervention. Establish a working relationship with the client that is safe, confidential, and non-judgmental. The client needs the hope that change can happen, and that the situation can improve so the future will be better. An important aspect of providing this type of support is normalizing. The client needs to know that his or her responses to the crisis are normal under the circumstances, even if the client feels that he or she is "going crazy" or not acting like his or her self.

  What might you say to Zahra to help normalize her response to the crisis in her life?

- **Reducing the risk of harm** – This can be accomplished by making a safety plan with the client, which will discuss in a few minutes.

- **Providing appropriate referrals** – Based on the nature of the crisis and the client's response to it, they client may benefit from referrals to outside resources. For example, a client whose husband is beating her may be able to get legal assistance from an NGO that addresses domestic violence. Other clients may need a referral based on their response to the crisis, rather than the crisis itself. For example, a client experiencing symptoms of depression and anxiety after a crisis or traumatic event might be referred to a physician or psychiatrist, who could prescribe psychotropic medication. Making such referrals requires using advocacy and community work skills, which we will discuss further in another training.

- **Encouraging use of strengths and coping skills** – An important part of crisis intervention is encouraging clients to use the strengths and coping skills that they have and helping them develop new ones. This includes helping clients learn simple things they can do to cope with stress and feel better in the middle of crisis, for example, finding time for themselves, exercising or praying. It also involves teaching clients problem-solving skills to help them cope with and

resolve their problems. Because people sometimes forget about the strengths and resources they possess when they are overwhelmed by a crisis, workers can also help clients by reminding them of how they can utilize all of their available resources and sources of support.

Supervision Note
During case reviews in supervision, check to see that CMHWs are considering all of these strategies for crisis intervention, as well as perhaps inventing some of their own. To increase CMHW competency in this area, ask questions such as:

- How did you normalize the client's responses to the crisis?
- Could this client benefit from outside resources? What are some possibilities?
- How can you strengthen the client's existing coping skills?
- Could you teach this client some new coping skills?

A. Developing a Safety Plan
Does anyone remember what a safety plan is from Module II?

Elicit responses and thank participants for their ideas.

A safety plan is a special tool that is part of crisis intervention and can help reduce the risk of harm for people in various crises, including suicide risk. It should include a very specific plan for how the client will spend his or her time until the next appointment, which may be as soon as the following day. The purpose of the plan is to help the client feel as safe and supported as possible, even when the CMHW is not present.

I'll distribute a handout now with a sample form that you can use to create a safety plan. You were first introduced to this form in Module II.

Distribute and review the handout titled, "Safety Plan."

B. Exercise 3: Zahra's Safety Plan – Role Play
Now we will do a role play to practice safety planning. Break into groups of two; one person will play the CMHW and one person will play Zahra. The CMHW will ask the questions on the safety plan. Write down the answers that the person playing Zahra gives you. The person playing Zahra should answer the questions in the way you think she might answer them in a meeting with a CMHW. We do not have time to perform these role plays for each other, but we will debrief as a group after you do the role play. Practice for about 20 minutes.

Circulate around the room as participants perform the role play. After about 20 minutes, call the group back together. Debrief using the following questions:

- What was it like to be Zahra in this role play?
- What was it like to be the CMHW in this role play?
- For those playing Zahra, how do you think this plan might help?
- How do you think you would feel completing a safety plan with actual clients?

VII. Crisis Prevention

Another way to help people is to prevent stressful events from escalating into crises. Whenever possible, it is best to intervene early to prevent escalation and defuse the situation. This can be accomplished when you:

- Learn the early warning signs of crisis and
- Encourage persons to develop coping skills for dealing with potential crises.

People who have repeated crises may be able to identify early warning signs that indicate early stages of a crisis. You can use simple questions to help them identify their early warning signs. Here are some examples of questions you can ask:

- Think about the last time you were in crisis, what happened early in the crisis?
- How were you feeling at the time?
- What thoughts came to your mind?
- What are some things that might tip you off (provide a clue) that a crisis is coming again?

Have the individual list their answers to these questions and keep track of them so that they can identify when crisis is occurring.

What questions might you ask Zahra to help her identify early warning signs of crisis and prevent future crisis?

Elicit responses and discuss.

VIII. Preventing Burnout

Helping people who are experiencing crisis situations can be extremely stressful for the worker. The stress can be so extreme at times that the worker may begin to display to some of the common reactions to crisis that we discussed earlier. When this occurs, the worker is said to be experiencing burnout.

Signs and symptoms of burnout that may be experienced by CMHWs include:

- Decreased level of energy
- Sadness, depression, social withdrawal from others or activities
- Apathy, indifference, emotional numbness
- A sense of having no time for oneself
- An increased disconnection from loved ones
- Forgetfulness, confusion, difficulty making decisions or concentrating
- Loss of sense of humor or playfulness
- Loss of creativity, loss of problem-solving skills
- Irritability, intolerance, anger and rage
- Feelings of helplessness, hopelessness, lack of control
- Sleep disturbances or nightmares related to the client's crisis
- Disbelief and denial of other people's experiences
- An increased sensitivity to violence, threats, or fear, as well as the opposite—decreased sensitivity, cynicism, generalized despair, and hopelessness
- Guilt for having survived or escaped crisis situations
- Preoccupation with safety of self or loved ones
- Physical complaints: gastrointestinal pain, headaches, joint pain, muscle aches, etc.

To prevent or manage the effects of this stressful work, CMHW's must learn to practice self care. Self care is the act of reducing and managing stress in personal and professional areas of life, so that one can find balance and support. Strategies for self care will be different for each person, and every individual must find the things that help him or her reduce stress and feel supported. As you think about how you can manage stress and take good care of yourself, here are some general strategies to keep in mind:

- Know the signs and symptoms that we just discussed and notice when they are happening.

- Do your best to live a balanced life. Seek balance in your daily activities, including work, leisure, and personal and family life.
- Build connections and supportive relationships. Maintain connections with people who support and love you, including friends, family, neighbors and colleagues.

There are a number of simple things that each of us can do every day to reduce stress and feel better, even when dealing with stress and crisis in our personal and professional lives. Let's review your handout, "Coping with Burnout," for some tips on managing stress and preventing burnout.

Distribute the handout titled, "Coping with Burnout" and discuss the tips with participants. Ask participants if they have other ideas to add.

> *Supervision Note*
> Good supervision is a useful tool in preventing burnout. Workers who feel supported by their supervisor and colleagues are less likely to feel helpless and overwhelmed, even when dealing with difficult cases. You can remind CMHWs in supervision that it is normal to feel extreme stress and develop signs and symptoms of burnout. Encourage them to talk about the stress they experience with yourself and each other, and use active listening to understand and validate their concerns. Remind them that they are not alone as they perform their work. Consider devoting supervision time to discussing new strategies for self care.

IX. Review

Here are some of the key points from today's training:

1. A crisis is any event or situation that is so far outside a person's normal experience that he or she is unable to resolve it with his or her usual methods of coping.
2. Crisis assessment should include a careful evaluation of the following: safety, client's perception of the stressor event, resources and support, and strengths and coping skills.
3. Suicidal behaviors must also be assessed, with awareness of the client's suicidal thoughts and intention.
4. Responses to crisis and trauma occur on emotional, behavioral, cognitive and physical levels and vary from person to person.
5. Crisis intervention may involve providing support, reducing risk of harm through a safety plan, providing appropriate referrals, and encouraging use of strengths and coping skills.

6. Crisis planning is the synthesis of assessment, intervention and prevention, in order to help clients manage crisis and anticipate and prevent future ones.
7. Feeling overwhelmed by working with clients in crisis is common among people who help people in crisis situations. Self care strategies, such as leading a balanced life and building supportive relationships, can help people to manage this stress.

X. Conclusion

Crisis assessment, intervention and planning are among the most important job duties you have as a CMHW. While the crisis situation itself is often beyond control of the client and the worker, you can help people tremendously by normalizing their concerns and teaching people new coping skills. In the case of a client who is contemplating suicide or engaging in risky or injurious behaviors, your interventions may save someone's life.

Do you have any questions about anything we discussed today?

Address any questions or concerns that participants raise.

As a final activity, I'd like to go around the room and have everyone name one thing they will remember about crisis assessment, intervention or self care.

Be sure to thank participants for their contributions and attention.

HANDOUT

Zahra Story: Discussion Case for Crisis Assessment

Let's read the following story out loud. This describes the client we will use throughout the training today on crisis and assessment. We will refer back to this story throughout the training to help us learn how to assess someone in crisis. As we read, note the details of this client that relate to crisis and the kinds of questions we would want to ask this person.

Zahra is a 35 year-old single mother who lives in a small room near an alley with her 12 year-old daughter. Zahra's husband disappeared six years ago and she now supports herself by making kubba and selling it to the local store owners. Lately, her electricity has not been working so she has been unable to cook and therefore unable to make enough money to pay her rent or get enough food to eat for herself and her daughter.

Zahra walks her daughter an hour each way to school every day because she fears for her daughter's safety. Zahra can occasionally get food from the local mosque, but the food supply has been limited lately.

Zahra's younger brother, Mohamed, was recently killed by a bombing in her family's town. Zahra was very close with her brother and is distraught by this tragedy. Since it happened, she has had trouble sleeping and when she does sleep, she often dreams about her brother's death.

Zahra states that she feels as though her life is falling apart and her brother's death has added to an already difficult situation that she feels she was barely coping with before this recent tragedy. She feels very sad and depressed most of the time.

Zahra was referred to a CMHW by her doctor after she complained of frequent headaches and feeling shaky and restless at night. In the course of making a crisis assessment, Zahra tells the worker that she has had thoughts of killing herself. These thoughts are strongest early in the morning, when she wakes up feeling hopeless about making it through the day and depressed about the future. Zahra does not have any weapons in the house. However, she mentions that she recently obtained a bottle of valium and has been taking more of the pills than she knows she should be and says she has had thoughts of taking the entire bottle "just to go to sleep and forget that all this is happening." However, Zahra says that she won't ever do this because she loves her daughter too much.

Zahra and her daughter are both physically healthy and both say they don't know how they would get through all of this without one another's support. They are very close and enjoy the walks to school together everyday.

HANDOUT

Suicide Risk Factors

Factors that increase the risk of suicide:

- History of previous suicide attempt
- Family history of suicide
- Presence of current severe depression
- Presence of active or recent substance abuse or dependence
- Aggressive or impulsive personality features
- History of sexual abuse
- History of previous suicide attempt
- Hopelessness, helplessness feelings
- Inability or change in ability to carry out activities of daily living
- Unemployment
- Stressful life events, e.g. recent major loss or personal crisis
- Socially isolated, lacks support of family or lives alone
- Strong sense of shame
- Active medical illness, especially with severe pain or incapacity
- Well organized, detailed suicide plan
- Giving away possessions, preparing for death

HANDOUT

Questions to Use for Crisis Assessment

Assessing Safety: Risk of Suicide or Harm to Self
Are you having thoughts of self-harm?
Have you been so distressed you thought about suicide?
How many times during the week do you think about killing yourself?
How long have you had thoughts to hurt yourself?
Do you have a plan for suicide or hurting yourself?
Have you made any preparations to hurt yourself?
Do you have access to _____? (i.e. firearms, knives, medications)
How close have you come to trying suicide? (If yes, have him or her describe it.)
Have you tried to hurt or kill yourself in the past?
How close have you come to intentionally hurting yourself?
Also ask about or observe client's behavior for any suicide risk factors.

Assessing Safety: Risk of Harm to Others (Aggression and Violence)
What kinds of things make you mad?
What do you do when you get mad?
What is your temper like? What kinds of things make you lose your temper?
What is the most violent (dangerous) thing you have ever done and how did it happen? When did it happen? (Be sure to ask about violence to objects, self, and others.)
What is the closest you have ever come to being violent? (Asked of individuals who deny committing violent acts.)
What would have to happen in order for you to get so mad or angry that you would hurt someone?
Have you ever used a weapon in a fight or to hurt someone?
Do you think about harming other people, getting even, or paying someone back for something? What are the thoughts, and toward whom are they directed?
Do you feel like your mind is being controlled by someone else? Who is controlling your mind?
Do you feel that thoughts are being put into your head that are not your own?
Do you feel that there are people who wish to do you harm?
Follow up: If the individual acknowledges any signs of having specific people in mind when thinking about doing harm to others, ask, "what would

you do if you came into contact with one of these people who you believe is tormenting or persecuting you?"

Assessing Client's Perception of the Stressor Event
What happened to you before you started feeling this way?
Do you think you need help to get through this or do you think you can get through it on your own?
If you think you need help, what kind of help do you want right now?
How does this affect your daily life?
How does this affect your future?
What needs to be done to resolve this problem?

Assessing Resources and Support
Do you have a friend or relative that could spend some time with you now?
With whom do you live?
Who do you talk to when you have problems?
Whom can you trust?
How did your family respond to the crisis event?
What strengths do you think you have that can help you cope?
What helped you get through crises or stressful events in the past?

Assessing Coping Skills
What kinds of things make you feel better when things are more difficult?
What do you usually do to manage when things are difficult?
Did you try to do that again this time and did it work?
What helped you through difficult times in the past?
What do you think may happen now?
What kinds of things make it more difficult when you are feeling this way?
How might you avoid these things right now?

HANDOUT

Coping with Burnout

Burnout is very common among people who work with clients who are in crisis or have experienced trauma. If you are experiencing symptoms of burnout, here are some things you can do to help yourself feel better quickly. Read through the following list. Check off the ideas that appeal to you and give each of them a try. Use these techniques whenever you are having a hard time or as a special treat to yourself.

- **Do something fun or creative,** something you really enjoy, like crafts, needlework, painting, drawing, woodworking, making a sculpture, reading or gardening.
- **Get some exercise.** Exercise is a great way to help you feel better while improving your overall stamina and health. The right exercise can even be fun.
- **Write something.** Writing can help you feel better. You can keep lists, record dreams, respond to questions, and explore your feelings. All ways are correct. Don't worry about how well you write. It's not important. It is only for you.
- **Use your spiritual resources.** Spiritual resources vary from person to person. For some people it means praying, talking with your Imam, or talking with a spiritual leader.
- **Do something routine.** When you don't feel well, it helps to do something "normal" the kind of thing you do every day or often, things that are part of your routine like taking a shower, washing your hair, making yourself a cup of tea, or calling a friend or family member.
- **Wear something that makes you feel good.** Everybody has certain clothes or jewelry that they enjoy wearing. These are the things to wear when you need to comfort yourself.
- **Learn something new.** Think about a topic that you are interested in but have never explored. Find some information about it at a library or on the Internet. Go to a class.
- **Listen to music.** Delight yourself with music you really enjoy. If you enjoy music, make it an essential part of every day.
- **Make music.** Drums and other kinds of musical instruments are popular ways of relieving tension and increasing well-being. Perhaps you have an instrument that you enjoy playing, like a harmonica, oud, piano, or guitar.
- **Sing and dance.** It fills your lungs with fresh air and makes you feel better. Sing and dance by yourself. Sing and dance for the fun of it. Sing and dance along with your favorite music. Sing and dance to your favorite songs you remember from your childhood.

Perhaps you can think of some other things you could do that would help you feel better.

Safety Plan

Name: _____ Date: _____
Date of Return:_____

How will you spend your time between now and when you return? (*Be specific: Who will you be with? What will you do? Where will you go?*)

What dangerous items are in your home or are easily accessible to you? What will you do with these items? (*Examples: medications, toxic substances, knives and other sharp objects, firearms*)

What will you do to avoid or cope with situations that place you in danger and who is available to help you with this? (*Who can you call? Who can you stay with? Who can come stay with you?*)

What will you do if the unsafe situation arises again?

Emergency Contact Information:

Competency-Based Training Exam – CMHW

Name: _____ Date: _____

Answer the following questions to the best of your ability.

1. Explain crisis and give one factor that may increase the risk for suicide during a crisis.

2. Give an example of a question you could ask to assess the client's suicidal thoughts, the client's intentions, and the lethality of the client's suicide plan.

3. Why is providing support an important aspect of crisis intervention?

4. List the five steps of crisis planning.

5. What is self care and why is it important for CMHWs?

Advocacy

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to use advocacy techniques in order to best meet their clients' needs.

Informational Competencies:
At the end of this training, the CMHW will know…

- The definition of advocacy
- How advocacy relates to client needs
- Techniques for inquiring about client needs
- Four intervention strategies for client advocacy
- Four ways to advocate for clients with physicians
- Principles of communicating as an advocate

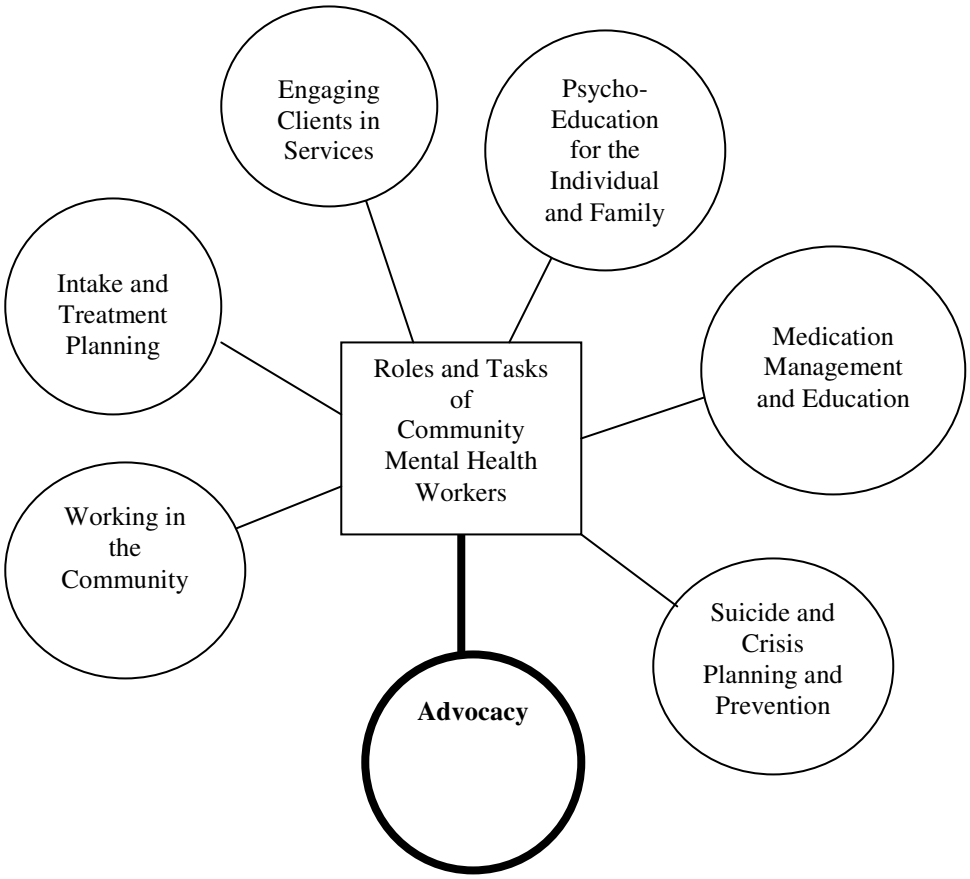
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Explain how advocacy differs from doing things for a client or telling a client what to do
- Identify client needs and problems that may require advocacy
- Advocate with clients' primary care physicians
- Advocate with other service providers
- Connect clients to community resources
- Acknowledge and work to eliminate stigma
- Use active listening, respect for confidentiality and collaboration to communicate effectively as an advocate
- Identify and address barriers to effective communication with physicians

Learning objectives:
The goal of this training session is to teach…

- Problem identification skills
- Advocacy skills and techniques
- Communication skills in an advocacy context

This training addresses the following CMHW Job Role(s):
Advocacy



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:

Corrigan, P.W. & Garman, A.N. (1996). Case management and severe mental illness. In S.S. Blancett & D.L. Flarey (Eds.), *The handbook of nursing case management: Health care delivery in a world of managed care* (pp.334-353). New York: Aspen Publishing.

Hepworth, D.H., Rooney, R.H., & Larsen, J.A. (2002). *Direct social work practice*, 6th ed. Pacific Grove, CA: Brooks/Cole.

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

This training is about your role as an advocate for your clients. We will begin the training with a discussion on advocacy and client needs.

II. Understanding Advocacy

Has anyone heard of the word "advocacy" or "to advocate" before? What ideas do you have about what this means?

Elicit responses and write participants' ideas on the board.

Advocacy means bringing about positive change. For CMHWs, advocating means working with your clients to facilitate access to resources or services that would otherwise not be available. This process is not always easy. Advocacy involves finding new ways of thinking about problems, and identifying and removing barriers that get in the way of what the client wants to accomplish.

It is important to recognize that advocacy involves working collaboratively with clients. Advocacy is not telling clients what to do, or doing things for them. Recall that giving a person orders or advice are both barriers to effective communication. Instead, advocacy involves creating options for your client to meet his or her needs and allowing your client to choose among them.

Supervision Note
CMHWs may often feel that giving clients advice or telling them what they should do is the best way to help. Use supervision time to explore the costs and benefits of doing this. An example of a cost is that a client does not learn how to help him or herself if the worker is telling the client what to do, while a benefit might be that telling a person what to do can be the fastest way to initiate action. Help CMHWs to find ways of presenting and reframing options for clients, instead of giving orders or advice.

III. Advocacy and Client Needs

In order to advocate for your clients, you must first understand the clients' problems, so together you can determine the resources they will need. This is

a very basic idea, but as we talk about advocacy, it is important to remember that there are in fact many different ways for systematically inquiring about clients' needs. What are some of your ideas for how you can learn about clients' needs?

Elicit responses. Encourage participants to be specific, and write their ideas on the board. Possible responses include: ask the client during intake, refer to the treatment plan, ask client what is lacking in his or her life, etc.

Here we have come up with several ideas for inquiring about client needs. Let's quickly review some of the main methods for learning about client needs now, since your advocacy efforts will be misdirected if they are not targeted at the client's needs as he or she perceives them.

Generally the first place to start is the intake form and the treatment plan. The needs and problems that the client describes during intake and lists on the treatment plan are the ones that he or she wants to address first in treatment. You and the client will determine how you can use advocacy, as well as other interventions, to help the client solve his or her problems. This process will be discussed further in our training on treatment planning.

Another idea for determining what unmet needs the client might have is to use Maslow's Hierarchy of Needs as a model. Does anyone recall this idea from Module I?

Elicit responses and thank participants for their contributions.

The Hierarchy shows that people have needs on several different levels, ranging from basic needs such as food and water at the base of the pyramid to the need for self-esteem, confidence and self-fulfillment at the top of the pyramid. When a client comes to see you, he or she may have unmet needs at multiple levels. The client may first want to address more basic needs, such as finding safe housing or managing anxiety. These will likely be the types of problems that the client lists on the treatment plan. It is very important to address these, but you can also inquire throughout treatment to see if the client's needs on other, more advanced levels of the pyramid are being met. For example, you might inquire to see if the client feels a sense of belonging in her community. You can use your advocacy skills to help clients meet these types of needs, as well as their more basic needs.

In addition, you might use the Domains of Mental Health Satisfaction Scale as a way of inquiring about needs. We introduced the scale as a way of learning about client strengths in the training on engagement. Recall that if the client is not satisfied in some of the domains, this indicates that there are unmet needs. You might want to periodically ask clients about their satisfaction in the different domains and use your advocacy skills to help clients increase satisfaction in certain areas.

Supervision Note
You can increase CMHW competency in this area during group supervision by asking questions such as:

- What questions did you ask to help the client identify his or her unmet needs?
- Considering Maslow's Hierarchy, what other unmet needs might this client have?
- Did you use the Domains of Mental Health Satisfaction Scale to identify areas of life in which the client is satisfied or unsatisfied?

IV. Using Advocacy to Help Clients

Once you and your client have discussed the client's needs, there are several intervention strategies you can use as a CMHW to advocate for your client. These strategies include advocating with primary care physicians, advocating with other service providers, creating access to resources, and addressing stigma. Let's discuss each of these strategies now in more detail.

A. Advocating with Primary Care Physicians

One of your main tasks as a CMHW is to act as an advocate for clients with their primary care physicians. Some clients may have difficulty clearly communicating their medical needs and problems to their physicians. Can you think of some reasons for this?

Elicit responses. Possible responses include: physician does not have enough time to listen to patient, patient is embarrassed, patient is intimidated by the physician.

There are in fact many reasons why clients may have difficulty communicating with physicians. Now let's discuss some ideas for how CMHWs can advocate with primary care physicians:

- **Accompany clients when meeting with physicians**. As we discussed in the training on medication management, some clients may feel more comfortable talking with their physician if a CMHW is present. The CMHW's presence may simply help the client feel supported, and can serve as a reminder for the client to voice concerns or questions he or

she has to the physician. When accompanying a client to an appointment, the CMHW may not need to say anything at all, but just be a quiet supportive presence for the client. Or, the CMHW might offer a prompt to the client, such as "Do you have any questions for the physician?" or "Do you understand what the physician just said to you?"

Because of privacy concerns, some clients may not want the CMHW to accompany them on physician visits. Therefore, the CMHW might offer to accompany the client as an advocate, but should not pressure the client to allow him or her to come to the appointment if the client says he or she does not desire this.

- **Help clients practice communicating with physicians**. In addition to actually accompanying clients on physician visits, CMHWs can help clients practice communicating with physicians. This may be particularly important if the client tends to be intimidated by physicians. Clients can rehearse by using their meetings with CMHWs to practice asking questions and voicing concerns to the physician. A good way to do this is for the CMHW to model the client's role, demonstrating how to be assertive while the client plays the physician. After the client has seen the CMHW modeling the skill, they can switch roles so that the client practices voicing questions and concerns with the CMHW playing the physician.

- **Provide feedback**. Generally it is preferable for clients to speak directly to physicians regarding their concerns, rather than CMHWs speaking on their behalf. However, there may be instances in which you advocate for your client by providing feedback to the physician. In most cases, you will spend much more time with the client than the physician does. By using your active listening skills, you can gather information on the client's unique problems, needs and treatment preferences. You might check with the physician to see if the client is relaying this information to him or her, and if not you can use your knowledge and experiences with the client to provide feedback.

- **Ensure quality of care**. As part of the treatment team, the CMHW advocates for client needs. If the client has medical or mental health needs that are not being addressed by the physician, talk to the

physician in your regular meeting. You may want to ask if he or she has a referral or other services in mind.

Supervision Note
You can increase CMHW competency in this area during group supervision by:

- Asking questions such as, "How could you advocate to facilitate better communication between the client and the physician?" during case reviews
- Doing role plays to give CMHWs the opportunity to practice giving feedback to physicians

B. Exercise 1: Advocating with Primary Care Physicians – Role Play

Now we'll do a brief role play to practice advocating with primary care physicians. Remember that one way of doing this is to help clients practice communicating with physicians. You will work with a partner for this role play. One person will play the client, and one will play the CMHW. Here is the scenario:

Rhema is a 63 year-old woman. Since her husband was killed a few years ago after being struck by a car on a busy road, she has been feeling very anxious. Rhema rarely leaves the house and when she does, she is usually overwhelmed with feelings of panic and fear, sometimes so severe that she has difficulty breathing.

After describing this to a CMHW, the CMHW informed her that there are treatments available, including medication, which can help with anxiety. Rhema is interested in talking with her physician about treatment options, but she is hesitant to ask because she is embarrassed by her problem. She told her physician she has difficulty breathing at times, but he assumed it is because she is older and overweight. Some of the questions that Rhema would like to ask her physician include:

- What medications or other treatments are available to help people with anxiety?
- How would I get access to these treatments?
- What do you think is causing my anxiety?

Remember that before Rhema can ask any of these questions, she must first tell the physician about her problem with anxiety.

The CMHWs should show how they would help the client practice telling her physician about her problem and asking these questions. Remember, the

CMHW can first model the skill for the client, and then have the client practice it. Do this for about five minutes and then I will call time and ask you to switch roles. We will not be performing these role plays for one another, but we will debrief as a group after both you and your partner have had the chance to play the CMHW. Do you have any questions before you begin?

Circulate around the room as participants practice the role play. Remind them to switch roles after about five minutes. After each participant has played both roles, call the group back together. Debrief using the following questions:

- When playing the CMHW, what are some of the things you did that you liked?
- As the CMHW, what are some of the things you might do differently when meeting with actual clients in the future?
- How did it feel to be the client in this role play?
- If Rhema were an actual client, do you think she would be ready to actually bring up this topic with her physician after practicing with the CMHW? Why or why not?
- What else might the CMHW do to advocate for Rhema?

C. Advocating with Other Service Providers

In some cases, the physician may refer your client to a specialist outside of the hospital, such as a psychiatrist at a private clinic. You can continue to advocate for your client after such a referral is made. First, make sure that the client has the resources to obtain the service. For example, the client may need help locating the place. You can also help the client determine the cost of the service, and discuss the client's financial resources to determine if it is affordable. If not, you and/or the client may need to return to the primary care physician to inquire about other alternatives.

You can follow up with the client after he or she has sought out the referral. Ask how the referral went and follow up with any new treatment that was indicated. This is an important way that CMHWs can ensure continuity of care.

D. Creating Access to Resources

Your client may have basic needs for food, clothing, shelter, safety or socialization that are not being met. Advocacy involves looking beyond the

resources at the hospital and seeing what services and resources are available in the client's community.
For example, an elderly client that you work with has diabetes and also signs of depression. You also know from talking to him that the client has very few friends and family members who are still alive. He complains that he is very lonely. The physicians at the hospital will treat the client's diabetes and give him medication for depression, but what else could you do to help this client? Where might you refer him?

Elicit responses. Possible responses include: suggest that the client get to know more people at his mosque, encourage client to introduce himself to his neighbors, help client locate places in the community where elderly men socialize, such as tea houses.

Community resources range from informal helping networks, such as neighbors who look out for one another, to formal organizations such as NGOs. Some of you have already started creating resource books for your community. Can you tell us about some of the resources that you have included?

Elicit responses. Participants who are not working on these books might suggest additional resources or organizations for the authors to consider including.

E. Exercise 2: Identifying Steps in Referring Clients to Community Resources – Discussion
Let's try to outline some of the steps in making a referral to a community resource. Has anyone referred a client to a resource in the community? I'd like to get a few examples and examine how you did this.

Elicit responses from the audience. Have participants describe exactly how they made the referral – what the client's problem was, how they identified that a community resource would help, how they contacted the resource, etc. Write these different steps on the board as the participant describes them.

Next, ask all participants the following questions:

- Based on these responses, what is the first step in making a community referral? *Most likely the response will be identifying the client's problem.*
- After you determine that a client's problem could be helped through community resources, how can you determine which resources are

available that are relevant to the client's problem? *Possible responses include: using a resource directory developed by the hospital (if one exists), talking to supervisors or colleagues who have made referrals in the past, visiting the client's neighborhood to look for community organizations or informal helping networks.*

In general, making a community referral starts with identifying the client's problem and determining which resources exist that might be able to help the client. However, this exercise demonstrates that after you determine the available resources, there is no set way to proceed. Sometimes you might simply give the client the name and location of an organization that can help him or her. For example, a client whose husband is beating her may seek assistance at a women's association or NGO that addresses domestic violence if you simply give her the contact information for such a place.

Other clients may desire more assistance. They might wish for you to make a telephone call on their behalf to an NGO that provides a service they need, or ask you to accompany them there. It is important to match your level of intervention with the type of support that the client requests. Also remember to follow up after a referral. You'll want to ask clients if the service met their expectations, if they will continue to receive the service, and if they are interested in referrals to other services to help solve their problems.

F. Addressing and Eliminating Stigma

The issue of stigma is another area in which you can use your skills as an advocate. Who remembers what stigma is from Module I?

Elicit responses and write participants' ideas on the board.

Right, stigma is a mark of shame, disgrace or disapproval that is placed on a person who is rejected or shunned by others as a result of prejudice.

Does anyone remember some of the particular stigma that people with mental illness experience?

Elicit responses and write participants' ideas on the board. Possible responses include: person is excluded from social, work or school activities; person's family is ashamed of them; other people act as if they are scared of the person; person may have trouble finding someone to marry.

There are many ways in which people with mental illnesses can be stigmatized. People with mental illness can be feared by society and therefore excluded from activities. Others may believe that people with mental illness cannot make their own decisions, and should be treated like young children. As an advocate, you can discuss and acknowledge the ways that your client feels stigmatized by society in general as well as by their family and friends.

Advocacy means fostering change, and this can go beyond the scope of your relationship with your clients. You can advocate to challenge some of the myths and ideas that people in this culture have about mental illness. Educate people in your community on how negative myths about mental illness hurt people with mental illness by limiting their opportunities. You can begin by talking with friends, coworkers or family members. We will further discuss how you can plan formal educational opportunities to inform people about stigma and other mental health topics in our training on community work.

Supervision Note
When CMHWs are discussing their cases, they may be so concerned with other job duties (i.e. psychoeducation and engagement) that they forget to use an advocacy perspective. Use supervision time to remind workers of how they can advocate for their clients while also providing other services. Here are some sample questions to ask during case reviews:

- Does this client need to be connected to resources in the community to meet his or her needs?
- Did you talk with the client about stigma and how it may be contributing to the client's problems?
- Are you presenting the client with options, or telling him or her what to do?

V. Communicating as an Advocate

Whether you are advocating with your client's physician or helping the client access community resources, the style of communication you use is very important. In fact, you'll notice that all of the skills we discuss this week are tied to our ability to communicate effectively and empathically. Your communication style should convey to the client and to the physician and other providers that you are interested in understanding them and want to work collaboratively. Please keep the following tips in mind to communicate effectively as an advocate:

- **Use active listening skills**. Can someone describe active listening?

Elicit responses and thank participants for their contributions.

Active listening is a critical skill needed for advocacy, as well as for all of your other job roles as a CMHW. As discussed previously, active listening involves using attending, following and reflecting skills to show that you are listening to the speaker and understand what is being said. Remember that both verbal and nonverbal communication, including body language and gestures, are important components of active listening.

- **Respect confidentiality.** Although physicians are part of the treatment team, clients may feel more comfortable if you ask their permission before relaying feedback or information about them to their physicians. For example, you can ask the client, "Is it all right if I speak with the physician about the problems you are describing?" Better still is to encourage the client to speak with the physician directly. While some clients may want or need referrals to community resources, others may refuse such referrals because they do not want anyone else in the community to know about their problem. Always respect a client's confidentiality concerns.

- **Emphasize collaboration, not authority**. Remember that advocacy means working WITH your clients—not giving them orders or telling them what they should do. Use language that emphasizes a client's choices. For example, you could say, "Here are some NGOs that provide legal assistance. Together we can determine which might be able to help you" instead of "I think you should call this organization immediately if you want help!"

  This aspect of advocacy can be quite challenging, as clients may sometimes ask for your advice or say "What do you think I should do?" Even if you feel you know what is best for a client, remember that telling people what to do does not promote independence or teach them any new skills. When clients ask you what they should do, you might start by asking them what options they have already considered, or simply reflecting their feelings of ambivalence and confusion back to them. Your role as an advocate is to create lasting change by helping clients help themselves, and it is difficult to do this if clients grow too depend on advice from CMHWs or other providers to solve their problems.

  It is also important to keep the principle of collaboration in mind when communicating with physicians. When talking with physicians, use

language that emphasizes that you seek to collaborate to provide the best care possible for the client. Your word choice, body language, and tone should not convey that you are trying to engage physicians in a power struggle or challenge their expertise. Even when you try to communicate collaboratively, communicating with physicians can be challenging, and now we will further explore this issue with an exercise.

VI. Exercise 3: Addressing Potential Challenges to Communicating with Physicians – Discussion

Clear communication with both clients and physicians is critical in advocacy. Just as there are particular challenges in communicating with clients, you may also encounter challenges in communicating with physicians. Think about your past experiences working with physicians. What are some of the communication challenges or problems that occurred?

Elicit responses. Write all responses on the board. Possible responses include: physician was too busy to talk to me, physician did not seem to really listen when I spoke, etc.

Now envision yourself advocating for your clients with physicians. You may be accompanying clients on physician visits, providing feedback about the client to physicians, inquiring about possible referrals and so on. Do you anticipate any additional challenges to communicating with the physician as a client advocate? Let's list those here as well.

Elicit responses. Write all responses on the board. Possible responses include: physician may be unhappy that I am in the room during a client appointment, physician may disregard my feedback or input, etc.

As we've discussed at several points throughout this training, effective communication is not an easy task. There are many challenges and barriers to good communication. We've just identified several possible challenges to communicating with physicians. Now let's try to think some solutions to these problems. As a group, let's try to identify at least one possible solution for every challenge we have listed here.

Lead participants in identifying possible solutions for each challenge. List at least one possible solution for each challenge listed on the board. Although the solutions you develop will depend on the specific challenges that participants have identified, here are some suggestions to keep in mind:

- *If the physician appears too busy to address the CMHW's questions and hear his or her input, the CMHW might ask the physician if he or she can set aside a period of time each week to do this. The CMHW could offer to list questions and state client feedback in writing prior to the meeting if this would expedite the process.*
- *If the CMHW feels that the physician is disregarding his or her input, the client might simply point this out to the physician. Perhaps the physician is not aware that he or she has been doing this. The CMHW might say, "It seems to me that you usually ignore the feedback I've been giving you about these cases. I'm wondering if you have noticed that this appears to be going on and if there is anything we can do about it."*
- *Some physicians may have difficulty communicating with CMHWs because they do not understand the CMHW job role. CMHWs may need to clearly explain their job roles to physicians, using information from these trainings. If necessary, the CMHW might refer the physician to a member of the national project staff to further clarify the CMHW role in client treatment.*

VII. Review

Here are some of the key points to remember from today's lecture:

1. Advocacy is the process of creating change by working with your clients to create access to resources and services.
2. The first step in advocacy is identifying client needs. This can be accomplished through completing the intake and treatment forms, using Maslow's Hierarchy of Needs as a model for exploring clients' unmet needs, and using the Domains of Mental Health Satisfaction Scale to identify areas of life in which the client wants to improve.
3. There are several ways you can advocate for your clients, including advocating with their primary care physicians and other service providers, creating access to community resources, and addressing stigma associated with mental illness.
4. How you communicate is just as important as what you communicate. As an advocate, your communication style should emphasize active listening and collaboration, and preserve client confidentiality.

Do you have any questions?

VIII. Practicing Advocacy

Now we will apply what we've learned today about advocacy by practicing with some role plays.

A. Exercise 4: Hakim – Role Play

Our first role play will focus on advocating with physicians. For this role play you will separate into groups of three. One person will play the CMHW, one will play the client, and one will play the physician. Here is the scenario:

Hakim is a 32 year-old man who has been coming to see his CMHW at the hospital for about a month. Hakim first came to the hospital complaining of headaches and backaches. In talking with his CMHW, he describes several other problems. Hakim reports that he has difficulty sleeping, has little motivation to go anywhere or do anything, has a poor appetite and feels sad, depressed and lonely most of the time. Hakim has not mentioned any of these symptoms to his physician. Past meetings with Hakim's physician have focused on his headaches and back pain.

Your role play should demonstrate how the CMHW can use any combination of the methods of advocating with primary care physicians to help Hakim. Recall that these methods include accompanying clients to physician appointments, practicing communication skills with clients, giving physicians feedback about clients, and ensuring quality of care. Remember to involve all three people in your group in the role play.

Your group will have 30 minutes to practice the role play. The role play itself should last five to ten minutes. You may leave the room to practice if you wish. When you return I will first model the role play for you. Then all groups will have the chance to perform. We'll quickly debrief after each performance, and then have a group discussion after all pairs have performed. Before you begin, do you have any questions?

Call participants back together after they have had at least 30 minutes to practice. Demonstrate the role play first, co-trainers or volunteers to play the client and the physician. Choose a combination of physician advocacy methods to demonstrate, such as helping Hakim rehearse communicating with the physician about his symptoms of depression and then accompanying Hakim to his next appointment with the physician as a support. Invite participants to describe what you did well in the role play and what they think you should have done differently. Then invite the participants to perform.

Immediately following each group's performance, debrief by asking the group members the following questions:

- How did you feel playing the role of the CMHW?
- How did you feel playing the role of the client?
- How did you feel playing the role of the physician?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief as a group using these questions:

- What techniques for advocating with physicians did you see demonstrated?
- How did the CMHWs handle the issue of confidentiality when communicating with physicians?
- What other skills did you notice CMHWs using, i.e. active listening or performing psychoeducation?
- If this were a real case, what other advocacy techniques might the worker use in the future (i.e. connecting client to community resources or addressing stigma)?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

B. Exercise 5: Maryam – Role Play

Our next role play will focus on advocating to connect clients with community resources. You will stay in your three-person group for this role play. One person will play the CMHW, one will play the client and one will play a member of the community. Please switch roles, so that you play a role that is different from the one you played in the last role play. Here is the scenario:

Maryam is a 24 year-old woman. She has been coming to the hospital for health care during her pregnancy with her second child. Her physician referred her to a CMHW because she seemed extremely anxious. During a meeting with the worker, Maryam reveals that she is having problems at home. Her husband was beating her severely, so she recently left with her child and moved in to her sister's home. Her sister is married and has three children. Maryam is anxious that she will overstay her welcome there and

have nowhere else to go. In addition, she is worried because she has very little money to give to her sister for expenses, and her sister is complaining that she is running out of food to feed all of them. Maryam's anxiety has gotten so bad that she rarely sleeps at night and has difficulty concentrating. Sometimes she is so nervous that her hands shake.

Your role play should demonstrate how the CMHW can advocate for Maryam by connecting her to a community resource. You can decide what sort of community resource it should be. Some examples are an NGO that provides housing or financial assistance, an NGO that provides counseling for abused women, or a wealthy woman in the neighborhood who is known to give donations of food to needy families. Your role play should show how the CMHW and the client define the client's problem, determine available resources, and gain access to the resource. Remember to involve all three people in your group in the role play.

Your group will have 30 minutes to practice the role play. The role play itself should last five to ten minutes. You may leave the room to practice if you wish. When you return each group will perform their role play. We'll quickly debrief after each performance, and then have a group discussion after all pairs have performed. Do you have any questions?

Call participants back together after they have had at least 30 minutes to practice. Ask participants if they would like you to model this role play before they perform. If so, demonstrate the role play, using co-trainers or volunteers to play the client and community member. Then invite the participants to perform. Immediately following each group's performance, debrief by asking the group members the following questions:

- How did you feel playing the role of the CMHW?
- How did you feel playing the role of the client?
- How did you feel role playing the community member?
- As the CMHW, what did you do that you liked? (*You may also ask the audience to offer their feedback*)
- As the CMHW, what might you do differently in the future, if you were actually meeting with a client? (*You may also ask the audience to offer their feedback*)

After all pairs have performed, debrief as a group using these questions:

- If this were an actual case, how might the CMHW follow up with the client after referring her to a community resource?

- Based on this role play, what are some of the challenges to referring clients to community resources?
- How did the CMHW address confidentiality issues in making the referral?
- What other skills did you notice CMHWs using, i.e. active listening or performing psychoeducation with the client?

Be sure to praise all participants for their performances and thank them for their contributions to the discussion.

IX. Conclusion

Today we learned what it means to advocate for our clients, and you had the chance to practice advocating through some role plays and exercises. As you saw, advocacy is not simple. It involves using all of your skills and resources to help your clients get what they need. Before we wrap up, are there any more questions on advocacy?

Address any questions or concerns that participants raise.

As a final activity, I'd like to go around the room and have everyone name one thing they have been doing or will try doing to advocate for their clients.

Be sure to thank participants for their contributions and attention. Have them complete the Competency-Based Training Exam.

Competency- Based Training Exam – CMHW

Name: _____ Date: _____

Answer the following questions to the best of your ability.

1. What is advocacy?

2. What is stigma and why is it relevant to advocacy?

3. Give an example of how you could communicate with your client in a manner that emphasizes collaboration.

4. When might a client need to be referred to community resources? Explain and give an example.

5. Describe three ways that you could inquire about a client's unmet needs.

Working in the Community

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to use community work as a means of helping clients and creating large-scale change.

Informational Competencies:
At the end of this training, the CMHW will know…

- How community work can benefit both individual clients and entire communities
- Interventions of community work, including making community visits with clients; gathering observational data; holding formal and informal educational forums on mental health issues; and performing outreach activities
- Skills needed for community work, including thinking small, networking, and public speaking

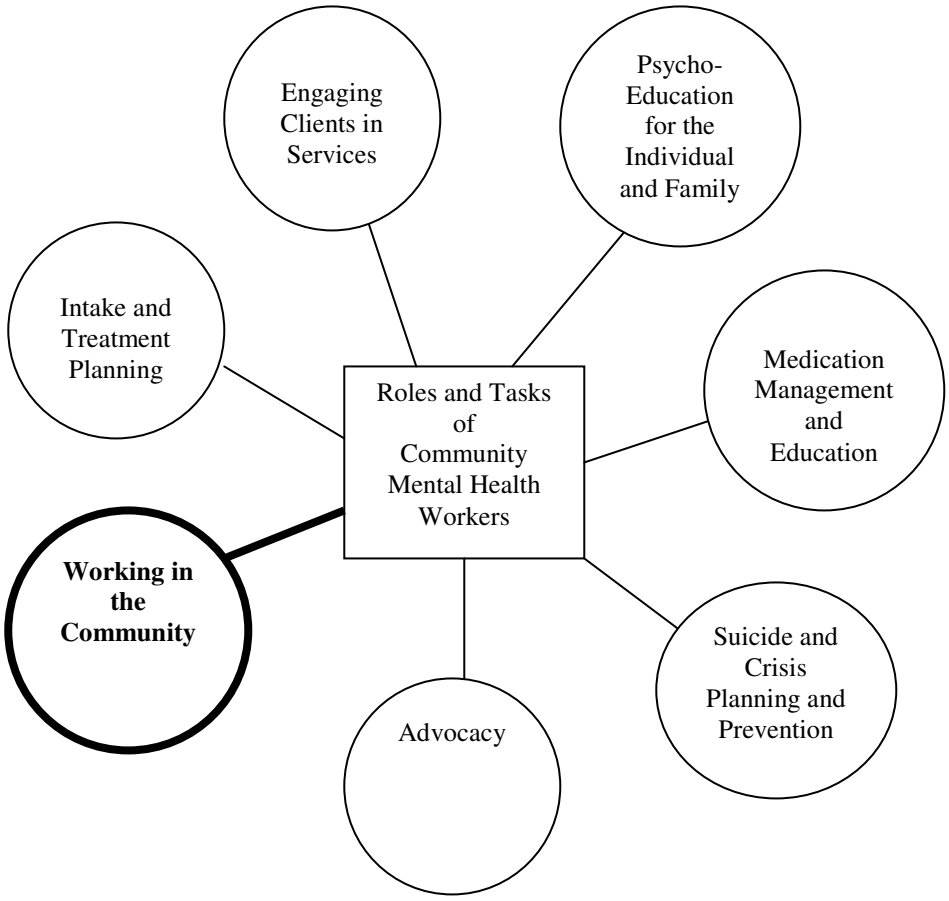
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Explain the importance of the community in providing mental health services for individuals and communities
- Use community visits to build rapport and facilitate clients' access to resources
- Collect information on community members' knowledge, attitudes and beliefs regarding mental health
- Perform community education tasks and understand the importance of community education in mental health
- Perform outreach activities in hospitals and community venues
- Demonstrate public speaking skills

Learning objectives:
The goal of this training session is to teach…

- Four interventions for working with and in the community
- Skills for community work, including thinking small, networking, and public speaking

This training addresses the following CMHW Job Role(s):
Working in the Community



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:

Corrigan, P.W. & Garman, A.N. (1996). Case management and severe mental illness. In S.S. Blancett & D.L. Flarey (Eds.), *The handbook of nursing case management: Health care delivery in a world of managed care* (pp.334-353). New York: Aspen Publishing.

Freedman, P. (2003). *What makes a solution?* Charlottesville, VA: Pew Partnership for Civic Change.

Hepworth, D.H., Rooney, R.H., & Larsen, J.A. (2002). *Direct social work practice*, 6th ed. Pacific Grove, CA: Brooks/Cole.

Pratt, C.W., Gill K.J., N.M. (1999). Chapter 8, Case management strategies. In *Psychiatric rehabilitation* (pp.122-133). San Diego: Academic Press.

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

We will start this training by defining community work and demonstrating its importance.

II. Definition and Scope of Community Work

As a CMHW, there are many different ways in which you can work in community settings to assist clients and educate people. One aspect of community work involves accompanying clients on community visits to build rapport and facilitate access to resources. Other types of community interventions target larger groups or systems, rather than individual clients. For example, interventions such as outreach or community education may be directed at residents of a particular neighborhood, members of women's associations and other local groups, representatives of NGOs, or government leaders. The goal of this type of intervention is typically to educate a large group of people about mental health, inform people of available mental health services, and begin to discuss other solutions for meeting people's mental health needs.

III. Importance of Community Work

The importance of community work must be addressed on two levels: its value to individual clients, and its value to the larger population. Let's start by thinking of some ways by which individual clients seeking services from CMHWs could benefit from any type of community intervention.

Elicit responses, giving examples of community interventions if necessary (i.e. worker accompanying a client to an NGO; worker leading a general discussion on mental health in a client's neighborhood). Participants' responses may include: client builds better rapport with worker due to community visit; client gets access to resources; effects of stigma on client are reduced as a result of community education.

You can see that there are many potential benefits for clients from community work. Some clients may obtain assistance from an NGO that they could not get on their own if a worker accompanies them there and helps them learn the

system for obtaining help. Others may benefit simply from the worker's supportive presence and knowing they are not alone in handling their problems.

Going on a community visit also gives the worker a chance to observe the client in an environment outside of the hospital. This may give the worker new insight into the client's strengths and problems. If the client permits it, it may be useful for the client and the worker to take a walk or find another outdoor area instead of meeting at the hospital. In addition to giving the worker the chance to observe the client in another environment, the change of scenery may help the client and worker build rapport with one another.

Supervision Note
If CMHWs seem reluctant to initiate community visits with clients, further explore some of the potential costs and benefits in supervision. For example, many people who have experienced trauma feel isolated and disconnected from their communities. If the client is ready, meeting in community settings might increase the client's sense of connection with his or her environment. An example of a cost is that it takes more time and the client may have confidentiality concerns.

In addition, individual clients can benefit from community education and outreach. People with mental health problems may find that they are treated better when others in the community are well informed about these problems. Over time, community education helps to reduce the stigma that people with mental illness encounter in many areas of life.

Can anyone share a story from your experience about how going on a community visit or community education benefited a client?

Elicit responses. If participants do not have any personal experience with this, you might describe an anecdote from your own experience.

Now let's try to think of some of the benefits of community work to the community as a whole. How can community education and outreach benefit the general population of a neighborhood, city, or town?

Elicit responses. Possible responses include: people gain a better understanding of mental health; people become aware of services and can refer others they know with these problems.
Though community interventions can be challenging to implement, they can benefit people in a number of ways. Community education aims to give

people a better understanding of problems such as mental illness, which affect many people, directly and indirectly, in all types of communities. Problems such as mental illness and trauma sometimes seem invisible because many people who are affected do not seek treatment or talk about these issues. Community education sheds light on such "invisible" problems. Ideally, when more people are aware of problems affecting communities, they can unite to discuss solutions and create resources.

Outreach is another activity that can benefit communities. Some people in distress may desperately want to seek help, but do not know where to go. Outreach activities in communities let people know about services that are available and how people in need can obtain them. People in the community can then refer themselves or others to services such as those provided by CMHWs when they realize these services exist to help with their problems.

IV. Types of Community Interventions

We have mentioned several different interventions for community work. Let's review them now and then discuss each in more detail:

- Conducting community visits with clients
- Making community visits for the purpose of collecting information on community members' knowledge, attitudes and beliefs on mental health issues
- Conducting formal and informal community education events on mental health topics, including suicide, trauma and stigma
- Conducting outreach activities to inform community members about services for people experiencing trauma and mental health problems

A. Community Visits with Clients

Earlier in this training and during our training on advocacy, we discussed some of the situations in which you might want to do a community visit with a client. One of the most common scenarios is accompanying a client to a place where he or she is seeking assistance, such as an NGO, private physician's office, court, or police office. Can you think of any other situations in which you might make a community visit with a client?

Elicit responses. Encourage participants to think of possible scenarios in which a community visit could help build rapport.

Perhaps the most important thing to remember in conducting community visits is to respect clients' confidentiality and comfort level meeting you in

the community. Some clients may not wish to be seen in public with their CMHW in order to protect their confidentiality. If this is the case, the worker should not pressure the client to meet in the community for any reason. A good strategy may be for the CMHW to offer to do a community visit—for example, "Would you like me to go with you to the psychiatrist's office? I want you to know that you are not alone in seeking help." If the client declines such a request, the worker should not push the issue.

In other situations, a community visit might occur because the worker and client simply want to try meeting each other outside of the hospital, or because private space in the hospital is limited. In considering other spaces, the worker and client should discuss the client's privacy needs. The worker should check to see that the client is comfortable with the destination before arranging a meeting outside of the hospital.

B. Exercise 1: Meeting Clients in the Community – Group Activity

Now let's try to generate some ideas for possible places to meet clients outside of the hospital. Since space to meet with clients at the hospital is often limited, it's important to keep some other options in mind. Please break up into groups of three or four and start thinking of some ideas. Your group should try to generate at least five ideas for places to meet with clients. Consider the privacy and accessibility of each location so we can discuss this. You have 15 minutes.

Call the groups back together in 15 minutes, allowing more time if necessary. Have each group list their ideas and write them on the board. Discuss each idea, evaluating advantages and drawbacks of each in terms of privacy and accessibility.

Each of these ideas could be a good venue to meet with a particular client under a particular circumstance. Remember that it is the client's preferences for privacy and confidentiality that matter most in choosing a location for a community visit.

Supervision Note

You can increase CMHW competency in this skill during group supervision by asking questions such as:

- How did you bring up the idea of doing a community visit with the client?
- Did the client have any ideas for places to meet for community visits?
- How did you respond if the client declined a community visit?

C. Collecting Information about Your Community

This intervention is actually related to another intervention, community education. Before planning a community education event, it is ideal to have some information on people's knowledge, attitudes and beliefs about mental health.

There are two main purposes for this. First, this information helps the worker know what sort of topics to address in community education. For example, if members of a women's association have some knowledge of depression but do not have any understanding of suicide and how to prevent it, then the worker knows that suicide is a good topic for community education. Or, if a worker observes that people in a community seem to have negative, false beliefs about mental illness and its causes, he or she may determine that it is necessary to educate people about stigma and myths about mental illness.

The other reason for gathering information prior to an educational intervention is to establish a starting point. After community education has taken place, the worker can continue to collect information and make observations in order to determine how people's attitudes, beliefs and knowledge base have changed.

There are both formal and informal methods of gathering information. An example of a formal method would be giving people a survey to complete on their attitudes about mental health. While this can be quite useful, most likely you will not usually have the time or resources for formal data collection.

D. Exercise 2: Ideas for Collecting Information - Discussion

Let's try to think of some informal ways you could collect information on topics like trauma, mental health and suicide. Has anyone done this before? What are some ideas?

Elicit responses. Possible responses include: discuss these subjects with colleagues, friends or family members and observe their responses; ask acquaintances or even strangers what they think about mental illness and why it occurs; observe staff at NGOs to see how they address topics such as trauma and depression.

These are good suggestions for collecting information. Now let's think about how you would keep track of the information you would collect. What are some ideas for documenting and keeping track of information?

Elicit responses. Possible responses include: jot notes in a notebook as you talk with people; write a summary of your impressions after the discussion; take discrete notes as you observe people.

Having some kind of written record of the information you collect can be helpful when it is time to plan community education events. Here are a few tips for keeping notes:

- Writing notes can get in the way of interacting with people. If you're talking with people to gather information, jot down only the most important details or phrases as they speak. Immediately after you finish talking with them you can write more detailed notes.
- Be sure to date and label your notes, for example "Observations of staff attitudes about mental illness and stigma, collected at the hospital on October 1, 2005."
- As you gather information and take notes, you might also want to jot down ideas that come to mind for community education events based on your observations.

E. Community Education

Creating formal and informal education opportunities is one of the most important tasks of community work. In your training thus far, you have received a great deal of information on topics such as symptoms of mental illness, suicide prevention, and stigma. You can help your community as a whole by finding ways to share this information with others.

Informal education opportunities do not have to require much advance planning. As a CMHW, you can engage family members, friends or coworkers in conversation about topics related to mental illness. When people understand the work you do, they may begin to come to you with questions, such as what causes a person to have mental health problems or how to respond to a person who is talking about suicide. You can use your knowledge and resources as a CMHW to respond to such questions with factual knowledge, thus educating others in your community.

Formal educational opportunities in the community require more planning. What are some examples of how you could educate others in your community about mental illness and trauma in a more formal way?

Elicit responses. Possible responses include: planning a lecture or discussion about mental illness at a local college or school; making a speech about

trauma at a community meeting; going to other hospitals to discuss suicide prevention with physicians and staff.

We will later discuss some of the skills needed for making such presentations. As people begin to discuss trauma and mental health in formal and informal ways, stigma for people who contend with these issues may decrease while treatment improves as a result.

Supervision Note
Conducting a formal educational event requires many sophisticated skills, including public speaking, networking, and organizing. CMHWs conducting educational events will likely need your guidance as they plan and prepare. CMHWs may wish to practice a presentation in group supervision before performing it in the community.

F. Outreach

Outreach means letting people in the community know about services and resources available to help people with particular problems. Outreach can start in your own hospital. Clients and their families who come to the hospital for various reasons should know what services CMHWs offer and how they can obtain them. How does your hospital let people know about the work that CMHWs do?

Discuss with participants. If hospital does not have a systematic way for letting people know about these services, discuss ideas, such as creating a pamphlet or appointing a worker to visit clients in all parts of the hospital and tell them about the services.

Outreach can also be conducted in the community, perhaps in connection with community education events. You can use both formal forums (i.e. giving a speech) and informal conversations to tell people about services available to help people coping with mental health problems and trauma. The organizations listed in your resources directories may be good places to start for outreach. You might visit some of these places to determine if people know about the services CMHWs offer. If they do not, this is a good opportunity to make an informative presentation.

V. Skills for Community Work

We've just discussed a range of interventions that are part of community work, including making community visits with clients, collecting information, community education, and outreach. Let's make a quick list of some of the skills one would need to perform these interventions.

Elicit responses and write them on the board. Possible responses include: public speaking skills, ability to network with community leaders, organizational skills, etc.

Some of the most important skills for community work include:

- **Thinking small**. The idea of trying to change the attitudes of an entire society about mental health is too daunting a task for anyone to accomplish. Community work involves maintaining a perspective of accomplishing change in small increments. Through outreach, education and helping individual clients, you can create lasting change in your community, one person at a time.

- **Networking**. Networking means making connections with others in your community and identifying individuals and organizations that can support you in your cause. Networking should extend beyond your professional contacts. You can seek out people who share your concerns in social settings, at mosques and even among your own family. Making connections with leaders in the community is essential for securing venues for client visits and education and outreach events.

- **Public speaking**. Formal educational and outreach events require a speaker who is skilled in speaking with public audiences. I'll distribute a handout now with some tips on public speaking. We'll review the tips and you'll have the chance to practice public speaking this afternoon.

  Distribute handout titled "Skills for Public Speaking." Go over items with participants and ask if they have any questions.

Supervision Note
Case presentations in group supervision are a good opportunity for CMHWs to practice public speaking skills. You may wish to review the public speaking tips before CMHWs make case presentations and give them feedback on their presentations (i.e. what they did well and things they could improve).

VI. Review

Here are some of the key points from today's lecture on community work:

1. Community work is a term for the interventions and activities that workers use in community settings to assist clients and educate people.

2. Community interventions can benefit individual clients and entire communities through education and increasing access to services and resources.
3. Community interventions include making community visits with clients; collecting information on community members' knowledge, attitudes and beliefs about mental health issues; conducting formal and informal community education events on mental health; and conducting outreach activities to inform community members about mental health resources and services.
4. Some of the skills needed for community education are thinking small, networking and public speaking.

Do you have any questions?

VII. Exercise 3: Practicing Community Work – Group Activity

Now we will do some group work to practice what we've learned about community work. I will explain the exercise and then you will divide into groups of four. Each group will start by thinking of a place in your community that you could use as a location for a community visit with a client. The place can be an outdoor area, a school, an NGO, or any other location you can think of. Think critically about your site and how it would serve as a venue for meeting with an individual client. Your group may wish to draw a picture of the place or describe some of its physical characteristics and dimensions

Once your group has selected a place, your job is to discuss the following:

- Why did you select this location as a site for a client visit? What are the benefits and drawbacks, in terms of privacy and accessibility?
- What is one idea you have for a community education event? Think about what topic you would discuss, how you would discuss it, where you would have the event, who the audience would be and who you would need to talk to in order to arrange such an event.
- What is one idea you have for conducting outreach about the services that CMHWs provide? You can discuss an idea for conducting outreach within the hospital or in the community. Some ideas would be giving a speech at another organization or speaking about CMHW services in a different part of your hospital. Discuss what your activity would consist of, who the target audience would be, who you would need to talk to arrange this, etc.

- Discuss your social and professional networks with your group members. What colleagues, community members and leaders do you know that could be helpful in conducting community education or outreach events? Together, identify a list of five people you could contact who have resources (i.e. venues, specialized knowledge or influence on others) that you might be able to utilize for community work.

Be sure to take notes on each of these topics. Your group can leave this room to discuss your ideas in privacy if you wish. When you return, each group member will give a short, two-minute speech on each topic area. That is, one member will discuss what location you chose for a community visit with a client and why; one will discuss your group's idea for a community education event; one will discuss your group's idea for outreach; and one will discuss your list of five contacts and why you selected them. Remember, the speeches will be very short, so you only need to give a summary of the most important information. The purpose is to give you some more experience in public speaking. You can break into your groups now. Please return to this room in one and a half hours.

Before you go, do you have any questions?

Encourage groups to leave the room to complete the exercise. Call the participants back together after an hour and a half. Announce that it is time to conduct the speeches on what the groups discussed. First, quickly review the handout with tips on public speaking. Next, model the skills by giving a two--minute speech on an idea you have for a location for community visits, or an idea for an education or outreach event. Invite participants to describe what you did well in your speech and what they think you should have done differently. Then have participants conduct their speeches. It may be necessary to enforce the time limit, so the speeches do not take up too much time.

After all members of one group have given their speeches, debrief by asking the group members the following questions:

- How did you feel doing this exercise (nervous, excited, etc.)?
- What did you like about your speeches?
- What might you do differently when doing public speaking in the future?

After everyone has taken a turn, thank participants for their participation and debrief as an entire group using these questions:

- What was the most challenging aspect of this exercise (i.e. finding the location, generating ideas for education and outreach or doing the speech)?
- Do you think you could actually implement any of the ideas discussed for community education and outreach?
- What did you learn about the social networks held by people in this room?
- Will you actually contact any of the people the groups discussed to facilitate community work activities?

VIII. Conclusion

Community work is one of the many complex job roles you have as a CMHW. It requires considerable skill in areas such as networking, public speaking, and creative thinking. Because there is not much precedent in many communities for such activities as community education and outreach on mental health and trauma, being the first to initiate such tasks is not easy.

This is why it is important to remember the skill of thinking small. Even if you are helping or educating only one person today, tomorrow the effects of your intervention may ripple far into the community. In time, this process can change the knowledge and beliefs people have about the clients you serve and the types of problems with which they struggle.

Before we end for the day, do you have any more questions about community work?

Address any questions or concerns that participants raise.

As a final activity, I would like everyone to name one new thing they learned today about themselves or their communities.

Be sure to thank participants for their contributions and attention. Have them complete the CMHW Competency-Based Training Exam.

HANDOUT

Tips for Public Speaking

Feeling some nervousness before giving a speech is natural and healthy. It shows you care about doing well. But, too much nervousness can be detrimental. Here are some tips for controlling your nervousness and making effective, memorable presentations:

1. Know the room. Be familiar with the place in which you will speak. Arrive early, walk around the speaking area and practice using the microphone and any visual aids.

2. Know the audience. Greet some of the audience as they arrive. It's easier to speak to a group of friends than to a group of strangers.

3. Know your material. If you're not familiar with your material or are uncomfortable with it, your nervousness will increase. Practice your speech and revise it if necessary.

4. Relax. Ease tension by doing breathing exercises.

5. Visualize yourself giving your speech. Imagine yourself speaking, your voice loud, clear, and assured. When you visualize yourself as successful, you will be successful.

6. Realize that people want you to succeed. Audiences want you to be interesting, stimulating, informative, and entertaining. They don't want you to fail.

7. Concentrate on the message -- not the medium. Focus your attention away from your own anxieties, and outwardly toward your message and your audience. Your nervousness will dissipate.

8. Gain experience. Experience builds confidence, which is the key to effective speaking.

Source: Toastmasters International web site,
http://www.toastmasters.org/tips.asp

Competency- Based Training Exam – CMHW

Name: _____ Date: _____

Answer the following questions to the best of your ability.

1. Name one potential benefit of community work to individual clients and one potential benefit to the community.

2. List two places to conduct community visits with clients and describe advantages and drawbacks of each (address privacy and accessibility).

3. What are the two purposes of collecting information in the community?

4. What is outreach? Give an example of how you could conduct outreach in the community.

5. Name and describe two skills needed for community work.

Treatment Planning

TABLE OF CONTENTS

INTRODUCTION

Purpose of Training:
To teach community mental health workers how to collaborate with clients to create comprehensive treatment plans.

Informational Competencies:
At the end of this training, the CMHW will know…

- The definition of a treatment plan
- Purposes of treatment planning
- Structure and purpose of different components of treatment plans, including client goals, activities for meeting goals, client strengths and resources, CMHW interventions, and descriptions of what the client will accomplish by the next session
- How to develop treatment plans with clients, utilizing information gathered on the Patient Intake Sheet
- How engagement, psychoeducation, medication management, crisis planning, advocacy and community work skills are linked to treatment planning

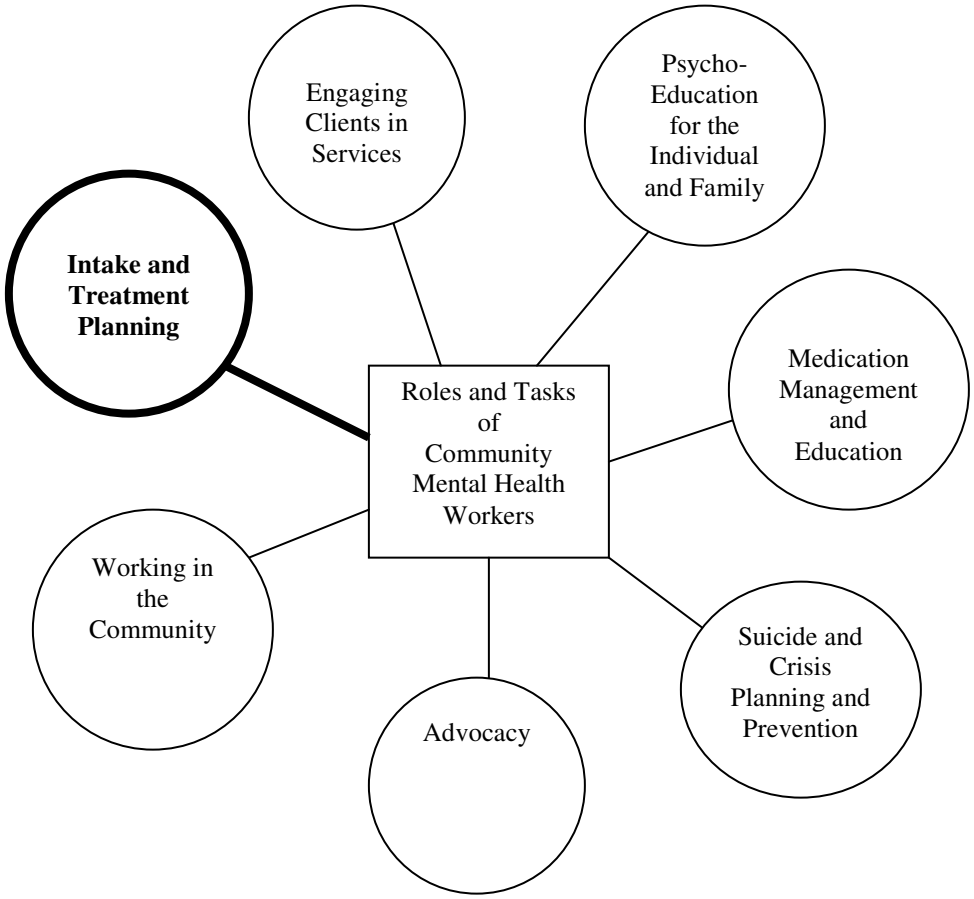
Interventional Competencies:
At the end of this training, the CMHW will be able to…

- Define treatment planning
- Describe the purposes of treatment planning
- Complete a treatment plan with a client that addresses the client's goals, skills and behaviors needed to meet goals, strengths and resources, and CMHW interventions
- Utilize skills in engagement, psychoeducation, medication management, crisis planning, advocacy and community work to facilitate treatment planning and identify CMHW interventions that can help clients in meeting goals
- Communicate collaboratively with the client throughout the treatment planning process

Learning objectives:
The goal of this training session is to teach…

- Treatment planning skills
- Review engagement, psychoeducation, medication management, crisis planning, advocacy and community work skills

This training addresses the following CMHW Job Role(s):
Intake and Treatment Planning



TRAINING SET-UP

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers

References and Recommended Readings:

Corrigan, P.W. & Garman, A.N. (1996). Case management and severe mental illness. In S.S. Blancett & D.L. Flarey (Eds.), *The handbook of nursing case management: Health care delivery in a world of managed care* (pp.334-353). New York: Aspen Publishing.

Hepworth, D.H., Rooney, R.H., & Larsen, J.A. (2002). *Direct social work practice*, 6th ed. Pacific Grove, CA: Brooks/Cole.

Pratt, C.W., Gill K.J., N.M. (1999). Chapter 8, Case management strategies. In *Psychiatric rehabilitation* (pp.122-133). San Diego: Academic Press.

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation.

TRAINING SCRIPT

Welcome, Introductions and Daily Agenda

Greet participants and address any unfinished business from the previous day's training. Discuss the Purpose of today's training. Review the Learning Objectives for today's training.

I. Agenda

This training will show you how to create a treatment plan with clients. First we will quickly review the purpose of treatment planning and the different components of a revised version of the treatment planning form you have been using. Then we will spend some time practicing using the form with a case study.

II. Definition and Purpose of Treatment Planning

You'll recall from Module II that a treatment plan is a written, structured description that precisely defines a client's problems, goals and resources, and describes how these will be addressed in treatment. Treatment plans are developed in a collaborative effort between the client and the treatment team (physician, CMHW, etc.). A treatment plan is a working document, meaning that it is periodically updated.

The main purposes of treatment planning include:

- Ensuring that the treatment team and the client are in agreement about the goals to be achieved and the skills and behaviors that the client will develop
- Facilitating the selection of appropriate interventions for the CMHW or other professionals to use to best help the client
- Emphasizing the strengths and resources that the client already possesses that can be utilized to meet goals
- Assisting clients and workers in monitoring process toward meeting goals

In addition, treatment planning can help to increase rapport between clients and workers. The plan lets the client know what is expected of him or her, and how the CMHW will provide support to help him or her meet his or her goals. When clients see a statement on a treatment plan describing precisely how and when they can meet their goals, they may feel more confident that they will succeed.

Next we will review the different components of a treatment plan. Afterward we will discuss the process of treatment planning and how to link treatment planning with intake. Then you will have a chance to practice completing a treatment plan.

III. Components of Treatment Plans

In your work and training thus far, you have likely seen several different types of treatment plans. Treatment plans can be organized in a number of ways, but all comprehensive treatment plans should include the following components at a minimum:

- Client goals
- Activities to achieve goals
- Client strengths or resources to utilize in reaching goals
- CMHW interventions to assist client in developing skills and reaching goals
- Description of what will be accomplished by the next session

I'll distribute a handout now that shows the treatment form you will use when working with clients. It is slightly different from the one you have been using. Please refer to this form as we review the different components.

Distribute treatment plan to participants.

A. Client Goals

You are already familiar with goal-setting from our training on engagement and Module II. On a treatment plan, goals should be phrased as specifically as possible. If a goal is too vague, i.e. "I want to feel better," it will be difficult to tell when the client has achieved it.

Goals listed on treatment plans can be daily, short or long-term. This depends on the nature of the client's problems and the skills and interventions that will be required to achieve the goal. It is important that goals are phrased by the client. It may be tempting for the worker to tell the client which goals would be appropriate for him or her. However, people are usually more motivated to work on the goals that they identify for themselves as important.

Examples of goals include: "I will sleep no longer than 8 hours per day," "I will eliminate thoughts of hurting myself," and "I will obtain a job that pays enough for me to provide for my family."

Supervision Note
You can increase CMHW competency in this area when CMHWs present treatment plans during supervision by asking questions such as:

- How did you and the client select these goals?
- Would you classify these goals as daily, short or long-term?
- Describe your opinion of the feasibility of these goals. What does the client think?

B. Activities to Achieve Goals

List the specific activities, skills or behaviors that the client will need to demonstrate in order to meet his or her goals on the treatment plan. Some goals may require that the client practice only one particular skill or behavior, while reaching other goals may require several skills and behaviors. For example, if the client has a relatively simple daily or short-term goal, such as taking some time each day to relax or read for pleasure, then the only new skill the client may need to learn is time management, so he or she can build this in to his or her schedule. Long-term goals, i.e. improving communication with one's spouse, will require the client to learn and practice a number of skills; in this example those skills might include active listening, assertively voicing concerns and using problem-solving skills.

Please recall from Module II that when describing skills and behaviors, it is important to include the following:

- Components of the skill or behavior
  Example: Client will practice relaxation techniques, <u>including deep breathing and meditation</u>
- Conditions under which the skill or behavior will occur
  Example: Client will practice relaxation techniques <u>at home</u>, including deep breathing and meditation
- Frequency and/or duration of the skill or behavior
  Example: Client will practice relaxation techniques at home <u>each day for 20 minutes</u>, including deep breathing and meditation

Supervision Note
You can increase CMHW competency in this area when CMHWs present treatment plans during supervision by asking questions such as:

- Did you describe all of the components of each skill, the conditions under which it will be performed, and its frequency and duration?
- Is this a skill the client has already mastered, one he or she knows but needs to practice, or an entirely new skill?
- Will the client need to learn any other skills and behaviors in addition to the ones you have listed to meet this goal?

C. Client Strengths and Resources

When some clients are completing the treatment plan, they may feel overwhelmed by the extent of their problems. Others may feel discouraged because it seems their goals will take so long to achieve. In such cases, people often forget about the strengths and resources that they already possess that can help them reach their goals. This is why it is important to include client strengths on the treatment plan.

You'll recall from our training on engagement that strengths and resources come in many forms, including personal characteristics (i.e. having good health), positive relationships with friends and family members, and things that people possess (i.e. houses, jobs, access to a computer).

In our engagement training we discussed some techniques for helping clients identify strengths and resources. These included asking clients what they like about themselves and what they are good at, and using the Domains of Mental Health Satisfaction Scale. Do you have any questions about these techniques?

Supervision Note
You can increase CMHW competency in this area when CMHWs present treatment plans during supervision by asking questions such as:

- Describe how the client identified his or her strengths and resources. How did you assist him or her in doing this?
- How will the client utilize these strengths when he or she performs the necessary skills to meet his or her goal?

D. CMHW Interventions

In this section the CMHW lists the services or interventions he or she will provide in order to help clients develop new skills and meet their goals.

CMHW interventions are listed on the treatment plan because doing so ensures that the client, the CMHW and the rest of the treatment team are clear on exactly what the CMHW is expected to provide and how it relates to the client's goals.

In completing this part of the treatment plan, you will be relying on the different skills and interventions you learned under each of the six CMHW job roles. In other words, you will use this section to list strategies of client engagement, psychoeducation, medication management, crisis planning, advocacy, and community work that are relevant to the client's goals or the skills that the client needs to learn. For example, a client lists taking anti-anxiety medication daily as a behavior she will demonstrate in order to meet her goal of reducing panic attacks. The CMHW interventions would include psychoeducation on the intended effects and side effects of the medication her physician prescribes and discussion of barriers to adherence that may come up.

Whenever possible, the interventions that the CMHW provides should build on the client's existing strengths and resources. Often clients will not need to learn entirely new skills, but will just need some assistance practicing or modifying skills they already possess. An important principle to keep in mind is that the combination of the client's existing skills, his or her strengths and resources, and the CMHW's interventions should allow the client to reach the goal over time. Otherwise, it is not a feasible goal.

Supervision Note
You can increase CMHW competency in this area when CMHWs present treatment plans during supervision by asking questions such as:

- How did you and the client identify which interventions you will provide?
- Do you feel you have all of the skills, knowledge and resources you need to provide the interventions listed on the treatment plan?
- How do your interventions build upon existing client strengths and skills?

CMHWs may periodically need "booster sessions" to practice previously learned skills in order to provide interventions with clients—i.e. public speaking, providing psychoeducation, linking clients with community resources, etc.

E. What Will Be Accomplished by the Next Session

The treatment plan should also include a short description of what the client plans to accomplish by the next session for each goal. This helps the client to break down long-term goals into shorter, more manageable goals and activities. For example, one of the client's goals on a treatment plan might

be improving his relationship with his brother. The description of what will be accomplished by the next session for this goal might be for the client to initiate three conversations with his brother. If the client follows through on this, he has not yet obtained his entire long-term goal, but he has made progress toward obtaining it. The worker should help clients determine what is feasible and important to accomplish by the next session for each goal. If the goal on the treatment plan is daily or short-term, such as taking a walk each day to get some exercise, then the client should be able to accomplish the entire goal by the next session.

Supervision Note
You can increase CMHW competency in this area when CMHWs present treatment plans during supervision by asking questions such as:

- How did you and the client determine what would be accomplished by the next session?
- How do you and the client monitor progress toward goals each session?

IV. Developing a Treatment Plan

By now most of you have had some experience developing treatment plans with clients. One source of information you have when completing treatment plans with clients is the Patient Intake Sheet. Can any of you describe your experiences using information from the Patient Intake Sheet to complete the treatment plan with the client?

Elicit responses. Discussion should include how the client's description of his or her chief complaint, history of present illness, and present symptoms can be broken into distinct problem statements by the client and CMHW.

Since the Patient Intake Sheet takes a great deal of time to complete, it is advisable not to attempt to complete the treatment plan in the same session. Trying to do so could overwhelm the client as well as the CMHW. Still, the treatment plan should be completed relatively early in treatment – perhaps by the third or fourth time the CMHW meets with the client. This is because the treatment plan sets the focus for the remaining course of treatment. It ensures that the client and the CMHW understand what is expected from one another.

Even though it is desirable to complete a treatment plan early on, please recall that this document is never truly finalized. The treatment plan will be modified over the course of treatment as clients accomplish some goals and

establish new ones. The skills and behaviors that clients need to develop, the strengths and resources they have, and the interventions CMHWS offer should also change over time. It is a good idea for the CMHW and client to review the treatment plan each week and make appropriate revisions.

The writing and modifying of the treatment plan should always be a collaborative process between the client and the CMHW. It is critical that both parties understand and agree to every component of the plan and every change that is made. Recall that people are generally more motivated to work on problems they identify and goals that they set for themselves, rather than ones that others set for them. A treatment plan that is client-driven will lead to a greater likelihood of the client achieving success in meeting his or her goals.

Do you have any questions about developing treatment plans with clients?

Supervision Note
You may wish to check periodically in supervision to see if CMHWs are periodically revising treatment plans with clients. Ask questions to determine if this process is client-driven or if CMHWs are mainly driving the revisions.

V. Skills for Treatment Planning

In essence CMHWs do not need to learn any new skills in order to complete treatment plans with clients. Rather, when you do treatment planning, you will be utilizing skills you learned in all of the previous trainings. What are some of the specific skills you have that are relevant to treatment planning?

Elicit responses. Possible responses include: active listening, goal setting, advocating, respecting client confidentiality, connecting clients with community resources, identification of symptoms of mental illness.

Since all of these skills are important in treatment planning, now is a good time to review them and answer any questions you might have. Do you have any questions or confusion regarding any of the skills or intervention strategies we have discussed in training so far?

Elicit responses and clarify any questions or issues that participants raise.

VI. Review

Here are some of the key points from today's lecture:

1. A treatment plan is a written, structured document that precisely defines a client's goals, strengths and resources, and describes how these will be addressed in treatment.
2. The plan ensures that the client and CMHW understand what is expected from one another and from the treatment process.
3. A treatment plan should include the following:
    - Client goals
    - Activities to achieve goals
    - Client strengths or resources to utilize in reaching goals
    - CMHW interventions to assist client in developing skills and reaching goals
    - Description of what will be accomplished by the next session
4. Though initially completed at the beginning of treatment using information from the Patient Intake Sheet, treatment plans should be modified by the client and CMHW throughout treatment.
5. Treatment planning involves utilizing skills in a number of domains, including engagement, psychoeducation, medication management, crisis planning, advocacy and community work.

VII. Practicing Treatment Planning

Now we are going to practice completing the revised treatment plan form with a client, using information gathered during the intake process. In a few minutes you will select a partner. You and your partner will role play a CMHW meeting with a client to develop a treatment plan. I will distribute a sample Patient Intake Sheet for you to use in the role play. The Intake Sheet has already been completed for a client named Salima. You will learn more about her story when you read the Patient Intake Sheet.

You and your partner can read the sheet together. Then begin role playing with one another. One person will play the CMHW and the other will play Salima. You can pretend that you completed the Patient Intake Sheet together in the last session. You are now meeting to create a treatment plan. Complete the entire treatment plan form, referring to the Patient Intake Sheet when necessary. It is important that you remain "in character" for the entire role play. This will give you a sense of how it feels to be a client completing a treatment plan, or how the CMHW should act in this situation. You and your partner will have 45 minutes to review the Patient Intake Sheet and do

your role play. Afterward we will come together as a group to share our experiences and ideas for completing the treatment plan. You can select your partner now and you may leave the room to do the role play if you wish.

As pairs do the role play, try to circulate among them to see if they have questions and observe their role plays. After about 45 minutes, call the groups back together. Debrief by drawing an outline of a treatment plan on the board. Then ask participants for their ideas on how to complete the treatment plan for Salima. Write participants' suggestions in each area of the treatment plan (goals, activities to achieve goals, client strengths and resources, CMHW interventions, and what is to be accomplished by the next session). After you have developed a comprehensive treatment plan using input from all participants, debrief with the group by asking the following questions:

- How did you apply some of your skills in the areas of engagement, psychoeducation, medication management, crisis planning, advocacy and community engagement to create the treatment plan?
- How did you feel role playing Salima? Was there anything you didn't like about the treatment planning process? Is there anything the CMHW could have done to help you feel more comfortable?
- How would you evaluate Salima's suicide risk?
- How would you link Salima to services in the community?
- What are some of the challenges of doing a treatment plan?
- How will you handle these challenges in the future?

Be sure to praise all participants' work and thank them for their contributions to the discussion.

VIII. Conclusion

We have discussed treatment planning late in our training course because it utilizes many of the skills you developed in previous trainings. The treatment plan should be beneficial for both the client and the CMHW. It specifies goals that the client has agreed to work on, and also gives you an idea of the skills you will need to help the client with and interventions that you must be able to provide. A treatment plan is a roadmap for both the client and the worker, creating some structure in situations rife with both potential problems and solutions.

Do you have any questions about treatment planning or how it relates to any of your other job roles as a CMHW?

Address any questions or concerns that participants raise.

As a final activity, I'd like to go around the room and have everyone name one thing they learned today about treatment planning.

Be sure to thank participants for their contributions and attention.

Treatment Plan

Today's Date: Next Treatment Plan Review Date:

Client Name: I.D.#

Physician: _____ CMHW: _____

Client Goal	Activities to Achieve Goal	Client Strengths and Resources	CMHW Interventions	What Will Be Accomplished by Next Session

Sample Patient Intake Sheet – for Role Play

Hospital / Health Center:
Name of the CHMW: Signature:_____

Form number:
First session: Duration:

Date:

Patient name: Salima Abid

Age: 28 Sex: Female

Full Address:

Education background: Some high school

Occupation: Mother

Social status: Married (husband missing) Telephone number:

Number of children: 2 Male - 1 Female - 1

Economic status: Middle class

Provisional diagnosis: Major depression

Major reason for the patient's coming to hospital:
"My husband has been missing for more than a year. I feel so depressed and sad since he left. I cry all the time and am exhausted from feeling so sad. I don't think I'm doing a very good job of taking care of my children."

Duration:
1.5 years – since July 2004

Intake of the present illness history:
Client reports that previously she was very happy to be married to her husband. He made a good salary as a government clerk and she was happy to be raising their two children. Client's health was good prior to her husband's disappearance in July 2004. At this time he had traveled to the capital on assignment for work. He did not return. Police reported that they think he was killed in a bombing, but his remains were not found. Client says that for months after his disappearance she was very anxious. She constantly worried that her children would disappear too and did not want them to leave the house. When client began to realize her husband was not returning, her anxiety largely turned to grief

and she began to feel very sad and depressed. She has been feeling depressed for about 6 months now.

Life events:
Client reports that her life prior to her husband's disappearance was normal. She married her husband at age 20 and they had their first child, a daughter, one year later. Their son was born two years later. Client says she had a happy childhood. She is the youngest child, with an older brother and sister. Client could not recall any significant traumas or events from childhood.

Present signs and symptoms:
-Feeling sad and crying most of the day
-Staying in bed most of the day
-Lack of energy to clean house and take care of children
-Anxious when leaving house
-Has severe headaches nearly every day

Client denied having any thoughts of hurting or killing herself - "My reason for living is to take care of my children."

Relation with his/her surroundings

- **Family**: Client's two children are ages 7 and 5. She says she loves them and they are very good, obedient children. She wants to feel better so she can be a better mother.
- **Relatives**: Client's parents live just a few houses away. They visit her often because they are concerned about her. So far they have been able to financially support her. Client feels guilty that she is making them worried. Client's husband's parents also live nearby but she does not see them often. They are also quite sad about the disappearance of their son. The client's older brother lives close in the same town, but her sister lives in the distant countryside.
- **Friends**: Client reports that she had a few close friends living nearby prior to her husband's disappearance. She has not seen them much since them.
- **Closest person the patient can talk to concerning his/her problems**: Mother

Means used by the patient for his /her condition:

- **Seeking physician**: Client took her son to the physician when he had a skin infection last spring. She herself has not visited a physician in several years.
- **Receiving medications**: None.
- **Traditional healer**: None.
- **Others:** Client reports that she prays every day and that her parents, brother and sister also pray for her.

Family history:

- **History of same condition in his family**
  Client reports that one of her aunts seemed to have a problem with depression and anxiety. She never married and did not leave the house often. She reports that the rest of her family is healthy.
- **History of suicidal attempt or suicide in the family**
  None.
- **History of prison or torture in the family**
  One of client's uncles was imprisoned for several years. He was eventually released and returned to his family.

Medications:

Prescribed (by whom, for what):
Client is not currently taking any medications.

Non-prescribed (over the counter) including herbal preparations:
Client's sister recommended drinking tea to help her relax. She does this periodically.

Habits:

• Smoking	Yes	No	Numbers / day
• Drinking	Yes	No	Amount
• Drug abuse	Yes	No	Kind

Past medical and surgical history:
Client reports that she fell and broke her ankle as a teenager. She recovered but it gives her some pain if she walks long distances.

Client started having severe headaches nearly every day following her husband's disappearance.

Hobbies:
Client enjoys reading and sewing. She still reads occasionally but hasn't had the energy to sew lately. She states that she used to enjoy meeting with friends and going for short walks.
Client also likes to cook and said her husband always praised her cooking.