Psychiatric Rehabilitation Skills in Practice:
A CPRP Preparation and Skills Workbook

EXECUTIVE EDITOR
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USPRA
US Psychiatric Rehabilitation Association
Assessment is considered a necessary first step in any healthcare practice, including psychiatric rehabilitation.\(^1\) With the help of a practitioner to guide the assessment process, a person with a psychiatric disability determines the need for personal change and sets goals and priorities. This diagnostic phase of psychiatric rehabilitation includes rehabilitation readiness assessment, goal setting, functional and resource assessment.\(^2\)

The following is a set of specific practitioner competencies (established by USPRA) that are necessary to conduct an effective assessment:

- Competency in the use of rehabilitation readiness and values clarification techniques to help individuals identify personal priorities and establish goals that are consistent with their personal worldviews, values, and lifestyles.

- Competency in performing strengths-based, holistic assessments that assist individuals to identify their personal strengths, and the supports and barriers to successful participation in their living, learning, and working environments of choice. This includes having the knowledge and skill in the use of functional, resource, and symptom assessments that identify the need for special services.

- Effectiveness in considering the individual’s personal preferences, strengths, and interests in order to develop goals that are consistent with his or her aspirations. Practitioners must be able to use engagement and motivational interviewing techniques, as well as to teach goal setting and problem solving skills, including the development of advanced directives, if appropriate.

- Competency in collaborating with individuals to help them discover their individual preferences for dealing with crises. A practitioner must be skilled in offering alternative coping mechanisms by using problem solving techniques, assessing individual coping styles, and developing proactive crisis plans.

\(^1\)Abbott, 1988; MacDonald-Wilson, Nemec, Anthony & Cohen, 2002.  
\(^2\)Anthony, Cohen, Farkas & Gagne, 2002.
Competency in helping individuals write goals that include discrete actions steps in order to develop effective treatment/rehabilitation plans. Practitioners must understand the elements of a goal statement and the behavioral language to define outcomes. They must be able to use action-oriented language to describe desired skills/supports and to identify logical outcomes.

To develop competency in assessment, the following tasks must be mastered:

- Task 1—Identify personal priorities to establish goals
- Task 2—Perform holistic assessments to identify strengths
- Task 3—Consider personal preferences when developing goals
- Task 4—Identify preference for crisis management
- Task 5—Use discrete steps in developing treatment/rehabilitation plans

### TASK 1 Identify personal priorities to establish goals

Competent professionals must develop the skill to assist persons with psychiatric disabilities to identify personal priorities in order to establish goals that are consistent with their personal worldviews, values, and lifestyles.

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“Stigma, discrimination, poverty, and the emotional, volitional and cognitive disruptions common to psychiatric disorders may further thwart efforts toward change for persons labeled with psychiatric disabilities.”
Background

For everyone, making lifestyle changes takes great effort. For those individuals with psychiatric disabilities, change may be even more challenging. Stigma, discrimination, poverty, and the emotional, volitional and cognitive disruptions that are common to psychiatric disorders further thwart efforts toward change.

In spite of these barriers, persons with psychiatric disabilities can and do make changes in their lives. Certainly, it requires a tremendous leap of faith. Deegan (1997) discussed the concept of “existential risk” that persons with psychiatric disabilities must take when they agree to partner with the practitioner to work towards recovery. Initially, often through faith alone, individuals must trust their practitioner to help them assess their readiness for change and clarify their values regarding the changes they want to make.

The importance of rehabilitation readiness

Current perspectives on rehabilitation readiness have been influenced by theoretical models that propose stages of behavioral change. Such models offer explanations for both successful and unsuccessful attempts to stop or reduce problem behaviors, or to add or increase helpful ones to a person’s daily routines. These models also argue that interventions designed to facilitate behavioral changes must be matched with each specific stage of change in order to result in positive outcomes (i.e., success in changing).

The assessment of rehabilitation readiness is the beginning phase in the psychiatric rehabilitation process. Its intent is to help individuals to explore their hopefulness for and commitment to change. Because it lays the foundation for any life change to occur, this phase must precede other assessment processes (i.e., functional and resource assessment).

Assessing a person’s readiness for change

Psychiatric rehabilitation practices focus on helping persons with psychiatric disabilities change their lives in particular ways. Therefore, it is critical that individuals learn to assess their readiness for these changes. Since persons with psychiatric disabilities have the basic human right and capacity to influence their own lives, the practitioner engages individuals in a set of thoughtful discussions and/or values clarification activities (i.e., individual or group exercises) that accomplish the following:

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3Prochaska; Rogers; et al.
4Roger, et al.
- **Help individuals reflect on how satisfied or dissatisfied they are with their current situation.**

  Are their current living, learning, working, and socialization environments supportive and meeting their needs? Do they feel emotionally and physically safe? Do they feel that they get to make decisions about things that are important to them? Do they feel that these decisions are honored by others, particularly family members and/or professional caregivers? Do they feel that they have activities that match their interests, values, preferences and skills? Do they feel that they have access to supportive people who are important to them? Do they feel that they have access to the resources they need (i.e., financial, transportation, etc)?

- **Help individuals reflect on their current commitment to change.**

  In light of the assessment of their satisfactions and dissatisfactions, what changes do they feel they need to make? Do they believe that making these changes will increase their satisfaction, safety, or support? Do they believe that these changes are even possible? Do they believe that they have the support they need to make these changes?

- **Help individuals reflect on their awareness of alternative living, learning, working, and socialization environments (i.e., people, physical place, and activities).**

  How aware are they of the expectations, obligations, opportunities, and supports available in their current living, learning, and working environments? What do they know or need to know about the expectations, obligations, and supports available in alternative living, learning, working, or socialization environments in the local area?

- **Help individuals reflect on their awareness of self/personal preferences.**

  What are their interests, values, strengths, abilities, and preferences regarding their living, learning, and working environments?

- **Help individuals reflect on their relationships i.e., with family, friends, colleagues, as sources of support.**

  Who do they identify as important to them? How supportive and available are those individuals to help them reach their goals? To what degree do they have access to, trust, and feel supported by their mental health providers, including psychiatric rehabilitation practitioners? To what degree do they feel that working with these providers will result in success with their targeted outcomes? To what degree do they feel that their providers have the knowledge and skills needed to facilitate success with targeted outcomes?
Clarifying values

In addition to facilitating rehabilitation readiness, the practitioner helps individuals clarify their values. Values are the personal beliefs about what is important, right, or good. Individuals make life changes as a result of their decision that there is not a good fit between what is important and how they are living, learning, or working.

By helping individuals to identity and affirm their values, the practitioner will be better able to help prioritize the changes that the individuals need and want to make. The practitioner can do this through counseling discussions or through guided values clarification exercises or group activities, such as checklists or card sorting exercises (where the person rates sorts the action/need/preference as very important, important, important somewhat, or not important).

Scenario

Romero has been referred to an assertive community treatment (ACT) team to assist him in moving out of the IMD (Institute for Mental Disease), where he has been living and receiving treatment for the last year. He was placed in that setting by the court after he failed several attempts at living in the community. The staff at the IMD have determined that he no longer needs the functional support provided by their program and have initiated the referral to the ACT team. Romero’s conservator does not agree that Romero is ready to be discharged.

Susan works as a case manager on the ACT team. She and Romero are meeting for the first time today. How would Susan demonstrate her skill in conducting a rehabilitation readiness assessment or values clarification exercises?

Since Romero will need to make a decision about where he would like to live, Susan begins by helping Romero reflect on the things that he likes and dislikes about his current living environment. She also explores with him how ready he is to leave.

On this first visit, she starts by asking Romero to give her a tour of where he has been living. As they go around, she prompts him to share his likes and dislikes. She asks him to share with her what his favorite activities have been and also the ones in which he has chosen not to participate. She asks him to share with her what things about his current environment have made him feel safe and comfortable.

Romero acknowledges that he is happy to be leaving the IMD. He has not been satisfied with his stay because of the restrictions and requirements to go to groups. He really enjoys listening to the radio, but the staff doesn’t let him do that as much as he would like. He says that he has never been a very active person. He never liked school, and groups remind him of sitting in a classroom (SKILLS A and B).
Susan meets with Romero on several occasions over the next week or two. She continues to help him identify his preferences for and awareness of alternative living environments. Romero acknowledges that he isn’t really sure where he wants to live, but remembers having lived in board and care homes before he came to the IMD. He said he liked the companionship and the availability of meals at the board and care home. He also liked having a house manager to help him with his medication and laundry. Although he has been taking his medication with the help of the staff at the IMD, he remembers that in the past he would stop taking his medication. He thinks that is why he had to leave the board and care homes (SKILLS C and D).

Susan also helps Romero to reflect on and identify people who will be supportive of him when he moves to a new living environment. Romero shares that he likes the doctor he is working with at the IMD because she listens. As it happens, the doctor who works with the IMD also works with the ACT team. Romero is happy about that and thinks that it will help him. Together, they determine that a board and care home would be the best living option for him given his preferences. Romero’s awareness of what may have contributed to his failed attempts at community living is also helpful. His shows a preference for help with daily living skills and he knows that board and cares provide it (SKILLS D and E).

Susan brings information to Romero about two local board and care homes, both of which have only nine residents. Susan selected them because they are small and have the kind of daily living supports that Romero said he preferred. She brings photos so that Romero can get a sense of how they look. They schedule visits at each of the homes. Before they go, Susan helps Romero to identify the questions that he will ask the house manager and other residents to help him decide which home will be best for him. Susan and Romero also take a walk around the neighborhood of each home to see what is nearby. After visiting the two homes, Susan helps Romero to evaluate the positives and negatives of each home. He decides that for the most part the homes are similar, but decides on the one that is near a public park where he can go and relax (SKILLS C and D).

**Activities**

**Exercise 1** Reflect on your engagement/participation in your current living, learning, and working environments in light of the preceding five areas for rehabilitation readiness. How satisfied/dissatisfied are you with your current situation? How effective are your environmental supports? How problematic are the barriers in your environment? How much effort are you willing to expend to change? How much and what type of risk are you willing to take to change (SKILLS A & B)?
Exercise 2  Because some individuals in recovery experience cognitive disruptions, some professionals believe that these episodes can limit their ability to make sound decisions. Review the literature or consult a colleague to identify the nature of these cognitive disruptions. Think about how you would facilitate the rehabilitation readiness of someone with whom you were working who is experiencing cognitive disruptions. What specific strategies would you use to mediate the cognitive disruptions (SKILLS A & B)?

Exercise 3  Family members and mental health professionals often believe that persons with psychiatric disabilities are unrealistic about their future goals. Even mental health professionals with training in a psychiatric rehabilitation perspective may sometimes disagree with the individual regarding the likelihood of success toward a particular goal. Reflect with a colleague on a time in your past practice experiences when you were in such a situation. What did you do? How did you support or thwart the person’s efforts? Review the literature on rehabilitation readiness. How might a rehabilitation readiness perspective have changed your assessment or actions (SKILLS A & B)?

Review Questions  
1. What is the purpose of a rehabilitation readiness assessment?
   a. To determine service eligibility.
   b. To determine desire for change.
   c. To determine functional abilities.
   d. To determine resource needs.

2. Who is responsible for conducting a rehabilitation readiness assessment?
   a. The person with a psychiatric disability without assistance from psychiatric rehabilitation practitioner.
   b. The psychiatric rehabilitation practitioner without assistance from the person with a psychiatric disability.
   c. The person with a psychiatric disability in collaboration with the psychiatric rehabilitation practitioner.
   d. The psychiatric rehabilitation practitioner in collaboration with members of the individual’s support system.

3. Which of the following is not included in a rehabilitation readiness assessment?
   a. Perceived need for change.
   b. Impact of symptoms.
   c. Commitment to change.
   d. Self and environmental awareness.
Answer Key

**Exercise 1**
Practitioners need to appreciate what individuals in recovery are asked to do as they engage in the rehabilitation process. The outcome of this exercise is for you to have “experienced” one aspect of that process by looking at your own life. You should successfully identify behavioral and environmental targets for change, which are the result of your having clearly reflected on the five areas identified as part of a rehabilitation readiness process. You should pay particular attention to the relationship of how dissatisfied you are in relationship to the risk(s) you are willing to take to make things different (i.e., to change). In addition, you should understand the perception of your strengths and how it relates to the associated risks. Often we may be very dissatisfied with a situation, but do not believe we have the strengths or resources to make a change.

**Exercise 2**
Practitioners should maintain the fundamental belief that persons with profound disabilities can engage or participate in a rehabilitation readiness assessment process and fully participate in the community. This belief is an important ingredient in facilitating hopefulness. Despite disruptions in memory, attention, and problem solving, persons with psychiatric disabilities can still engage in the process. To reduce the impact of attention difficulties, practitioners can limit meeting times or the amount of time the individual needs to focus on a particular activity. Sensory strategies can be used to help the individual stay alert.

Meeting in familiar and safe surroundings is important because an anxious or uncomfortable person has difficulty concentrating. Meetings to discuss important concerns should be held when the individual is most alert. For those taking psychiatric medications, early mornings are often difficult because the sedative effects of the medication are worse at that time. To reduce the impact of memory difficulties, such as verbal memory, the practitioner can use visual prompts (e.g., photos or other personal objects). The practitioner can conduct sessions in the person’s home or another environmental context. Finally, the practitioner can use written materials to cue the person through each of the five rehabilitation readiness areas.
**Exercise 3** Reflecting on your practice behavior is a critical and ongoing obligation for all practitioners, particularly if there is a behavior that is counter to the values of psychiatric rehabilitation. This can occur for many reasons. For example, even with a fundamental belief in the right and capacity for persons with psychiatric disabilities to make their own decisions, it may prove difficult to agree with these decisions for fear that they present undue risk or are unrealistic, i.e., that the match between the skills/resources and goals is over emphasized or the barriers that could impede goal achievement are under emphasized. Reflecting on past experiences challenges a practitioner to identify ways to provide support to individuals in recovery in the future.

**Review Questions**

1. **b**

   Although rehabilitation readiness involves more than determining the desire for change, it does not involve (a) determination of eligibility, (c) determination of functional abilities, or (d) determination of resource needs. The determination of functional abilities (c) and resource needs (d) does not happen until after the readiness assessment has been completed.

2. **c**

   With help from the practitioner, the person with the psychiatric disabilities identifies areas of satisfaction and dissatisfaction, his or her preferences, the impact of environmental resources, the level of commitment for change, and the supports needed for the change to be successful. The practitioner cannot complete the rehabilitation readiness assessment alone (b), nor would he or she simply collaborate with the individual’s support network (d). Self-assessment (a) is important because the individual uses rehabilitation services to accomplish personal goals, however, the practitioner is an important part of the process.

3. **b**

   A rehabilitation readiness assessment is not designed to assess symptom status, functional status, or resource needs. The focus is on an individual's perceived need for change (a), commitment to change (c), and self and environmental awareness (d).
Please note that the following section
“TASK 3 – Minimize the negative effects of relapse”
is a excerpt from Chapter 8: Integrating Treatment and Rehabilitation
**TASK 3** Minimize the negative effects of relapse

When working with persons with psychiatric disabilities, the practitioner must develop intervention strategies (for health and mental health conditions) in order to minimize the negative effects of relapses.

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<td>A. Assessing changes in psychiatric symptomatology</td>
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<td>B. Assessing changes in behavior or appearance that may be indicative of relapse</td>
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“In order to assess changes in psychiatric symptomatology, behavior, and appearance, it is important that practitioners develop strong supportive relationships with individuals with whom they work.”

**Background**

To assess changes in psychiatric symptomatology, behavior, and appearance, practitioners must develop strong supportive relationships with the individuals they serve.

Practitioners can review events, thoughts, behaviors, and feelings that might signal relapse to identify key symptom clusters (e.g., hallucinations, delusions, negative thoughts) that are unique to each individual. Practitioners should always collaborate with the individuals in recovery to develop an inventory of these characteristics.
Interventions that minimize the negative effects of relapse can improve an individual’s quality of life and increase his or her ability to occupy productive roles in the community. Sometimes, practitioners need to make referrals for care to appropriate medical personnel, including primary care physicians or specialists for consultation on health maintenance strategies for diabetes, high blood pressure, or obesity. Ongoing linkages with medical services provide support to people in recovery because they learn about the interrelationship of physical and psychiatric disorders.

Practitioners must listen to other somatic complaints about medication side effects that may prevent successful role acquisition. For example, if tremors or drowsiness make it difficult for an individual to work, his or her practitioner can connect with the team psychiatrist to consider medication changes. When people in recovery report increases in psychiatric symptoms, the practitioner can teach illness self-management strategies and refer the individuals to seek psychiatric consultation if necessary.

Finally, if the individual is experiencing suicidal ideation, the practitioner may need to involve family members for 24-hour supports, hotlines or crisis intervention centers, and increased follow-up contacts to make sure that supports are effective, that stressors and symptoms are diminishing, and that the quality of life is sustained.

Scenario  
**Michael is the director of a case management program and coordinates services for people in recovery in Clubhouse, residential, and employment programs. He is anxious to reduce hospitalization rates, but he is also committed to the USPRA principle of psychiatric rehabilitation that “all people can grow and change” and that recovery is the ultimate goal of helping them establish normal roles in the community. What training and supervision strategies should Michael develop to help his program staff learn the skills that minimize the negative effects of relapse for the people in recovery?**

Michael should teach his staff about the primary symptoms of serious mental illness, the typical characteristics of early warning signs or stressors that may lead to anxiety and symptoms, and the natural supports that can help prevent relapse. Symptoms may include hallucinations, delusions, depression, suicidal ideation, bizarre behavior, paranoia, loose associations, flat affect, and incoherent speech (SKILL A).

Michael reviews the importance of talking with people in recovery about the early warning signs (e.g., insomnia, appetite disturbance, and irritability) and developing strategies if these signs are observed or reported. Substance abuse and physical illness may be common signals, but Michael wants to educate staff and people in recovery to recognize more subtle stressors, for example seeking isolation, reaction to being criticized, and issues related to intimacy, employment, and family relationships.
Practitioners need to help individuals in recovery develop many natural supports, i.e., people and activities that will provide support when needed (SKILL B). They need to pay attention to an individual’s physical problems and encourage regular check-ups with primary care providers. They can help establish concrete steps to pursue when somatic complaints are raised. Individuals in recovery may need support in making the necessary contacts and may need follow-up meetings to assess outcomes and/or the need for additional interventions (SKILLS C, D, E, and F).

Michael and the program staff can encourage individuals to work together to develop illness management plans that prevent relapse, preserve valued jobs, relationships, housing, and income, and avoid costly and painful hospitalizations (SKILL G).

Activities

Exercise 1  Rick has been referred to a new case manager for mental health services and is embarrassed to report a history of frequent hospitalizations. Previous providers have offered hope for him, but he doesn’t believe them. How can the new case manager help Rick understand his symptoms and early warning signs in order to prevent relapse?

Exercise 2  Susan is in an employment program, but frequently misses work. She tells her job coach that things just happen or she can’t get up on time. She reports that for the past week she has been feeling tired and dizzy. Get together with some colleagues and look at stressors that could be part of the problem. Then develop strategies to increase supports so that Susan is more successful in her new role. What skills might you rely upon?

Exercise 3  Joey lives in his own apartment, but consistently calls the crisis hot line. First, he complains that he is feeling anxious. Several hours later, he calls to say that he can’t sleep and is hearing voices that tell him to kill himself. Connect with another staff person and discuss how you might help Joey respond to his stressors and early warning signs with increased supports.

Review Questions 1. Helping an individual identify early warning signs can be important to:
   a. Help set new goals.
   b. Prevent hospitalization.
   c. Increase socialization.
   d. Maintain a healthy lifestyle.

2. Which of the following is not necessarily a stressor?
   a. Drug abuse.
   b. Physical illness.
c. Employment.
d. Toxic environment.

3. A person in recovery can increase natural supports by:
   a. Identifying activities that reduce anxiety.
   b. Listing people who are supportive.
   c. Developing a comfortable daily routine.
   d. All of the above.

**Answer Key**

**Exercise 1**

The new case manager can complete a clinical assessment that outlines current symptoms, those reported in the past, and a treatment history at previous hospitals, outpatient programs, and rehabilitation programs. He can also obtain consents to request information from previous providers. In the process of developing a relationship with Rick, he should ask which services were the most helpful in the past and which were not. He may ask to talk with family members who can share insight into behaviors that indicated a relapse in the past (SKILLS A and B).

The new case manager should help Rick understand that together they will develop goals and objectives that may help Rick avoid future hospitalization. They may decide that Rick should consider a goal that is more positive than one of avoiding hospitalization. He may offer alternatives, such as a comfortable daily routine, people to interact with, joining a Clubhouse, and finding employment.

Through a discussion of primary symptoms, the new case manager and Rick should review potential obstacles that have resulted in hospitalization and behavior changes that provide clues of early warning signs. They can also make an agreement about discussing symptom increases so that participation in new activities is not undermined (SKILLS D and E).

**Exercise 2**

Staff can review possible stressors by completing an inventory of Susan’s previous ones. Initial questions include the possibility of drug abuse, medical problems, overly critical or intrusive contacts, and/or a change in routine, such as irregular sleep patterns or appetite problems. If any of these exist, staff can make a referral to Susan’s primary medical care provider to assess treatment for recurrent medical diagnoses, such as diabetes, and to monitor the appropriateness of her current medications. Staff will suggest education for Susan about how to monitor sugar levels, check for body sores, eat healthier, and exercise regularly (SKILL C).
Staff should connect the team psychiatrist with Susan's primary care provider to provide a linkage between medical and psychiatric conditions. Staff may need to be assertive about this collaboration, which is vital to Susan's overall health and her ultimate success (SKILL G).

Finally, staff should pay particular attention to Susan when she has somatic complaints that may result in her not taking medications, medical or psychiatric, because of uncomfortable and unwanted side effects. Continued communication with prescribing providers will be essential to minimize these stressors (SKILL E).

**Exercise 3**

The practitioner can talk with Joey to find out more about the stressors that are causing him difficulties at night. As Joey describes his anxieties, the practitioner probes to find out Joey's activities during the day and during the evening at home. This is an attempt to ascertain if he is being over-stimulated (or not stimulated enough as can happen at a bland drop-in center), involved in substance abuse, experiencing a complicating medical condition, or is being stigmatized (SKILL D). Referrals can be made to other providers for these or other clusters of stressors. Counseling to learn how to deal with intrusive behavior, AA for alcohol abuse, and group meetings with neighbors to deal with stigma are some of the interventions that can be recommended (SKILLS D and G).

The practitioner should talk to Joey about his support network (people and activities) that empowers him to deal with the stressors more independently. The residential counselor does play a role at first, but Joey needs to gradually include relatives and neighbors who can provide positive interventions, which will lead to positive results on Joey's part. Helpful activities include listening to music, playing cards with a neighbor, doing a puzzle, or getting on a baseball team. All of these can become complimentary supports that reinforce each other (SKILL B).

**Review Questions**

1. **d**

   The goal of relapse prevention is to teach people in recovery how to anticipate and cope with the problem of recurrent symptoms in order to improve the quality of their lives and improve their ability to occupy productive roles in the community. Answers (a), (b), and (c) are important activities for people in recovery, but are not a broad enough reasons for practitioners to encourage identification of relapse prevention strategies.

2. **c**

   Employment is not necessarily a stressor if the person in recovery has a good job fit and has supports in the work environment. Answers (a), (b), and (d) are clearly stressors.
3. d

Pleasurable activities, friends who reinforce healthy life styles, and a regular daily routine increase the natural supports of people in recovery. Answers (a), (b), and (c) are all correct answers, but the combination significantly increases successful relapse prevention strategies.
Please note that the following section
“Task 7 – Advocate for changes to support optimal living”
is a an excerpt from Chapter 10: Systems Competencies


**TASK 7**  Advocate for changes to support optimal living

Practitioners need to learn the skills to advocate for system changes to support optimal living for persons with psychiatric disabilities.

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<td>A. Convening meetings of individuals from different service systems</td>
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<tr>
<td>B. Strengths of local, state, and federal resources</td>
<td>B. Suggesting changes for integrating services and resources</td>
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<tr>
<td>C. Service delivery system features</td>
<td>C. Matching service system and resources to a person’s needs</td>
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<tr>
<td>D. Limitations of local, state, federal, and services delivery systems</td>
<td>D. Matching service system and resources to a person’s goals</td>
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<td>E. Strengths of local treatment delivery systems</td>
<td>E. Acting to use services and resources from diverse systems</td>
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<td>F. Limitations of treatment delivery systems</td>
<td>F. Writing succinctly to communicate on behalf of the person’s needs</td>
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“There is no ‘one-size-fits-all’ in regard to services for persons with psychiatric disabilities. Therefore, there is no ‘one-size-fits-all’ solution.”

**Background**

Every person is unique and has different needs. Everyone needs resources for housing, health care, leisure, transportation, and other key components of life. People living in the community access these resources through multiple sources. For example, an individual might see a family practitioner for a cough, attend Abundant Life Community Church for spiritual needs, meet with friends at Joe’s Coffee Shop, ride the Metro bus, and live in the Green-tree Apartments.

**Different solutions for different people**

The same is true for individuals diagnosed with a mental illness. However, there is no “one-size-fits-all” in regard to services for persons with psychiatric disabilities. Therefore, there is no “one-size-fits-all” solution. Resources, in and out of the mental health system, must be uncovered and accessed to meet each individual’s needs and goals.
To meet the need, the practitioner should first determine if the resource is available in the community and how to obtain it. For example, if someone wants to get a GED, the practitioner helps by exploring natural community resources for help. A contact at the local community college to sign up for tutoring or classes could be a first step.

**The importance of community meeting groups**

Many individuals in recovery find themselves caught between provider systems because of eligibility requirements, funding streams, or other systemic barriers. Others have difficulty getting the resources they need because organizations can be narrowly focused and, therefore, do not interact effectively with other agencies.

These barriers, among others, can be addressed by the practitioner. Community-wide social service meetings can identify gaps in the service system, promote service integration, and determine effective solutions. These meetings are well established in many communities, often meeting monthly to discuss needs, plan projects, and exchange information about resources.

If there is no meeting group in the practitioner’s community, organizing one should be a priority. With one in place, the practitioner can bring service gaps or opportunities to integrate services to the attention of the community group and see a resolution of the problem.

Social service provider organizations, health care facilities, transportation providers, and others should be invited to the meeting by phone calls, email, and letters. Personal contact is always best, especially if the practitioner already knows someone inside the organization.

A diverse group that includes staff at all levels of the organizations, individuals in recovery, their families, business leaders, government representatives, and others becomes an effective problem-solving team. The diversity of the group also provides additional perspectives and reflects the make-up of the community. It also allows and encourages the use of natural resources, such as colleges, parks, libraries, and recreational facilities for individual needs.

**Scenario**

*Yolanda is a practitioner employed by Feathering Case Management Services. At a staff meeting, one of Yolanda’s co-workers talks about four individuals who need housing. The co-worker suggests that Feathering purchase a house for them and they could easily provide everything the residents need to remain in the community. Everyone, except Yolanda, thinks this is a great idea.*

*What is the problem with this plan? What should Yolanda do?*
Yolanda should point out that this plan does not take into consideration what any of the individuals want, e.g., where they want to live, how many people they want with them, or how much independence they want (SKILL D). While it appears to be an effective solution, it does not consider the housing needs or goals of the individuals involved (SKILL C).

Yolanda should suggest that the individuals be interviewed to determine their housing needs and goals (SKILLS C and D). She should follow up her comments with a letter that specifies her concerns (SKILL F). If existing resources do not meet the individual’s needs and goals, Yolanda could convene a meeting of community providers to brainstorm solutions, plan new resource development, or identify ways to better integrate existing resources (SKILLS A and B). She should include representatives from throughout the community, including business, health care, transportation, government, public resources, and social services (SKILL E).

Activities

**Exercise 1**  Marlene is a program manager for case management services. She notices that the supportive housing and employment service providers tend to serve the same individuals as her program does, and that some of the services are duplicated. Marlene’s agency has been notified that their budget will be cut. She is concerned about maintaining services, while making the needed changes in the budget. How can Marlene resolve this problem?

**Exercise 2**  Role-play the following scenario: One person will be Julie, who, after three years, will soon be discharged from the state hospital. Julie would like to live in an apartment with a roommate, find a job, and go back to school to upgrade her computer skills. The other person is the practitioner (you choose the type of program you are working in) who will help Julie transition to the community. Role-play an interview to determine what services and resources would help Julie meet her goals.

**Exercise 3**  Using the scenario from Exercise 2, write a letter on Julie’s behalf to the college she attended before her hospitalization. She has asked that you tell them she is receiving services, is in recovery, and would like to resubmit her admission application for the fall semester.

**Review Questions**  1. Heather is in recovery from alcoholism and a bi-polar diagnosis. Which of the following is an example of an integrated service for Heather?
   
   a. Double Trouble meetings
   b. Alcoholics Anonymous meetings and stress management groups
   c. Bi-polar support group and case management services
   d. Alcoholics Anonymous meetings and medication management
2. Which of the following is the best example of convening a meeting of people from different service systems?
   a. As a Supported Education Specialist, you attend a local Vocational Counselors meeting each month.
   b. As a Supported Education Specialist, you create a network meeting including other education specialists in your community, such as college special needs department representatives, state vocational rehabilitation counselors, and literacy council representatives.
   c. As an Employment Specialist, you attend your agency’s monthly safety committee meetings.
   d. As an Intensive Case Manager, you attend monthly meetings at the residential program live to stay informed of the progress of the residents.

3. You are a program manager for a full care residential facility and notice that none of the residents attend church even though their files indicate religious affiliations. What would be your best course of action?
   a. Invite your pastor to talk to the residents about services in the area.
   b. Advocate for a spirituality group for the residents once a week.
   c. Advocate for staff to introduce the residents to their church.
   d. Advocate for the resident’s opportunity to access the religious or spiritual community of their choice.

**Answer Key**

**Exercise 1** Marlene should contact the other provider agencies and suggest they meet to discuss how they can integrate their services and reduce duplication (SKILL A). The group might begin by listing all their services to identify areas of unnecessary duplication (SKILL B). They could develop a referral mechanism to facilitate access among services. They could review intake forms, eligibility requirements, and other agency or program-defined requirements to streamline the application process when someone needs services from multiple organizations (SKILL B). Using the list of available services, Marlene can determine where she can make changes in her agency to meet the budget reductions.

**Exercise 2** *Role-play dialogue:*

**Practitioner:** Congratulations, Julie. I hear you will soon be released from the hospital. My name is Ted, and I’m here to talk with you about your goals for living in the community.

**Julie:** Hi Ted. Thanks. I’m pretty excited about leaving here. I have been thinking about it a lot.
**Practitioner:** Great! Tell me what you’re thinking so far.

**Julie:** Well, I’d like to live in an apartment, but I think I’d like a roommate so I don’t get too lonely. I also want to get a job. Before I came here, I worked in a doctor’s office doing transcription. I was very good. Can you get me a job like that again?

**Practitioner:** You really have been giving this some thought. That’s great. Let me make sure I have your goals straight. You’d like an apartment with a roommate and a job as a medical transcriber.

**Julie:** That’s right. I know I’ll need to take my medications and all that, so I’ll need to find a new psychiatrist. I didn’t like the one I saw before. I also would like to have friends again. It’s been really lonely in the hospital, and my old friends probably have moved on by now.

**Practitioner:** That’s understandable. Let’s talk about the goal of getting an apartment. Are you working with anyone on that yet?

**Julie:** No. I don’t know how.

**Practitioner:** That’s ok. I can help you find the right person to help. Hearth and Home provides supportive housing services in your community. We can call them to see if they can help with the apartment (SKILLS C and D).

**Julie:** Yes. Let’s do that.

**Practitioner:** Where did you work as a transcriber? Do you think they would hire you again?

**Julie:** I worked for Dr. Blumstead. He got really mad at me for taking time out for meetings with my therapist. I don’t want to work for him. I need someplace where I can change my schedule around for appointments, support group meetings, and other stuff I need for recovery.

**Practitioner:** That sounds sensible to me. Would you be interested in receiving supported employment services to help you find a job and ask for any accommodations you might need (SKILLS C and D)?

**Julie:** Wow! There’s someone who can help with that? I’d love it. I also need to get back in school because my computer skills could use a boost.

**Practitioner:** Ok. The community college might be a good resource for the classes you want (SKILLS C, D, and E).

**Julie:** Yeah, I was thinking about that. I need extra help for school, though. I did badly before, and they asked me to leave. I’m not sure how to get back into school there. Can you write a letter for me and ask them to let me in?
**Exercise 3  Review letter** (SKILLS C, D, and E):

To Whom It May Concern:

I am writing on behalf of Julie Riotti, a former student at Garden County Community College. Ms. Riotti would like to enroll in computer courses at GCCC to improve her keyboard skills. She is a long time resident of Garden County and has had a career as a transcriber because of the skills she previously learned in GCCC courses.

Late in her previous enrollment, an illness prevented Ms. Riotti from being successful in her courses. Since that time, she has received treatment for the illness, and she continues to receive the services she needs to remain healthy and maintain her commitments.

Please allow her to enroll at GCCC for the coming semester. I am certain that Ms. Riotti will do her best to complete her courses successfully.

Respectfully,

Ted Dawkins

**Review Questions**

1. **a**
   
   Answers (b) and (d) only allow Heather to discuss her challenges separately. Answer (c) does not address her need for support with substance abuse.

2. **b**
   
   Answers (a), (c) and (d) are not from different service systems.

3. **d**
   
   Answers (a), (b) and (c) do not accommodate individual needs and may impose another person’s values on the residents.